Learning from research on experiences of health diplomacy in Africa

Rene Loewenson* & Bente Molenaar-Neufeld**

Citation: Loewenson, R. & Molenaar-Neufeld, B. (2015). Learning from research on experiences of health diplomacy in Africa. Journal of Health Diplomacy, Vol. 1, Issue 3.
Editor: Rachel Irwin, Karolinska Institute
Guest Editor: Rene Loewenson, Training and Research Support Centre (TARSC)
Manuscript Type: Review article – Peer-Reviewed

*Director, Training and Research Support Centre (TARSC), Zimbabwe. Email: rene@tarsc.org.
** Research associate, Centre for Trade Policy and Law, Carlton University, Ottawa, ON Canada

Learning from research on experiences of health diplomacy in Africa

RENE LOEWENSON & BENTE MOLENAAR-NEUFELD

Abstract
This paper presents the findings of research conducted under a wider two-year project (2012-14) that examined the role of African agency in global and south-south health diplomacy in addressing selected key challenges to health and health systems in east and southern Africa (ESA). This research synthesis draws from two desk reviews and a content analysis of three case studies on: (i) the involvement of African actors in global health governance on financing for health systems; (ii) overcoming bottlenecks to local medicine production, including through south-south co-operation; and (iii) health worker migration and the implementation of the World Health Organization (WHO) Global Code of Practice on the International Recruitment of Health Personnel. Based on the content analysis, the paper reviews evidence on African intervention in four key areas of health diplomacy: agenda setting, policy development, policy selection and negotiation and implementation. The evidence highlights the political and complex nature of global health diplomacy. Effective engagement is enabled in ESA by political leadership and champions with clearly articulated policy positions, regional interaction and unified platforms across African countries and good communication between sectors within countries, between national actors and embassies and with allies in the international community. Negotiators' understanding of issues and access to credible evidence mattered in policy development and selection. Technical actors, the domestic private sector and civil society appeared to play a weak role relative to the influence of development aid. The case studies suggest there is an opportunity cost in framing health diplomacy in the region within a 'development aid' paradigm, if the compromises agreed to lead to a dominance of remedial, humanitarian engagement in African international relations on health, with less sustained attention to structural determinants.

Background

From 2012 to 2014 the Regional Network for Equity in Health in East and Southern Africa (EQUINET) implemented a research programme in east and southern Africa (ESA) that examined the role of global and south-south health diplomacy in addressing selected key challenges to health and strengthening health systems in the region.

Global Health Diplomacy (GHD) refers to the processes through which states, non-state actors and intergovernmental organizations negotiate responses to health challenges or use health in negotiations to achieve other political, economic or social objectives. While health has been brought into foreign policy processes for several centuries, GHD is still an emergent concept, without a shared definition (Lee and Smith, 2011). While there is no articulated 'African approach' to GHD, a thematic analysis of published literature on African negotiations in global health found that these often invoked a liberation ethic, African unity, and developmental foreign policy (Loewenson et al., 2014). Shared positions have been built by the Africa Group at the World Health Assembly (WHA) and in continental and regional bodies on intellectual property, medicines access, migration of health workers, control of breast milk substitutes, food security, debt cancellation and fair trade (SADC, 2009; Loewenson et al., 2014).

There have been debates about whether it is in the best interest of public health to raise health in foreign policy (Hoffman, 2010; Gagnon, 2012; Haynes, et al., 2013; Loewenson et al., 2014). Fidler (2005) has suggested that health can be brought into foreign policy in various ways: (i) as regression, when health is purely addressed as a security issue, overriding public health norms and values; (ii) as remediation, when health is addressed through traditional foreign policy and has no special, transformative or ethical role in international relations, or (iii) as revolution, as a right, goal and shared global responsibility that has a transformative role in foreign policy. The review of literature on African negotiations in global health found concerns over the loss of sovereignty, on the role of private actors and over weak attention to underlying determinants of health (Loewenson et al., 2014). At the same time globalization, the level of external financing of African health systems and rising international interest in African resources have intensified global and international negotiations (AU, UNECA, 2007; Amosu, 2007). Drawing on specific experiences of GHD within the ESA region, we explored whether health and health system goals have been advanced in GHD processes and what factors have affected this. We did so through document reviews and through a deeper exploration of three areas that regional policy makers had prioritized: (i) involvement of African actors in global health governance on financing for health systems; (ii) collaboration in overcoming bottlenecks to local medicine production, including through south-south relationships; and (iii) health worker migration and the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel (termed the 'Code') (Loewenson et al., 2011).

The results of the desk reviews and of the three case studies are reported in full in separate published papers, including those in this issue of the Journal of Health Diplomacy. This paper seeks to synthesize the learning across the whole programme of work on the factors affecting the agency and uptake of African interests in global health diplomacy during the agenda-setting phase, policy selection and negotiations and implementation.

Methods

The methods for the reviews and case studies that this paper draws on are more fully described in separate papers (Loewenson et al., 2011; Loewenson et al., 2014; SEATINI and CEHURD, 2014; Barnes et al., 2014; Dambisya et al., 2013; Blouin et al., 2012). The document reviews (Loewenson et al., 2014; Blouin et al., 2012) included published and grey literature obtained using key word searches in online databases such as Google Scholar, Google Books, pubmed, medline, PAIS International, and other political science and foreign policy online libraries. The selected papers were reviewed first as abstracts, then as full papers and selected based on criteria related to the purpose of the paper (GHD in Africa in the first review and GHD conceptual frameworks and research methods in the second).

