Global Health Diplomacy and regional health standards in the extractive sector

SESSION REPORT

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

Report of a session held during the 2017 ECSA HC Best Practices Forum

April 10 2017
Arusha, Tanzania

With support from Medico Int

Contents

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The session was organised with input from Dr Emmanuel Makasa of the Africa Group of Health Experts, whose inputs with other session presenters named in the report are gratefully acknowledged. The participation of senior officials and technical agencies from the ESA region is also gratefully acknowledged, particularly Dr S Magagula (Swaziland) who chaired the session, and Dr Mahomed (Tanzania) and Dr Mulenga (Zambia) who chaired working groups. We are also grateful to Medico International for financial support and to ECSA HC staff for logistic support. The report has been prepared by R Loewenson, TARSC/EQUINET.

1. Background and objectives

Since 2010, the East, Central And Southern African Health Community (ECSA HC) has convened several regional meetings on global health diplomacy and from 2011 the organisation has, together with Regional Network for Equity in Health in East and Southern Africa (EQUINET) and the University of Nairobi implemented work to strengthen regional evidence, capacities and policy dialogue in global health negotiations and engagement, under the Strategic Initiative on Global Health Diplomacy (GHD). EQUINET, as a consortium network of organisations based in the region has for several decades built research capacities and evidence at country and regional level on global health issues relevant to health equity in the region. Through SEATINI and TARSC, EQUINET leads the research and information component within the ECSA HC strategic initiative. In follow up to proposals from stakeholders in a 2015 regional meeting on GHD, EQUINET has implemented research on extractive industries (EIs) and health to review how far key guidance principles/standards on health in EIs are contained in domestic laws in ESA countries as a basis for identified good practice that can inform the content for regional guidance for policy and law on EIs and health.

This 2017 session within the Regional ECSA HC Best Practices Forum was convened by ECSA HC and EQUINET in line with HMC Resolution – ECSAHMC50/R2 and with proposals from the 2016 Regional meeting on GHD. The objectives of the meeting were to

a. To share information on progress in the ECSA HC GHD programme and issues for policy dialogue and follow up work
b. To present and discuss evidence supporting and proposals for harmonised regional standards on health in the extractive sector
c. To review and discuss positions on selected agenda items in the 2017 World Health Assembly (WHA) agenda

The meeting recommendations were further summarised and reviewed in the Best Practices Forum and then in the Directors Joint Consultative conference, where the *outcome of what was formally recommended is separately reported by ECSA HC*. The full programme is shown in *Appendix 1.* Delegates were provided with specific background materials through distributed publications. The report is organised by theme, with the presentation and group discussions on each area shown together.

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

2. Opening

The opening was chaired by *Dr Samuel Vusi Magagula - Director of Health Services, Ministry of Health, Kingdom of Swaziland.* Swaziland is the current chair of the Regional Health Ministers in the ECSA HC. He welcomed the delegates, reminded them of prior activities on GHD in the EHCSA HC Strategic initiative on GHD, and outlined the objectives, agenda and process for the session. Delegates introduced themselves and the agenda was adopted by the delegates.

3. Work implemented in the GHD programme in 2015/6 and issues arising

*Mr Rangarirai Machemedze, Programme co-ordinator, SEATINI/ EQUINET r*eported on work implemented by ECSA HC and EQUINET in 2015-6 in the Strategic Initiative on GHD. He noted that since 2010, in line with a Ministerial resolution, the ECSA HC has been implementing work to strengthen regional evidence, capacities and policy dialogue in global health negotiations and engagement on various areas of GHD. An evaluation of

the initiative in 2013 highlighted the need for improved follow up of global negotiations to implementation at regional and country level; more consistent information links between the regional programme and country personnel and diplomats; and more sustained follow up of issues.

Accordingly in February and September 2016, he reported that ECSA HC and EQUINET held meetings with the Geneva based African diplomats in the Africa Group pf Health Experts to identify the key issues to take forward within the existing agenda of the WHO and how to take them forward. The meetings also discussed new agendas from the previous and next WHA, the 66th WHO Afro Regional Committee (RC) and other UN processes to be prepared for. Finally they discussed methods for working on GHD and follow up with the Africa Group.