The three case studies used document reviews, semi-structured key informant interviews, and observation and thematic analysis of policy dialogue. The first case study investigated how local, national, regional and global health actors in South Africa, Tanzania and Zambia participate in decision-making processes related to performance-based financing mechanisms associated with the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund or GFTAM) and World Bank (Barnes et al., 2014). The second case study explored whether and how co-operation on production of medicines, including with co-operation with emergent economies, is addressing the bottlenecks (as identified by African and regional bodies) to pharmaceutical manufacturing, with a focus on Kenya, Uganda and Zimbabwe (SEATINI and CEHURD, 2014). The third case study explored how the policy interests of African countries informed the Code and how it has been used, implemented and monitored in ESA countries, particularly in Kenya, Malawi and South Africa (Dambisya et al., 2013). The studies obtained ethics clearances/authorizations and permission and verbal consent from all informants. National and regional diplomatic, policy and technical personnel in the relevant fields reviewed and validated the findings for all the studies.

This paper applied a manual thematic content analysis on the text of the reviews and case study reports, focusing on specific content areas within four phases in the policy process:

- Agenda-setting phase: analysing the timing, roles, processes and expressed interests of African and other actors; the policy content, relative to policy statements within the region, and the policy actors, forums and processes involved.
- Policy development phase: analysing changes in policy content and their African and other sources and the role of African actors, networks and alliances.
- Policy selection and negotiation phase: analysing stated factors influencing policy adoption and the role of and communication among African countries, regional and diplomatic actors.
- Policy implementation phase: analysing the factors influencing policy implementation and the use of implementation to raise agendas and negotiation issues.

The analysis identified common and different findings for each thematic area, particularly across the case studies, while the desk reviews were used to triangulate evidence, understand limitations of methods and interpret findings.

A number of limitations were identified. While the case studies sought to obtain deeper qualitative information, they included a limited number of countries and there were difficulties in accessing evidence not in the public domain, gaps in institutional memory and sensitivity in discussing some policy issues and processes (SEATINI and CEHURD, 2014; Barnes et al., 2014; Dambisya et al., 2013). Many African diplomacy interactions are unrecorded or unavailable, or documented through the lens of northern or global actors (Loewenson et al., 2014). There are inadequate theoretical or analytic frameworks for this area of work, and much published work is descriptive (Blouin et al., 2012). Despite these limitations the case studies yielded valuable information as one of the few empirical research projects on GHD in ESA (Blouin et al., 2012). The three case studies shared a policy analysis framework developed collectively at the inception, with evidence gathered on process, actors and policy content. Each study used a stakeholder analysis to locate the main actors at the outset and included new stakeholders identified during interviews, and the majority of key actors/sectors were included in the interviews. The case study interviews were supported and supplemented by other research strategies, including literature reviews and direct engagement with policy makers to review and validate evidence.

Findings

This section presents the findings of the content analysis on the three case studies, reported within the four focus areas of agenda setting, policy development, policy selection and negotiation, and implementation, and with a focus on the thematic categories outlined in the methods section.

The agenda-setting phase

The three case studies were selected because they address policy concerns in ESA countries (Loewenson et al., 2011). However, they show different levels of integration of ESA policy concerns in global or international policy agendas.

Partnership, participation and agency in global health policy are well-established normative aims at national to global levels, and regional policy bodies have sought to strengthen effective African representation in global bodies (Loewenson et al., 2011). The research conducted for the case examining performance-based financing (PBF) found divergent views, however, on how far Africans had shaped the PBF measures used by global agencies. On the one hand, the Rwandan government was widely cited as an innovator, whose experience on PBF had informed scale-up of the approach 'south to south' in other ESA countries. On the other hand, interviewees in Africa and in UN bodies reported a perception that external funders, particularly World Bank and Global Fund, had driven the introduction, design and in some cases even the targets of PBF (Barnes et al., 2014). Various factors blurred how and by whom the PBF agenda was defined. This case study also reported that the design was introduced as an expression of existing, rather than new, policy, operationalizing existing policy goals like participation, control of corruption, improved health and system outcomes and value for money. Informal dialogues in both Geneva and in countries were reported to play a role in shaping the design and uptake, as commented on by an interviewee:

> *"Geneva is a small place and we all know each other. We often chat about what's working and what's not, what needs more attention and what's getting too much.*

> *These chats filter into WHO policy and these policies affect the operations of the Global Fund and World Bank" (Barnes et al., 2014).*

These informal interactions made the features applied in the design of PBF appear to already be familiar to those involved by the time they were raised in more formal processes.

Technology transfer and access to medicines have become prominent issues in the current global agenda. The case study on south-south co-operation in overcoming bottlenecks to local medicine production explored these issues as they escalated in profile as a global trade issue. The resulting debates emerged with the intensely contested African Group draft declaration in 2001 on the TRIPS (Agreement on Trade-Related Aspects of Intellectual Property Rights) Agreement and Public Health, successfully negotiated as the landmark Doha Declaration that protected public health and access to medicines in the interpretation of the TRIPS Agreement (WTO, 2001; Loewenson et al., 2014). Africans levered support by linking medicines access to a recognized global issue – the AIDS epidemic – with further support from pressure from civil society on access to treatment as a human right.

While the case study on health worker migration, discussed later, found that this issue was largely brought to the global agenda by health ministers, international co-operation on local medicine production affects a number of sectors. African plans such as the Pharmaceutical Manufacturing Plan for Africa (PMPA) 2007 were raised at the level of heads of state (SEATINI and CEHURD, 2014), with meetings on the issue between African countries and those in the BRICS (including Brazil, Russia, India, China and South Africa) led by ministers of foreign affairs (South Centre, 2009). The health sector played a role in technical co-operation, such as in the African Network for Drugs and Diagnostics Innovation (ANDI) set up in 2009 to support research and development (R&D) on medicines, vaccines and diagnostics (SEATINI and CEHURD, 2014). Nevertheless, a decade after Doha, Kenya proposed a resolution at the 65th WHA in 2012 that the Director-General convene an intergovernmental negotiating body to draft and negotiate a WHO Convention on Research and Development Financing and Co-ordination, again elevating African voice on global negotiations on medicines, this time on technology and skills transfer, in alliance with Brazil and India (WHO, 2012; SEATINI and CEHURD, 2014).

Such south-south alliances appear to have given useful support to African voice in global platforms. A content analysis of policy statements made in high-level meetings of the BRICS (the collective body of Brazil, Russia, India, China and South Africa), of bilateral forums with Brazil, India and China and of the AU, SADC, East African community and East Central and Southern African Health Community (ECSA-HC) reported shared concern on medicines access in support of such south-south alliances (Brown et al., 2015). At the same time, the analysis also found divergent interests on how to achieve medicine access and less evidence of operational commitments supporting local production in Africa (Brown et al., 2015). The evidence suggests that while some alliances may help to raise the issue on policy agendas, others may be needed to support their implementation. This was also found in relation to the Code, discussed later.

Of the three case studies, the global policy agenda and policy articulated in the region were most directly linked in the case of health worker migration and the Code. African actors were at the forefront of raising concerns on health worker migration, with the 2001 Southern African Development Community (SADC) issuing a strongly worded ministerial statement that:

> *"the active and vigorous recruitment from developing countries…could be seen as looting from these countries…similar to that experienced during the periods of colonisation when all resources, including minerals, were looted to developed countries" (SADC, 2001).*

Similar concerns were articulated in other ESA policy forums between 2003 and 2010. ESA ministers of health escalated the issue to a global level in meetings with global institutions in that decade (WHO, World Bank, UNESCO), with health worker losses blamed as undermining the achievement of the Millennium Development Goals (Dambisya et al., 2013; Kirigia et al., 2006). From 2004, when African health ministers raised a resolution at the WHA, they maintained pressure on the issue, with a subsequent WHA resolution in 2005 (tabled by South Africa for the Africa group) urging implementation of the 2004 resolution. This was followed by high-level meetings and processes (described below) that sustained attention on the issue and motivated the drafting first of bilateral and multilateral codes and then the global WHO Code (Dambisya et al., 2013). The language used – and reference to colonial practices – evoked a liberation ethic, while linking the issue to delivery on the MDGs raised its global relevance and built support from northern actors, backed by evidence on health worker shortfalls to support the arguments (Dambisya et al., 2013). African voice, particularly that of health ministers and regional organizations, was identified as instrumental in raising health worker migration and recruitment as a global policy issue (Gilson & Erasmus, 2005; Chen & Buofford, 2005; Taylor & Dillon, 2011). Subsequent sections explore how far this agenda was sustained in the course of policy negotiation.

The policy development phase

The changes that took place as the policies examined were developed are not always reported in the public domain, especially where they were advanced in informal networks. Nevertheless, supported by evidence from key informants, this section presents the findings on how the policies or agreements developed and the roles, processes and factors that affected this. The three policy areas reported in the case studies are rather different: one (agreements on medicine production) with international co-operation negotiated nationally; one (on PBF) largely negotiated and spread within ESA countries by global finance institutions; and the last (on the Code) negotiated at global level. This affects the policy development phase.

As noted in the case study on medicine production, bilateral negotiations on local production took place at the executive level of government and generally not in the public domain. How far BRICS positions on fair access to medicines and to innovation reported in the policy content analysis (Brown et al., 2015) were carried into bilateral negotiations on medicine production thus needs to be inferred from subsequent practice. The case studies on medicines production reported the presence of clear policy statements in the region on the bottlenecks to be addressed in local production that

would be expected to inform co-operation on local production. These bottlenecks included shortfalls in capital and public investment, skills, regulation and enforcement capacities and R&D capacities; disabling tariffs and infrastructures; competition from cheaper imports and fragmentation of local markets. The case studies also reported limited links and mechanisms for technology transfer and sourcing of active pharmaceutical ingredients (SEATINI and CEHURD, 2014).