Mr Machemdeze further reported on the April 2016 meeting on GHD held to prepare for the WHA2016. It involved representatives of both capitals and embassies, technical actors and the regional organisations and provided an opportunity to have deeper discussion and to develop negotiating positions on key agenda items for the WHA 2016.

April 2016 Regional GHD Meeting

HMC Resolution – ECSAHMC50/R2 to prepare and discuss issues on the 69th World Health Assembly (WHA) Agenda and Regional GHD work

The strategic issues discussed in these three meetings included positions for WHA and for country level work on:

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

Mr Machemedze reported that in 2010 and 2015 ECSA-HC senior official and Regional Health Ministers meetings, member states asked: *'Are we making progress in GHD'*? To respond to this an assessment was implemented at the 2016 regional GHD meeting:

- To provide a means for regular monitoring and participatory strategic review and discussion by countries in the annual pre WHA meetings
- To assess key areas of progress and improvement in engagement in GHD at country and regional level in the ESA region.

A tool was developed based on capacities and processes identified as key for progress. It was piloted and reviewed in 2016 and revised an evaluation tool for use in strategic review by countries. Repeating it means that comparison can be made over time to assess progress in GHD, as well as to identify issues for follow up research and training.

The 2016 assessment identified a range of issues:

Institutional issues

- Setting up a desk / focal point for GHD in each country.
- Strengthening involvement of relevant non-state and technical actors in GHD.

Information / capacity issues

- Carrying out research in the region to provide up to date evidence for negotiations.
- Short courses and internet resources to support capacities.
- Extend focus to global issues and institutions beyond the WHO.

Research/ evidence issues

- Unpacking 'health systems strengthening' from a regional lens.
- Assessing health worker adequacy and the implications for global agreements.
- Assessing progress in implementation of the capacities and measures for the International Health Regulations (IHR) 2005.
- Assessing regional and AU co-operation and CDC centres on IHR/ emergency responses.

The meetings with senior officials and diplomats raised a number of areas for follow up work in the GHD programme, including:

In the World Health Assembly:

Taking the Executive Board agenda an important starting point for preparations, for

- ECSA-HC, EQUINET and Africa Group to analyse the EB agenda to identify the priority issues for discussion; to inform the pre WHA meeting and for capacity building activities in countries; to link with and involve central and west African organisations such as WAHO, to develop common positions and to link with African and Geneva-based think tanks for input on priority issues.

Beyond the WHA

- Countries to advance establishment or strengthening of a GHD focal point/ desk in Ministries of health, and to work with young researchers and officials to build GHD cadreship, including for technical reviews in priority areas.
- The region to build a sustained and deeper analysis of the issues and documentation in the WHO governance meetings - EB, WHA, RC - from an African lens, over time adding input for other platforms affecting health - WTO, World Bank, IMF, WIPO and UNCTAD.

Mr Machemedze reported suggestions made from the meetings held in 2015/6 for the future GHD programme to support capacities and negotiating positions, including

- A one day *pre-WHO EB Meeting* with the Africa Group of Health Experts on priority issues in the EB agenda, with information materials on relevant agenda issues, noting that one had been held in January 2017
- *Before the WHA, holding an ECSA HC and partners workshop* on the priority WHA agenda items including government GHD focal points, diplomats, RECs, WAHO and technical institutions, to support capacity building in selected countries on technical areas, and for countries to hold review meetings including government, university/ technical institutions, and possibly domestic private sector.
- *At the WHA.* involvement of ECSA-HC, EQUINET and other regional and country capacities to support and build learning
- *After the WHA,* participation in the WHO Afro Regional Committee meeting of ECSA-HC and regional partners as observers with follow up technical work and meetings on specific issues arising.