An assessment of the co-operation between the Uganda Quality Chemicals International Limited (QCIL) and India's Cipla Limited suggested that some of these bottlenecks were addressed through African influence on the content of the agreements, including establishment of an R&D unit, capital investment, skills training and some level of technology transfer. The involvement of officials at top levels of government in Uganda facilitated provision in return of favourable tax and tariff measures, infrastructure and market access. In both cases these provisions were limited to the QCIL plant and not more widely spread in the industry (SEATINI and CEHURD, 2014). A number of international co-operation initiatives were reported in the ESA region, such as on ANDI, on pharmacist recruitment and on market access. However the medicines production case study reported that other bilateral agreements between the ESA countries studied and emergent economies had not materialized or had taken significantly longer than planned, thus making it difficult to assess policy development in these cases. Key informants raised concern that despite stated policy intentions on co-operation in south-south forums, the fact that technical partners from countries in BRICS also provide the finance and technology makes them relatively powerful in negotiating agreements. This means that African countries must negotiate mutuality of benefit, as in any other form of international co-operation, notwithstanding shared policy intentions. Hence, for example, China's role in providing active pharmaceutical ingredients for Indian generic production, and the dominance by India of the supply of generic medicines to countries like Kenya "raises questions about how far there will be real willingness to support local African production" (SEATINI and CEHURD, 2014: 37; UNDP, 2013).

Evidence on the process of policy development was more accessible in the other two case studies: first the case considering the involvement of African actors in global health governance on financing for health systems; and the second on the Code. The first, the study on African participation in the design of global financing explored (i) pay for performance (P4P) schemes, where attainment of specific targets resulted in payments, and (ii) older models of aid conditionality, where objectives, indicators and targets are set by recipients. The case study noted "the design and conception of PBF [to be]... politically complex" (Barnes et al., 2014:21). The process built on relatively well-established technical working groups, review meetings, subcommittees and formal networks, often involving a range of national stakeholders.

The African negotiations were thus less affected by the level of formal participation than by its quality, in terms of negotiators' understanding of and familiarity with the proposals and their access to credible evidence of their impact on the health system. Negotiations were also significantly affected by the relative power of different groups in these forums, particularly given the involvement of external funders. External funder interests were reported to be accepted largely as a reasonable demand of aid delivery, focusing the debate in policy development less on whether PBF should be applied than

on the targets and how they would be monitored and evaluated. Even in these areas, some inequality was reported in the negotiations, depending on the economic strength of the recipient country. On the one hand, external funders were seen to be open to concerns. Differences and uncertainties were addressed in part through visits to countries where PBF was being applied, through evaluation of pilot sites and through brokerage support from other global agencies, such as UNAIDS. On the other hand, some African interviewees raised concerns that highlighting negative impacts was seen to threaten access to new external funding linked to PBF, and that external consultants and accountancy firms had a large influence on design of targets and evaluation of performance. In all the case study countries the 'bottom line' for policy development was an end goal of access to additional health system funding that overrode uncertainties on design. As stated by a Zambian respondent: "They ask if you want the money, you want the money, so you do the project" (Barnes et al., 2014: 23).

While countries did thus have input to policy development, the compromises made led to a number of concerns over the targets and design fragmenting the system, the targets selected, conditional accounting targets, high administrative and monitoring demands, a lack of confidence in the audit system used by external funders and their local fund agent and lack of clear, nationally owned arbitration procedures (Barnes et al., 2014).

The relative power imbalance noted in the two case studies above on medicines and financing was less evident in the early years of policy development on the Code. The African political leaders that led this process and their political framing of the issue may have provided some leverage in this power imbalance. African political, technical and diplomatic actors negotiated bilateral and multilateral codes before the global negotiations, often after dialogue within regional organizations, and the Africa Group facilitated unity across countries in the inputs made in the WHA and on the global Code. Tracking development of the global Code, Taylor and Dhillon (2011) found that many of the issues raised by African countries were integrated into the text. However, the clauses on compensation and mutuality of benefits faced strong opposition from developed countries, many of whom were both external funders and destination countries of health workers from ESA countries. African key informants observed that the final Code fell short in addressing issues of compensation to source countries, support for training health professionals, arrangements for return, thus inadequately addressing the impact of health worker migration on health systems in the region (an issue termed "mutuality of benefit"). They were also dissatisfied with the soft law nature of the Code (Dambisya et al., 2014). Taylor and Dhillon (2011) relate these losses in policy content to a loss of African voice in policy development. However, they also noted that when this voice was regained during the final drafting committee process, monitoring and reporting mechanisms that northern countries had initially opposed were reintegrated (Taylor and Dhillon, 2011). At the same time, the case study suggests that perceptions on the issue also shifted within the ESA region, with migration falling as a concern as development aid began funding health workers. While Africa Group positions strengthened unity, the case study reports that there may have been inadequate engagement with individual country views as positions shifted, attenuating African voice in the process (Dambisya et al., 2014).

The policy selection and negotiation phase

African states were reported to be actively engaged in the policy selection and negotiation phase in some areas, but less so in others. The processes noted above in relation to the Code case study, included strong policy statements within the region, and a decade of diplomatic engagement, advocacy and meetings. Critically, the negotiation of multilateral instruments such as the 2003 Commonwealth Code of Practice on Ethical Recruitment of Health Personnel and bilateral instruments such as the 2003 Memorandum of Understanding between South Africa and the United Kingdom on ethical recruitment of health workers, reinforced the ultimate adoption of the global Code in 2010. On local medicine production, African global engagement on public health protections in intellectual property agreements and on research and development (R&D) on medicines were supportive of local production, although not directly so (Loewenson et al., 2014; SEATINI and CEHURD, 2014).

Notwithstanding the positive role model of Rwanda in the work on global financing, in the case study examining PBF, African actors were seen to have weaker influence in designing financing policy than that of external funders:

> *"The World Bank and Global Fund have a key role in driving (or attempting to drive) forward PBF interventions within African health systems. External funders have invested significant volumes of money in generating knowledge about health sector-oriented PBF" (Barnes et al., 2014:29).*

Being less dependent on external funding, as was the case in South Africa, was reported to give countries more power to shape policy and implementation.

Unity of voice, strong regional, national and international linkages among stakeholders and multisectoral engagement-were also found to strengthen African influence in policy selection. This was evident, for example, in negotiations on the Code (Dambisya et al., 2013) and in decision-making on the design of PBF (Barnes et al., 2014). Partnerships, both south-south across countries and public-private within countries, were also reported to facilitate uptake of African policy positions on medicine production (SEATINI and CEHURD, 2014).

Having prior bilateral or multilateral instruments, as with the Code, or positive role models in countries were reported to facilitate and inform policy selection (Dambisya et al., 2013). Another example is drawn from the case study on medicines production, where the partnership between QCIL and CIPLA Limited on R&D and capacity development enabled processes for compliance with WHO Good Manufacturing Practices (GMP) in the ESA region. Such examples acted as role models, motivating and informing further negotiations and reinforcing policy implementation, discussed further below (SEATINI and CEHURD, 2014).

Policy selection was reported to be enhanced by 'champion' countries and actors: Kenya, Zimbabwe and Malawi through, amongst other things, engagement at the WHA, were mentioned as champions of regional interests on the Code and on intellectual property, medicines access and R&D (SEATINI and CEHURD, 2014; Dambisya et al., 2013; Loewenson et al., 2014). South Africa was noted to have had strong influence in shaping global financing for HIV in line with national system targets "through internally

driven mechanisms" (Barnes et al., 2014: 44; Biesma et al., 2009). Regional agreements and champions were also supportive, such as the African Union (AU), SADC and East African Community (EAC)'s pharmaceutical policies, the statement by SADC health ministers on the recruitment of health personnel by developed countries, and various SADC and ECSA-HC resolutions on health worker recruitment (Dambisya et al., 2013; SEATINI and CEHURD, 2014).

By contrast, competing interests, and especially opposing interests from northern actors, appeared to be a significant barrier to the inclusion of content proposed from African countries in global policies and agreements. Opportunities of external funding were noted earlier to influence positions on PBF design, while a powerful pharmaceutical lobby allied with high-income countries (some of whom fund medicines supplies through development aid), presented a strong opposing lobby in negotiations on patent protection (SEATINI and CEHURD, 2014; Elbeshbishi, 2007).

Influence in policy selection was weakened when ESA countries had conflicting or competing interests and positions or weak domestic policy support, poor communication and co-ordination across domestic actors and limited involvement of African civil society (SEATINI and CEHURD, 2014; Dambisya et al., 2013; Barnes et al., 2014). For example, the case study on the Code reported that the resistance of many high-income countries to clauses on compensation, mutuality of benefit or enforceability of agreements became a more influential factor in policy negotiation and selection when some African countries also began to see migration as a source of income or better dealt with through traditional aid approaches, raising competing interests on the issue (Dambisya et al., 2014; Taylor and Dhillon, 2011).

Communication flows appeared to have a key influence on both policy negotiation and implementation. Dialogue, regular meetings, communication between capitals and embassies, through the Africa Group at the WHA and through regional organizations in the ESA region were found to strengthen and co-ordinate African voice in negotiations on the Code (Taylor and Dhillon, 2011). Conversely, the design of PBF and agreements on pharmaceuticals were noted to be weakened by irregular communication between national organizations and between national and regional actors, weakening national input and "learning…generated between national governments and their individual experiences" (Barnes et al., 2014: 56).

The implementation phase

The presence of specific mandates, leadership, implementation and the use of monitoring and reporting can increase the likelihood that diplomacy leads to actual change in health systems and supports accountability on policy commitments. As noted earlier, leadership may shift during diplomatic processes, from those who negotiate agreements to a different group of actors who implement them.

Despite strong policy commitments from within the region and some measures being implemented, comprehensive implementation on both the Code and policies for overcoming bottlenecks to medicine production had been slow by the time of the research. The time taken to negotiate the Code made institutional memory critical to translate negotiation into implementation. While it is still early to evaluate the outcome,

weaker implementation of the Code was attributed to a decline in concern over health worker out-migration by 2010 compared to internal migration, underfunding and absolute shortages of health workers (Dambisya et al., 2013). The lag in implementation was further attributed to a range of factors: turnover and loss of leading national and regional voices, lack of dissemination and awareness of the instrument, poor communication with other sectors affected and weak follow-up from the WHO with changes in its global secretariat apparently downgrading the issue (Dambisya et al., 2013). There is also a reported perception that agreements represent the end, rather than the start, of the process. One key informant summed it up as:

> *"What happened at the WHA in 2010 was it for the Code. We then went back to other things. For the Code, it was mission accomplished, and we didn't have any more energy for it" (Dambisya et al., 2013: 20).*

Implementation appears to be more likely when it is synergistic with existing domestic practice. For example, speaking of the Code, a key informant from Malawi stated:

> *"… in all honesty, we have not done anything directly related to the Code. But when looking at the Code you can see that we are doing things expected from the Code… the discussion on support for training, our strategic direction on HR, all those are in the spirit of the Code. Yeah, but not because of the Code, perhaps…" (Dambisya et al., 2013: 26).*

Implementation was thus found to depend in part on the existence of appropriately resourced actors and institutions. Overburdened ministry level human resource (HR) departments saw the Code as adding to, rather than, supporting other responsibilities, thus weakening implementation. One key informant put it this way:

> *"You get back from the World Health Assembly full of morale, many new ideas, but also many tasks generated. As you settle down, you realize that the work you left pending before the WHA is waiting for you. And the work plans do not include the new issues for the remainder of the year" (Dambisya et al., 2013:25).*

The strength of the monitoring and evaluation frameworks, availability of information and dissemination of reporting were found to support implementation. Conversely, a lack of dependable information, limited up-to-date data and weak public reporting on agreements and their implementation meant that policy-makers, parliamentarians and the public were less able to assess whether interventions are working as designed and to build learning for the next round of negotiation (Barnes et al., 2014; SEATINI and CEHURD, 2014; Dambisya et al., 2013).