3.1 Group work discussions and report on the future GHD programme

The delegates addressed the issues raised in a group work discussion that specifically addressed three questions, viz: Noting the progress, issues and recommendations raised in the GHD programme to date

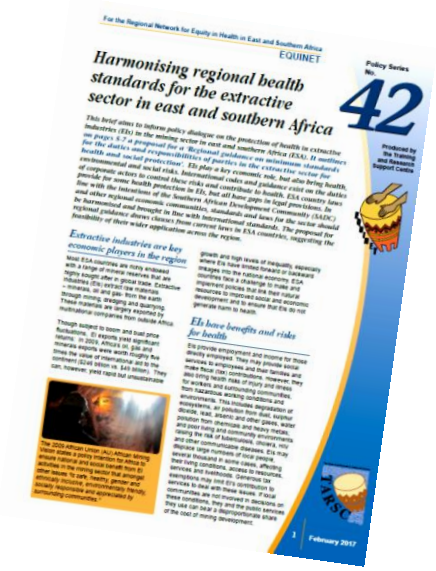
1. What actions should be integrated in the GHD work to consolidate gains in / strengthen processes for early preparation, technical review and development of common positions for the WHA?
2. What measures/ actions should be integrated in the future GHD programme (beyond the WHA)?
3. What policy issues and (global) forums should be prioritised in the future programme?

Following discussion of the questions the group reported in plenary and the meeting recommended that in the future regional GHD programme:

i. Countries
   a. advance measures to institutionalise and strengthen continuity in their work on GHD in Ministries of Health by establishing or strengthening an International Health Relations / GHD unit, desk or focal point; noting that different countries have different names for this. It would be helpful to share the terms of reference of such departments to support those setting them up.
   b. build a pool of people working on GHD, including senior and junior cadres and supporting technical non state actors; and monitor and report on their progress in achieving this;
ii. Regional institutions in dialogue with countries develop briefings and information materials on key agenda items on GHD, with evidence and experiences from the region, to inform policy dialogue from an African lens;
iii. Dialogue meetings be held with capitals and embassies to review key agenda issues for GHD and for the regional GHD processes, with next steps and time frames for them to take actions forward and for the forums where they are being discussed;
iv. Commitments and resolutions made are tracked and their implementation assessed and reported on at country and regional level;
v. Work be implemented or taken further forward in the future GHD programme on health financing, including the adequacy, efficiency and equity in the use of resources; on the assessment and responses to the regional disease burden; on different dimensions of trade and health; and on the role and co-ordination of the regional economic communities, the African Union and other regional actors in GHD

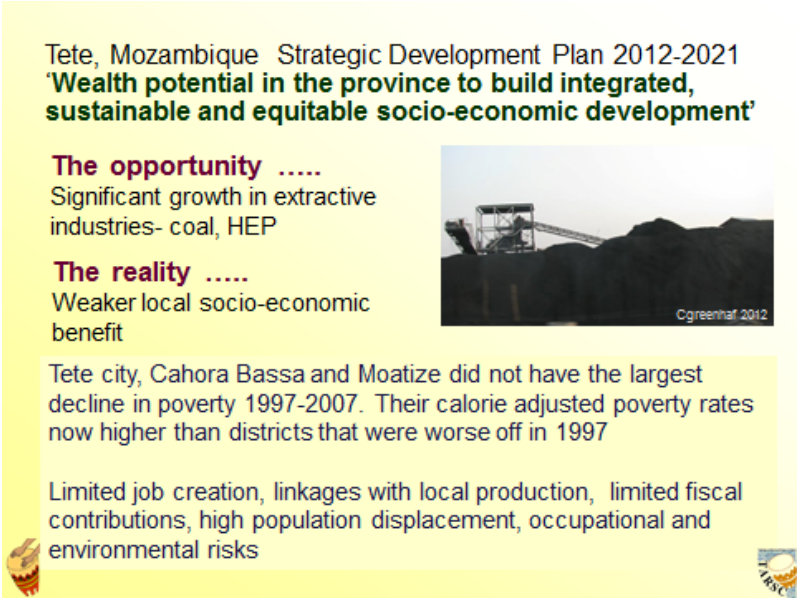
4. Standards and proposals for regional guidance on health in the extractive sector

Dr Rene Loewenson, Director, Training and Research Support Centre/ EQUINET reported on work implemented on the protection of health in extractive industries (EIs) in the mining sector in east and southern Africa (ESA). In line with the intentions of the Southern African Development Community (SADC) and other regional economic communities, standards and laws for the sector should be harmonized and brought in line with international standards. Her presentation outlined findings of an analysis of current laws in ESA countries on health in EIs and their coverage of these standards as a basis for proposed areas for harmonized minimum standards on health in EIs in the region. She distributed a discussion paper and policy brief on the findings (Loewenson R, Hinricher J, Papamichail A (2017) Harmonising regional standards for extractive industry responsibilities for health in east and southern Africa, TARSC, Policy brief 42 EQUINET, Harare).