Implementation also depends on enabling policy and legal frameworks. For example, Kenya's national industrialization policy framework (2010) was reported to encourage procurement of locally manufactured pharmaceutical products (SEATINI and CEHURD, 2014; Government of Kenya, 2010). Other factors affecting implementation of agreements included leadership from a designated authority (as observed in the Code) (Dambisya et al., 2014) and dissemination of negotiated outcomes to all implementation levels, as found in the work on PBF (Barnes et al., 2014).

These factors do not depend only on the health sector. In all three case studies, beyond the involvement of foreign affairs in negotiations, the implementation of policy commitments called for other sectors to act, such as to reduce tariffs on imported inputs, provide reliable infrastructures, domestic financing (in PBF) and skills training and to implement legal reforms on medicine production. In all three case study areas, ministries of foreign affairs, finance, education, labour, planning and national development, immigration, infrastructure, and various regulatory councils needed to be co-ordinated for implementation (Dambisya et al., 2013; SEATINI and CEHURD, 2014; Barnes et al., 2014). Also, in all cases, the weak involvement of civil society was reported to not only weaken leverage of African positions in global negotiations, but also to weaken accountability in implementation (Dambisya et al., 2013).

Discussion and conclusions

Overall, the research carried out in this project suggests that there is variation in the factors that influence the effectiveness of negotiation of health agreements and co-operation at different phases of the policy process, depending on the issue. Nevertheless, some conclusions may be drawn from the findings within the theme areas of agenda setting, policy development, policy selection and negotiation and implementation.

African agency and interests in global policy agendas

On agenda setting, the three cases highlight that there is no 'toolbox' for bringing ESA policy concerns to the global agenda. Some strategies do appear more frequently, including linking the issue to existing global norms (such as fair participation; rights to access treatment), commitments (such as MDGs) or concerns (such as HIV); building and articulating unified positions across African countries through regional bodies and through alliances with other strong actors (including from northern countries, Brazil and India); and linking political, sectoral and diplomatic leadership to technical and/or civil society support. The findings highlight that the process is complex and that it takes time to build support to push an issue forward. The cases appeared to have limited involvement of civil society or domestic private sector actors, except in the early negotiations on medicine access. It could be argued that weak involvement by non-state actors deprives state actors of support from sustained social pressure, local technical information and domestic role models of practice, all noted to be contributors to agenda setting and policy selection. The case studies highlight the complexity of advancing health sector policies, such as those medicines and HR, where many other sectors have influence; and suggest these are more easily addressed where there is already multisectoral co-ordination in countries (Loewenson et al., 2014).

The successful escalation of the issue of health worker migration from the regional to global level appeared to be due to a strong starting position and clear policy rooted in regional principles and dialogue; sustained and amplified through ministerial, multilateral and other forums; and consolidated through negotiation of subsidiary instruments, even before it got to the global level. Political and diplomatic actors appeared to be the most influential 'policy innovators' in that issue. This pathway suggests the importance of links between capitals and embassies in the agenda-setting phase, to give a platform in diplomacy to political actors in ESA countries, and also for diplomats to engage more effectively in global-level informal networks and alliances that play a role in shaping agendas. It points to the positive value in building positions,

evidence and support regionally over a sustained period to create and maintain momentum on agenda setting and policy development and selection. It further highlights the value of information across governments, including to and from diplomats, to support political voice with evidence.

Uptake of African interests in global policy development and selection

The findings highlight that the process of policy development globally is a political one, whose technical dimensions can widen or reduce power imbalances between international actors. While in two cases (medicines and financing instruments) it was crafted as 'co-operation', this did not negate the fact that different interests and levels of power were involved, with mixed outcomes in the policy content a reflection of this power differential across those involved. The findings consistently point to the influence on agenda setting and policy selection of agencies that are both technical partners and funders. These may be global agencies, such as on HR, or emergent economy 'partners', such as on medicines, who bring both funding and technical resources to processes, often to underfunded sectors in ESA countries. The economic status and level of external funding of African health systems appeared to play a significant role in the power relations around policy development in all three areas, with external funders – and the consultants they bring – having leverage beyond the technical arguments and processes.

A number of factors were noted to enable African influence in shaping policy development in this context. Policy selection and negotiation appear to rely on strong, unified positions, effective leaderships and sound knowledge of the issues, particularly as power imbalances sharpen during negotiations. Hence, for example, in the Code case study, leadership and strong policy statements within the region and a history of diplomatic engagement and advocacy on the issue of health worker migration supported negotiation and adoption of the Code. A unified African position helped promote shared African interests in the final outcome, even in the face of strong opposing positions (Dambisya et al., 2013). Other factors included having: clear policy positions on the issue, at country and regional levels, shared across sectors and with diplomats; strong political leadership and sufficient public articulation of issues and positions to engage wider stakeholders; clarity and support from technical actors; and alliances across countries within and beyond the region. Strong political leadership, champions and positions, regional and continental unity and evidence from role models and alliances were also noted in the findings to redress this power imbalance.

Consultants from global agencies appeared to play a more visibly influential role in policy development and selection than local technical personnel. The link between technical and funding power raises an argument, however, for involvement of independent technical brokers, not linked to funding, whether from WHO or from within the ESA countries and regional organizations. Investment in public sector research and development, in the quantity and quality of scientific/technical personnel, collaboration across R&D and technical institutions and with domestic private sector were noted in India, for example, as contributing to the country's successful capacities in international trade (Lunogelo and Baregu, 2013). Other factors were less clear in their impact: informal networks appeared to play a role in shaping policy development, such as in the dialogue on PBF, but are less transparent and so their role is not as easy

to define. African unity at a global level strengthened African voice, as noted above, but there was a question in the negotiation on the Code about how far it accommodated or ignored individual country views. Civil society representing affected groups appeared to play a limited role in policy development in all three case study areas reviewed, despite the evident political nature of the process.

Several additional factors affected policy selection. Firstly, the presence of policy and legal frameworks provided parameters for choosing policy. Regional or other agreements or role models; alliances and partnerships on shared positions, champion countries linked to regional networks and exchange and unity of voice, as built in the Africa Group provided support for African positions in negotiations on the Code and on medicines production. Also in these two areas, making reference to domestic policies and having examples of local practices that demonstrate the policy positions being negotiated were observed to support policy selection and implementation.

Barriers and facilitators to implementation

At the same time the case studies highlighted shortfalls: in the use by African actors of informal spaces for engagement and regional processes for reviewing and informing policies; in the implementation of domestic policies that align to foreign policy positions (such as in the case of local production); and in domestic capacities and communication on global processes within and across ESA countries.

These shortfalls in communication and wider awareness of the content of global negotiations and co-operation agreements were found to combine with inadequate support from global institutions and limited data to weaken implementation and monitoring of agreements. The Code case study particularly highlights this point. The authors conclude that three years after its adoption, the Code was largely unknown in the region, in part due to an absence of local champions and overburdened HR departments (Dambisya et al., 2013). The negotiations on PBF were noted to face challenges in the lack of reliable information and effective monitoring frameworks to both set and adequately evaluate the success of targets (Barnes et al., 2014).

The implementation stage generally brings a new set of actors to translate negotiated agreements/policy into health system change that need to be appropriately informed and resourced. At the same time, as found in the studies, embedding implementation within existing processes so they do not represent additional tasks is important for already overburdened actors. The long time frames in which many negotiations take place call for mechanisms for institutional continuity, whilst recognizing the need to communicate and transfer mandates to different management actors for implementation. The existence of clear and effective monitoring and evaluation frameworks can help increase the likelihood of effective implementation. The findings suggest that co-operation agreements and global negotiations need to include resources, duties and information systems and support for monitoring and evaluation methods and capacities to facilitate implementation.

Opportunities, challenges and limitations to diplomacy in health

This paper began with Fidler's three ways in which health is applied in foreign policy, viz: as regression, as remediation or as revolution (Fidler, 2005). In the case studies, African actors raised health in the 'revolution' framework, seeking greater global justice on health worker migration, health financing or medicines access. However, the negotiations themselves evolved more as remediation, with compromises made reflecting more traditional relations. The policy initiative to challenge losses from health worker migration, to strengthen local production or negotiate fairer global measures on innovation and intellectual property represent forms of structural diplomacy, challenging current global norms. However, over time the forms of co-operation around these areas have been shaped more by development aid paradigms than by critiques of global inequality and injustice that are used to influence public perceptions and generate the symbolic capital of public diplomacy in order to advance or protect regional interests (Bustamente & Sweig, 2008).

Proposals to strengthen proactive, political and policy driven approaches that sustain pressure for public health norms and goals, including through the inclusion of key domestic stakeholders, can play a role in more transformative global health diplomacy. Many measures are domestic, and some call for strengthened regional co-operation as a basis for global engagement, while recognizing the different situations of member states in these organizations.

There is, however, also a question of the paradigm of health diplomacy prevailing in Africa, as is suggested by the findings, particularly given the significant interest in African resources. The case studies suggest that there is an opportunity cost in framing health diplomacy in the region within a 'development aid' paradigm, if the compromises agreed to weaken longer-term systems and capacities. As one key informant noted in the case study on medicines access, donations of essential medicines produced outside the country, while important for health services, also raised dependency on donated medicines, reducing the incentive to invest in local pharmaceutical production. Disease-focused aid initiatives can be argued to have led to a dominance of remedial, humanitarian engagement in African international relations on health, with less sustained attention to structural determinants, such as the public health impacts of unfair trade. In such circumstances, as raised in the case study on governance, for health to have a transformative role in foreign policy, countries would need to be willing to say no.

Acknowledgements

This work was implemented in a research programme of the Regional Network for Equity in Health in East and Southern Africa (EQUINET) on global health diplomacy in east and southern Africa supported by IDRC (Canada). Special thanks to Andreas Papamichail for support with analysis and to the case study teams for their separately published reports.