Dr Loewenson noted that most ESA countries are richly endowed with a range of mineral reserves that are highly sought after in global trade. Extractive industries (EIs) extract raw materials – minerals, oil and gas- from the earth through mining, dredging and quarrying. These materials are largely exported by multinational companies from outside Africa. Africa's oil, gas and minerals exports were worth roughly five times the value of international aid to the continent ($246 billion vs. $49 billion). ESA countries thus face a challenge to make and implement policies that link their natural resources to improved social and economic development and to ensure that EIs do not generate harm to health. She noted that this is a policy intention in the 2009 African Union (AU) African Mining Vision which states the intention to ensure national and social benefit from EI activities in the mining sector that amongst other issues "*is safe, healthy, gender and ethnically inclusive, environmentally friendly, socially responsible and appreciated by surrounding communities*."

She noted that EIs bring benefits in employment and incomes; purchasing power; local capacity building; investment in technology, infrastructure and tax contributions. However they have also been associated with health risks, including accidents and hazardous working conditions; poor environmental, living condition; loss of biodiversity, pollution; displacement of local people; HIV, TB and STIs in surrounding communities and tax exemptions reducing fiscal contributions. These health problems affect the economic and social returns companies, communities and countries gain from EIs. Dr Loewenson recounted the experience of Tete province in Mozambique where the districts that had large EI projects did not show the greatest reductions in poverty and food insecurity over a decade, despite the wealth generated.



These issues have been dealt with in various international standards on EIs, including

- UN and international guidance, such as the UN Guiding Principles on Business and Human Rights, the International Labour organisation Declaration on Multinational Enterprises (MNEs); The Extractive Industries Transparency Initiative (EITI)
- OECD guidance, such as Guidelines for MNEs
- Financial institution guidance, such as the International Finance Corporation Performance Standards on Social and Environmental Sustainability;
- Business standards for corporate responsibility, such as the International Council on Mining and Metal Sustainable Devt Principles; and
- The AU African Mining Vision.

These set standards for

1. Consultation, impact assessment and protection of health in prospecting rights
2. Health and social protection of displaced communities
3. OHS for employed workers and sub-contractors
4. Health benefits for workers and their families
5. Environmental, health and social protection for surrounding communities, and remedy for harm
6. EI fiscal contributions for health promotion and care
7. Fair local benefit from EI activities; and
8. Transparent, democratic and accountable governance of these issues, by government, civil society, affected communities and industry, on an equal footing.

There is a process underway in SADC and ECOWAS for regional harmonisation of standards in the mining sector. Dr Loewenson suggested that it was important for health to be included in this process. To support this work was implemented to explore the extent to which health standards were already incorporated in the laws in ESA countries. As shown in the tables below, there is variability across countries, with some areas of health better protected than others, and some countries better protected than others. No single ESA country addresses all the standards on health in EIs but different ESA countries have good practice clauses that could be used for regional guidance on minimum standards, and that suggests the feasibility of the standards.

COUNTRY	Consultation and protection of health in negotiation of prospecting rights/ licenses and EI agreements	Health and social protections in resettlement/ relocation of affected communities	OHS for employed workers/ contractors	Health benefits for workers and families	Environment, health and social protection for surrounding communities
Angola					
Botswana					
DRC					
Kenya					
Lesotho					
Madagascar					
Malawi					
Mozambique					
Namibia					
South Africa					
Swaziland					
Tanzania					
Uganda					
Zambia					
Zimbabwe					

Source: Analysis of ESA country laws in Loewenson et al (2016) EQUINET discussion paper 108 and supplement.

COUNTRY	Health benefits for surrounding communities	Fiscal contributions towards health and health services, specifically in relation to EIs	Forward and backward links with local sectors and services supporting health; use of wealth funds, community ownership for local well-being	Post-mine closure obligations	General governance issues
Angola					
Botswana					
DRC					
Kenya					
Lesotho					
Madagascar					
Malawi					
Mozambique					
Namibia					
South Africa					
Swaziland					
Tanzania					
Uganda					
Zambia					
Zimbabwe					

Source: Analysis of ESA country laws in Loewenson et al (2016) EQUINET discussion paper 108 and supplement.

Dr Loewenson summarised policy proposals for regional guidance on health and EIs, with information on which ESA countries have good practice laws for such guidance, as shown in the Table below.

Proposed areas for harmonised regional health standards

Legal provision for protection of health	From law in
In negotiation of prospecting rights/licenses / agreements	
Approval subject to preventing harm to health; Environment, health and social impact assessment and costed plan to prevent harm, including for displaced communities, involving local authorities and communities, and updated EHSIAs for license renewal	Zambia, Mozambique, Kenya, South Africa, Angola and DRC
Of relocated and resettled communities	
No forced evictions, and displacement avoided or minimised, with company duty to pay fair compensation, include resettlement plans in the EHSIA, respect community culture and to re-establish living standards, incomes and services and to inform, dialogue with local communities and fair grievance management.	Mozambique, Angola, and DRC
For employed workers and contractors	
Promotion, protection of OHS, training and information to workers on OHS, prevention, reporting of and compensation for accidents and injury, periodic medical examinations. State powers to suspend hazardous work, worker rights to refuse dangerous work	Kenya, South Africa, Angola, Tanzania and DRC
Benefits for workers, families and surrounding communities	
EI duties to ensure healthy environments, prevent harm to health, prevent and report communicable and notifiable disease in the surrounding community. Support access and make fiscal contributions to health care. Prohibit child labour on mines; ensure healthy conditions for migrant workers	Botswana, Zambia and Lesotho
Health and environment protection for surrounding communities	
Protect rights to a healthy environment, to not disturb integrated social and economic development, to provide public information; EI duty to implement ESHIAs, to repair or compensate for damage during and after holding a right; State duties to suspend operations that cause harm and hold financial security for remedy of damage	Angola, Kenya. Swaziland, Zimbabwe, Kenya and DRC
Related fiscal contributions	
EI duties to make fiscal contributions for health, to not seek exemptions for health and to report on funding and use of local services; with direct (10%) share to communities and local authorities; levies for EI activities that impact on health	Angola, Zimbabwe and Tanzania
In forward and backward linkages	
By employment of local citizens, training, skills transfer and socially responsible investment with local benefit	Kenya
In post mine closure obligations	
EI duty to provide post closure plans in ESHIAs, post closure fiscal, environment reclamation and public health duties, including for screening, care and compensation for chronic diseases	Angola and Tanzania
In governance arrangements	
Rights to information, association and participation; EI good corporate governance, compliance with laws and duty to ensure and support informed and consistent participation of affected communities; transparency and accountability, independent oversight of agreements; protections against conflict of interest in decision-making	DRC, Tanzania and Kenya

She noted that while standards were only one step, they set a basis for making clear the duties for health, and the multisectoral co-operation, roles and capacity inputs needed to protect health, and gave an example of how Tete Province in Mozambique has begun to implement such co-operation for improved health under the leadership of the provincial government.

4.1 Group work discussions and report on regional guidance on health and EIs

The delegates addressed the issues raised in a group work discussion that specifically addressed four questions on this area, viz:

1. Should health standards be included in the regional harmonised standards on EIs/ mining?
2. What minimum standards on health in EIs should be included?
3. How can multi-sectoral support for these health standards be built?
4. How can awareness of *current* health laws be strengthened?

Following discussion of the questions the group reported in plenary in the session and the meeting recommended that

i. Health be included in the harmonised regional standards, and steps be taken to advance this by countries and regional economic communities working with technical partners, and support built through dialogue with key sectors (trade, mining, environment, labour) and parliaments;

ii. Minimum Health standards be included in the following areas (noting that some areas call for advocacy by health sectors to other co-operating sectors for their implementation)
    a. Integration of health in Environment Impact assessments as Environment, Health and Social Impact Assessment (EHSIA), with approval on EHSIAs a requirement for granting and renewal of mining rights; ministries of health included in the implementation and approvals, and such EHSIAs to include identification of impacts; costed impact prevention/ mitigation plans, resettlement action plans where relevant; and post closure mitigation plans.
    b. District level EHSIAs implemented at company level for large mines, and by local governments with relevant sectoral technical support for small mines (cumulatively).
    c. When displacement is not avoidable, a duty for companies to provide resettlement plans in dialogue with government and affected communities; with resettlement in houses, water, sanitation and related health infrastructure and health services to defined and improved standards.
    d. EI companies to avoid harm to health in surrounding communities, to prevent nuisances that would be injurious to health and to report and prevent the spread of infectious and notifiable diseases.
    e. Fiscal exemptions provided to EIs to not include health specific taxes or levies nor any exemptions of health or health related standards.
    f. EI duties to identify, prevent and manage health impacts after closure, including for chronic health problems arising from their activities, and termination of a mining right and operation to not relieve EIs from their health obligations.

iii. These proposals be advanced through the RECs, by building multi-sectoral dialogue with key sectors on them and on the evidence supporting them, including in terms of their economic and social benefit and for control of disease burdens, in terms accessible for other sectors.

iv. Measures be taken to strengthen awareness and enforcement of and accountability on existing laws, including by taking the information to parliaments and other sectors.

v. Further work be implemented to assess the extent to which small scale and informal sector miners are protected by these standards, on the health issues they face and how protection of health can be operationalized.

5. Priority issues in the 2017 World Health Assembly agenda

Dr. Emmanuel M. Makasa, Counsellor-Health, Permanent Mission of the Republic of Zambia to United Nations, Geneva presented an overview of the 70th WHA and its processes, theme and agenda. He observed that the WHA is the top level summit for the WHO. He outlined selected issues within the full set of agenda items found at http://apps.who.int/gb/e/e_wha70.html).

He noted that the WHA70 has a wide ranging agenda, including the election of a new Director General; the management of emergency responses and antimicrobial resistance; research and development (R&D) for neglected diseases; the capacities for and evaluation of preparedness for the International Health Regulations (IHR) 2005, migrant health; and the Sustainable Development Goals (SDGs), amongst other items. It will discuss progress in the implementation of resolutions from prior WHAs and the governance and programmes of the World Health Organisation (WHO). He noted that this years' WHA has a long working Period (10 days), with 24 Agenda items with 76 subthemes and 13 progress reports. It is also a year where a new DG will be elected. Three candidates have been identified: Dr David Nabarro (UK), Dr Sania Nishtar (Pakistan) and Dr. Tedros Adhanom Ghebreyesus (Ethiopia) and he urged African countries to use their vote wisely and to avoid disunity.

In the agenda item on preparedness, surveillance and response, he noted there are 5 key issues: Health emergencies, Antimicrobial resistance (AMR), poliomyelitis, implementation of IHR (2005) and a review of pandemic influenza preparedness. Dr Makasa noted that while progress has been made in the development of a vaccine against Ebola and control of the yellow fever epidemic in central Africa, a Zika virus disease outbreak recently reported in Angola from the *Aedes* vector responsible for transmitting dengue fever, yellow fever and chikungunya virus infections indicates a cross border risk of transmission, and a need to go beyond epidemic control to raise a demand for strengthened investment in measures for prevention. He also noted that too little attention has been given to cholera in prevention and control of epidemics, although it is common in the region.

He noted the progress in emergency responses, the establishment of Incident Management Systems in a number of African countries to strengthen coordination of responses to emergencies and the implementation of Joint External Evaluations of IHR core capacities in African countries. However he noted the need for a stronger link between the evaluations and the actions and resources to remedy gaps found for the evaluations to have value, suggesting that this be flagged in the WHA. He further noted that there needs to be attention beyond infectious diseases to cross border issues from non infectious agents such as chemicals. In relation to the IHR 2005, he observed that key issues for the region are the co-ordination of the necessary health workforce teams for implementation and the development of cross border emergency response plans.

He noted that the discussion at the WHA on AMR will be focused on the stewardship framework. Dr Makasa question however why there is a heavy focus on bacteria when the region has many other microbial threats, and raised that measures to combat antimicrobial resistance should be linked to those that ensure equitable access at affordable cost to good quality antibiotics, vaccines and diagnostic tools, and to progress in the measures to support R&D, technology transfer, laboratory capacities and local production in African countries.

A number of health systems issues are on the WHA agenda in 2017, including the agenda on health workers; principles of donation & management of blood products; addressing the global shortage of & access to medicines and vaccines; evaluation and

review of gaps in public health, innovation and intellectual property; the financing and coordination of R&D and the health of refugees and migrants. In addition to the issues already noted, Dr Makasa alerted that in the discussion at WHA on the Global Vaccine Action Plan there is need to ensure in documents that there is explicit note of ethical procedures being addressed in vaccine trials, such as when trials are implemented in Africa. He observed that migrant health is a key issue for the region both in relation to internally displaced people and those crossing borders, given the extent to which African populations are affected.

He pointed to various areas on non-communicable diseases that will be discussed at the WHA, including the UNGAS 2018 high-level meeting preparations, the public health prevention and management response to dementia; to harmful drug use; to childhood obesity; to cancer control and for prevention of deafness and hearing loss.

Two years from the declaration of the Sustainable Development Goals (SDGs), he urged that countries advocate for attention on what actions have been taken to implement them, particularly in terms of the public health issues that are a priority for the region. He also urged that countries attend the sessions on progress report, as this is where accountability is strengthened on resolutions already taken in prior Assemblies.

Dr Makasa noted the need for an African lens on these issues, and for strong African voice, given the large share of public health issues from Africa.

4.1 Group work discussions and report on issues in the 2017 WHA agenda

The delegates addressed the issues raised in a group work discussion through discussion guided by three questions, viz: For issues identified as priority on the WHA 2017 agenda

1. What are the proposed positions / amendments/ inputs to be made on the item, with (as relevant) what supporting arguments/ evidence?
2. What questions and information gaps still need to be addressed on these issues?
3. What other 2017 agenda items are prioritised for collective positions?

Following discussion of the questions the group reported in plenary in the session and the meeting recommended that

i. In the forthcoming WHA
   a. ESA countries focus attention at national and global level on progress made in the actions taken to *implement* the SDGs, particularly in terms of the public health issues that are a priority for the region;
   b. ESA countries ensure accountability for implementation of resolutions from prior WHAs that are important for the region, particularly in the WHA session on progress reports.
   c. ESA countries avoid maternal and child health being treated as a vertical programme and profile linkages with one health and health system strengthening;

ii. In the WHA processes generally,
   a. At regional level map information on the global policies, measures and funds for health security; and develop a regional position in the framing of and priorities for global health security from an African lens;
   b. A position based on evidence and good practice be developed on the co-ordination of health personnel in emergencies, including on cadreship development, and on the protection and care of health workers in conflict and emergency zones.
   c. Further evidence and analysis be gathered on why maternal and child health has recorded slow improvements despite the level of funding applied to it, to inform global policy dialogue on MCH.

iii. In preparing for the WHA. for Ministries of Health in countries to meet early before the WHA and again after the WHA on key agenda items with relevant sectors outside health, including finance, trade, local government, education, parliament, professional associations and civil society.

iv. The ECSA Health Community and countries to generate income from African institutions to support the GHD work for the WHA and other global platforms.

5. Conclusions and closing remarks

Dr Magagula, Swaziland thanked the presenters, chairpersons, rapporteurs and delegates for their contributions. He commented that the session had brought useful new information that was pertinent for countries, observing for example that he had recently been invited to a multisectoral committee discussion on the mining sector. He noted that the inputs made would be shared with the wider conference delegates on the following day through the report back session and would be discussed for the areas to be reviewed by the senior officials in the Directors Joint Consultative Conference on the 12th April.

Professor Yoswa Dambisya, Director General, ECSA HC also thanked delegates for their participation, and expressed ECSA HC's commitment to strengthening GHD, and to facilitate member state interactions and partnerships towards this. He thanked the presenters, chairs and partners for support of the session and for the ideas shared.

Dr Magagula, Swaziland closed the session at 18.10

Appendix 1: Programme

Monday 10 April 2017, 1400-1700

TIME	SESSION	RESPONSIBLE
14.00-14.05	Overview of objectives of the session	Chair: Dr S Magagula, Ministry of Health, Swaziland
14.05-14.25	Work implemented in 2015/6 in the GHD programme and issues arising	Mr R Machemedze, SEATINI/ EQUINET
14.25-14.45	Internal, national laws and proposal for regional guidance on health responsibilities in the extractive sector	Dr R Loewenson, TARSC/EQUINET
14.45-15.05	Overview of priority issues in the 2017 World Health Assembly Agenda	Dr E Makasa, Counsellor-Health: Permanent Mission of Zambia to the UN
15.05-15.10	Introduction to working groups	
1510-1530	Tea Break	All
1530-1615	**Working groups** GROUP 1: Next steps and policy issues in the GHD programme GROUP 2: Proposal for and follow up actions on regional guidance on health responsibilities in the extractive sector GROUP 3: Positions on issues in the 2017 World Health Assembly Agenda	Chairs: Group 1: Dr M Mulenga, Zambia Group 2: Dr S Magagula, Swaziland Group 3: Dr M.A. Mohamed, Tanzania *Each group also includes:* Presenter Rapporteur (identified by the group) Delegates
16.15-17.00	Plenary report back and discussion of group work, recommendations for the DJCC	Dr S Magagula, DG ECSA HC, Prof Y Dambisya
17.00-17.10	Closing	Dr S Magagula, Swaziland

Appendix 2: Delegate list

(In alphabetical order)

1	Dr. Kabalo Abel, Ministry of Health, Zambia
2	Prof. Midion Chidzonga, Dean, UZCHS, Zimbabwe
3	Professor Yoswa Dambisya, Director General, ECSA HC
4	Dr Pamela Juma, African Population Health Research Centre, Kenya
5	Dr. Isaac Kadowa, Ministry of Health, Kampala, Uganda (invited but apologies due to late flight)
6	Mr Edward Kataike, Director of Programmes, ECSA HC
7	Dr. Damson Kathyola, Director of Research, Ministry of Health, Malawi
8	Ms Lynette Kamali, African Population Health Research Centre, Kenya
9	Dr Rene Loewenson, Director, Training and Research Support Centre, Zimbabwe Cluster lead, EQUINET
10	Mr. Rangarirai Machemedze, Southern and Eastern African Trade, Information and Negotiations Institute (SEATINI) and SADC Council of NGOs, Cluster lead, EQUINET
11	Dr. Emmanuel Makasa MD,MPH Counsellor-Health, Permanent Mission of the Republic of Zambia to United Nations
12	Dr. Samuel V. Magagula, Director of Health Services, Ministry of Health , Swaziland
13	Ms Masuma Mamdani, Ifakara Health Institute, Tanzania, Theme lead: EQUINET
14	Mr Ernest Manyawu, Director of Operations and Institutional Development, ECSA HC
15	Dr Esther Masuma, Infectious Diseases Institute, Uganda
16	Dr. Mohamed Ally Mohamed, Director Health Quality Assurance, MOHCDGEC – Tanzania
17	Dr. Emmanuel Makasa MD,MPH Counsellor-Health, Permanent Mission of the Republic of Zambia to United Nations
18	Dr Christopher Mihae, Praxis, Tanzania
19	Dr Mwifadhi Mrisho, Research Scientist , Ifakara Health Institute, Tanzania
20	Dr. Modest Mulenga, Director, Tropical Diseases Research Centre, Ministry of Health, Zambia
21	Dr. Robert F. Mudyiradima, Principal Director, Ministry of Health and Child Care, Zimbabwe
22	Mr Patrick Mugirwa, PPD ARO, Uganda
23	Dr. Deogratias Kaheeru Sekimpi, Ag. Executive Director, UNACOH, Uganda
24	Ms. Diana Warira, Comunications Officer, AFIDEP, Kenya

NB a further 11 delegates participated in the session but did not sign on to the circulated participant list. (Total number from head count was 35 delegates).
ECSA HC have the full delegate list for the BPF.