Disclaimer of interest

The authors declare that they have no competing interests.

References

Amosu, A. (2007). Dangerous times for Africa. *Review of African Political Economy*, 34(114), 711-713.

AU, UNECA (African Union, United Nations Economic Commission for Africa). (2007). Accelerating Africa's development through diversification. Ethiopia: AU, UNECA.

Barnes, A., Brown, G., Harman, S., et al. (2014). African participation and partnership in performance-based financing: A case study in global health policy. *EQUINET Discussion Paper 102*. Harare: EQUINET.

Biesma, R.G. et al. (2009). The effects of global health initiatives on country health systems: A review of the evidence from HIV/AIDS control. *Health Policy and Planning,* 24:239-52.

Blouin, C., Molenaar-Neufeld, B., Pearcey, M. (2012). Annotated literature review: Conceptual frameworks and strategies for research on global health diplomacy. *EQUINET Discussion Paper 92* CTPL\EQUINET, July 2012.

Brown, G.B., Loewenson, R., Modisenyane, M., Papamichail, A. (2015) Business as usual? The role of BRICS co-operation in addressing health system priorities in East and Southern Africa. *Journal of Health Diplomacy*, 1(3).

Bustamante, M. & Sweig, J. (2008). Buena vista solidarity and the axis of aid: Cuban and Venezuelan public diplomacy. *Annals of the American Academy of Political and Social Science,* 616(1), 223-256.

Chen, L.C. & Boufford, J.L. (2005). Fatal flows – doctors on the move. *New England Journal of Medicine,* 353:1850-2.

Dambisya, Y.M., Malema, N., Dulo, C., Matinhure, S., 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*. Harare: EQUINET.

Elbeshbishi, A.N. (2007). TRIPS and public health: What should African countries do? *ATPC Work in progress No. 49*. Addis Ababa: Economic Commission for Africa.

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

Gagnon, M.L. (2012). Global health diplomacy: Understanding how and why health is integrated into foreign policy (Doctoral dissertation). Retrieved from: http://www.ruor.uottawa.ca/en/handle/10393/23142.

Gilson, L. & Erasmus, E. (2005). Supporting the retention of HRH: SADC policy context. *EQUINET Discussion Paper 26*. Johannesburg: EQUINET and Health Systems Trust.

Government of Kenya. (2010). Kenya National Industrialisation Policy Framework (draft five), Nairobi: Ministry of Industrialisation.

Haynes, L., Legge, D., London, L., McCoy, D., Sanders, D. & Schuftan, S. (2013). Will the struggle for health equity and social justice be best served by a Framework convention on Global Health. *Health and Human Rights*, 15(1), 111-116.

Hoffman, S.J. (2010). Strengthening global health diplomacy in Canada's foreign policy architecture: Literature review and key informant interviews*. Canadian Foreign Policy Journal,* 16(3), 17-41.

Kirigia, J.M., Gbary, A.R., Muthuri, L.K., Nyoni, J. & Seddoh, A. (2006). The cost of health professionals' brain drain in Kenya. *BMC health services research,* 6:89.
Lee, K. & Smith, R. (2011). What is 'global health diplomacy'? A conceptual review. *Global Health Governance,* V(I). Available at:
http://blogs.shu.edu/ghg/2011/11/21/what-is-%E2%80%98global-health-diplomacy-a-conceptual-review/.

Loewenson, R., Machemedze, R. & Manyau, E. (2011). Research to support strategic leadership in Global Health Diplomacy in east, central and southern Africa, TARSC, SEATINI (EQUINET) and ECSA HC. *Discussion Paper 88*. Harare: EQUINET and Arusha: ECSA HC.

Loewenson, R., Modisenyane, M. & Pearcey, M. (2014). African perspectives in global health diplomacy. *Journal of Health Diplomacy*, (March).

Lunogelo, H.B. & Baregu, S. (2013). Indo-Africa relationship: Opportunities for technology transfer between India and African countries, *Economic and Social Research Foundation Discussion Paper No. 52*. Dar es Salaam.

SADC (Southern Africa Development Community). (2001). Statement by SADC health ministers on the recruitment of health personnel by developed countries' [Cited by Pagett, C. & Padarath, A. (2007) in A review of codes and protocols for the migration of health workers. *EQUINET Discussion Paper 50*. Harare: EQUINET].

SADC (Southern Africa Development Community). (2009). Round 9 proposal. London: HIV Cross Border Initiative.
SEATINI, CEHURD. (2014). Medicines production and procurement in east and southern Africa and the role of south-south co-operation. *EQUINET Discussion Paper 104*. Harare: EQUINET.

South Centre. (2009). South-south co-operation principles: An essential element in south-south co-operation. Geneva: South Centre.
Taylor, A. & Dhillon, I. (2011). The WHO Global Code of practice on the international recruitment of health personnel: The evolution of global health diplomacy. *Global Health Governance* 5(1).

UNDP (United Nations Development Programme) (2013). *Intellectual Property Rights and Access to Affordable ARVs in China*. Bangkok

WHO (World Health Organisation) (2012). Research and development co-ordination and financing report of the expert working group. Geneva: WHO. Available at: http://www.who.int/phi/documents/RDFinancingEN.pdf

WTO (World Trade Organisation) Ministerial. (2001). Declaration on the TRIPS agreement and public health. Geneva: WTO. Adopted on 14 November 2001, Doha. Retrieved from:
http://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm.