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Regionalism in the Southern African Development Community: Integration for better health?[1]

Erica Penfold

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Contents

Executive Summary

The dominant thinking post-1945 in the international realm was the commitment to the principles of multilateralism and collective security to prevent future conflicts. The aspiration was that, by acting collectively (via multilateral organisations), rather than acting bilaterally, global conflict could be avoided. The hope was that such collective action (via the United Nations (UN) community) would moderate some of the nationalistic aggressions of the pre-1945 period, creating a sense of collective security, rather than insecure unilateralism.

Multilateralism as a political project was also expressed through economic and commercial variants, and so in addition to the UN the international community established the Bretton Woods Institutions (BWIs), which include the International Bank for Reconstruction and Development (IBRD, or 'World Bank'), the International Monetary Fund (IMF), and eventually the General Agreement on Tariffs and Trade (GATT) (the latter was the precursor to the World Trade Organisation (WTO)). Again, the aspiration was that global commercial and trade integration would render war illogical, so that the norm of liberal institutionalism would replace the norm of military aggression.

In Western Europe this norm of political and economic integration found traction through the gradual and incremental establishment of a regional multilateral project, which culminated in the creation of the European Union (EU).

The idea of regionalism and the process of regionalisation are not new to Southern Africa. The Southern African Customs Union (SACU) – established in 1910 – is the oldest in the world. Southern Africans have long realised the potential economic and political benefits of closer regional cooperation. Indeed, the Southern African Development Coordination Conference (SADCC) was established in 1980 amongst nine of apartheid South Africa's neighbouring states in an effort to decrease economic dependence on South Africa, and to combat apartheid.

As apartheid began to be dismantled the SADCC was replaced by the Southern African Development Community (SADC) in 1992, with an expanded membership (including democratic South Africa, which joined in 1994) and a mandate to complement the socio-political programmes of the African Union (AU), which in 2001 succeeded the Organisation of African

Unity (OAU). SADC's overall goal is to foster closer political, economic, and security cooperation amongst its 15 member states.

In this paper we are particularly interested in how health impacts on or is impacted by this nexus of regional political, economic, and security interests. There are few areas of study that are more demonstrably and directly concerned with issues of life and death than health. Given the severe burden that ill health (particularly the AIDS pandemic, malaria and tuberculosis) place on the governments and people of SADC, we examine the two questions posited by the ESRC-DfiD Poverty Reduction and Regional Integration research project:

1. Does SADC have a committed pro-poor focus in its health policy regarding access to healthcare, as indicated by policy agendas, policy development processes and resourcing?
2. What can national, regional and international actors do to promote pro-poor practices and methods for access to healthcare and medicines in the SADC region?

To answer these questions, we interviewed governments, multilateral organisations, non-government organisations (NGOs), and community-based organisations (CBOs) in Botswana, Zambia and Swaziland. Certain interviewees represented the interests of the health sector, whilst others represented governing institutions involved with policy development.

We were able to confirm the particular and devastating impact of the three epidemics noted above, and how central they are to the health profile of the Southern African region. In addition, we soon discovered that it does not make sense to speak of health in the region without referring to the scale and impact of poverty – these epidemics are made worse by the high levels of indigence across the region, and poverty in turn is exacerbated by ill health. In Southern Africa it does not make sense to separate health and poverty from one another; no sustainable development is possible without addressing the socio-political determinants of health.

Initially, SADC defined 'health' as a discrete area of attention, and allocated each such issue area to a specific member country. However, this has changed, and in more recent years the SADC Secretariat has done away with such a portfolio approach and replaced it with an issue mainstreaming approach. Instead of a top-down course where SADC identifies, introduces, develops and implements policy initiatives, it is up to individual member states to bring an issue

area to the Secretariat, and to then consult with other member countries before mandating the Secretariat to develop policy initiatives.

SADC has developed a corpus of policy frameworks and protocols that speak to health horizontally (collectively, generically); it also has vertical policy frameworks and protocols, which suggest regional interventions targeting specific diseases or health issues (e.g. HIV, malaria). 'Frameworks' and 'protocols' do not, however, imply great regional and institutional capacity for policy initiation and implementation; nor do they guarantee compliance by all member states.

Instead, our research exposed a number of at times surprising and counter-intuitive findings.

Firstly, the SADC Secretariat works at the behest, prerogative, and pleasure of its member states. It thus follows a bottom-up protocol for policy agenda setting, development, and implementation. In fact, the SADC Secretariat does not implement policies on its own; instead it acts as a locus of (limited) policy development and technical assistance. Individual member countries have to identify issues for policy development in the first place, and then implement those policies themselves (the Secretariat may provide some technical assistance – at most).

Secondly, individual member countries often identify health and other policy issues in tandem with and/or at the suggestion of international donors or multilateral development organisations. The latter typically make technical expertise and funds available for the development and eventual implementation of policies. When member states lack the capacity to implement such policies themselves, they outsource the implementation function to national NGOs and CBOs, who apply for funding in dedicated 'rounds', and then roll out specific national health programmes.

Stated differently: donors and multilateral aid organisations work together in national health policy agenda setting, then facilitate some consultation with national governments, and provide the means (funds) for governments to then contract civil society in implementation. The SADC Secretariat has a very limited role in health policy agenda setting, development, and implementation – nationally and regionally. In fact, the SADC Secretariat is now actively cutting back its involvement in regional and/or national health programmes.

With this in mind, this study's response to our two initial research questions can be summarised as follows:

Does SADC have a committed pro-poor focus in its health policy regarding access to healthcare, as indicated by policy agendas, policy development processes and resourcing?

SADC is loath to separate a socio-economic developmental focus from any putative focus on health. The bidirectional causal links between health and poverty are presented as a given, with socio-economic development, prosperity, and social justice on the whole viewed as the ultimate and appropriate response to health deficits and inequalities. The Secretariat itself does not initiate policy making, but responds to the demands and instructions of member states; it then provides technical assistance in policy development – if requested to do so. All policy implementation is left to individual member governments. Thus health policy is a member state project rather than a factor assisting in regional integration.

What can national, regional and international actors do to promote pro-poor practices and methods for access to healthcare and medicines in the SADC region?

National, regional and international actors should continue to consult each other in policy innovation, development, implementation, and evaluation. In terms of the role played by international actors, member states have expressed concern that the regional integration agenda runs the risk of becoming dominated by donors. The SADC Secretariat can make itself available as a useful interface for such consultation, and in this paper we offer a number of suggestions for such policy and process innovations.

Although Southern Africa is no stranger to regionalism, health-specific regionalisation and diplomacy do not have significant precedent in the region. However, given the relative youth and dynamism of regional integration and approaches since the early 1990s, this implies opportunity and potential for greater regional integration and cooperation, rather than indicating or suggesting their abandonment. Multilateralism and collective security (human and state) can be effective for Southern Africa as well.

1. Introduction

Southern Africa is poor and bears a massive disease burden. Some development specialists indicate regional ill health as the result but also as the cause of a lack of economic growth and development. *Health* can be used as a mirror of a country's or a region's development status: there are few indicators of wellbeing and prosperity that more directly demonstrate a society's successes and failures, which show who the winners and the losers are, who survives and who perishes, who governs, and who benefits from governments and their policies.

This paper is interested in whether the countries of Southern Africa have been and/or can be successful in using regional integration as a pathway to better governance, greater material wellbeing, improved health, and greater social justice. The Southern African Development Community (SADC) has specific health policies and protocols in place, but do these reflect a discrete and specific commitment to pro-poor policy making and implementation? What can governments, civil society, and multilateral development partners do to facilitate greater access to healthcare and medicines?

Given the success of regional political and economic integration in Western Europe and elsewhere in fostering economic development and prosperity, we are particularly interested in whether the norm of regionalism and the process of regionalisation have had or can have similarly positive consequences in Southern Africa. Regionalism is widely viewed as a way of strengthening development and prosperity; in developing countries, however, there may be marked challenges to this 'best' practice. Can Southern Africa emulate the success of, for instance, the health regionalisation and the health diplomacy that are so apparently successfully pursued in South America (Amaya et al, 2015; Riggirozzi, 2015)?

To address these questions, the paper first reflects on the promise of regionalism generally, and then on whether and how regional organisations specifically can be effective conduits for social policies and development. The paper then reviews the role that SADC plays in Southern African regionalisation, initially with limited geostrategic goals, but increasingly with a socio-economic (developmental) policy and normative commitment. The paper discusses the policy development process within SADC, and considers the organisation's focus on health.

We then present some primary data resulting from case study work in three SADC member countries and the SADC Secretariat (based in Botswana) in particular. The paper

concludes by reflecting once again on our initial research questions, before offering some suggestions for improved policy development and implementation across the region.

2. The idea of regionalism – the process and promise of regionalisation

The idea of regionalism and the process and promise of regionalisation are not new to Southern Africa. The Southern African Customs Union (SACU) – established in 1910 – is the oldest in the world. Southern Africans have long realised the potential economic and political benefits of closer regional cooperation. Indeed, the Southern African Development Coordination Conference (SADCC) was established in 1980 amongst nine of apartheid South Africa's neighbouring states in an effort to decrease economic dependence on South Africa, and to combat apartheid.

Regional organisations are steadily becoming significant actors in the global development community and increasingly so in the global health community (Deacon et al., 2010; Söderbaum and Van Langenhove, 2006). Regional action as a process presents the promise of regionalisation and regionalism, with regard to institution creation, governance, policy development, and implementation. Reframing social policy at a regional level reflects on how regional bodies participate in social policy reform in the Global South (Deacon et al., 2010; Munck and Hyland, 2014; Yeates and Deacon, 2010).

Why and how is regionalism and regionalisation becoming more prominent? How does this play out in the Global South? Regional structural development is becoming integral in global political and economic spheres. The Global South has begun to challenge Northern global social reform. Yeates and Deacon (2006; 2010: 28) argue that the creation of new policy and power, with a Southern regional lens, can better address development interests in the Global South. The emergence of regionalism speaks to the need to create a more robust social policy agenda, as the Global South seeks to identify its own capacity to develop sustainable social policy in the development sphere (Yeates, 1999, 2001, 2002). The emergence of "new regionalism" since the end of the Cold War speaks to how the Global South is responding to policy action and agendas within the process of globalisation (Riggirozzi and Yeates, 2015).

There is still limited knowledge of Southern regional policy creation, mandates and practices, and whether regionalisation is conducive to a new path of development activity. Theoretical analysis of regionalisation and regionalism contribute significantly to an understanding of regional social policy (Riggirozzi and Yeates, 2015). This has traditionally

been limited to understanding governance at a multilateral level. There is a need to reflect on this through a regional development lens (Deacon and Yeates, 2014c). Regional organisations and how they develop policy agendas highlight this process (Yeates, 2014b, 2014c; Yeates and Deacon, 2006, 2010; also Kaasch and Stubbs, 2014; Cavaleri 2014; Bianculli and Hoffman, 2016).

The emergent regional narrative provides an interesting analytical framework for how regional organisations are expanding beyond regional integration as a trade and investment focal point. It has begun to explore how development policies and agendas are being reframed, reset and implemented in other policy spheres, posing a challenge to normative frameworks that emerged in the 1980s and 1990s. The need for a more robust social policy agenda is a continual analytical agenda which has been academically framed for an already significant period of time (Deacon et al., 2007, 2010; Yeates, 2014a, 2014b, 2014d; Yeates and Deacon, 2006, 2010).

Can we better understand the promise of regionalisation in Southern Africa? SADC is the dominant regional organisation in Southern Africa. Although it originally developed as a counterpoint to apartheid South Africa, it was restructured as an economic and developmental organisation with the goal of regional integration and poverty reduction. SADC self-defines as an economic and political institution. However, in its vision and mission, SADC additionally considers itself as a "regional community that will ensure economic well-being, improvement of the standards of living and quality of life, freedom and social justice and peace and security for the people of Southern Africa" and a community that "promote[s] sustainable and equitable economic growth and socio-economic development through efficient productive systems, deeper co-operation and integration, good governance, and durable peace and security" (SADC, 2014b).

How does SADC negotiate the restructuring of social policies in a development context? The next section provides contextual understanding of how SADC developed, to provide a better sense of the regional organisation's goals and how the promise of regionalisation manifests in a developing context.

3. The Southern African Development Community

The SADC Vision, formulated in 1992 (SADC, 1992), is to build a region in which there will be a high degree of harmonisation and rationalisation, to enable the pooling of resources to achieve collective self-reliance in order to improve the living standards of the region's people. The vision is one of creating a common future with economic well-being, good standards of living, quality of life, freedom and social justice and peace and security, secured.

SADCC (the precursor to SADC) had a modest vision to promote economic coordination among its members and to ensure development aid flowed to the region from the North. In 1992, the SADCC became SADC, with the signing of the Windhoek Treaty. The change in the global landscape at the end of the Cold War and the end of apartheid shifted the focus to economic, societal and environmental security, instead of military and political security as in the Cold War era. Economic growth became a priority in light of the levels of underdevelopment in the region (Schoeman, 2002), and against the background of the 'triumph' of the West and its economic system with the end of the Cold War. The goal for the region was to integrate, based on increased levels of economic growth and market integration, which in turn would assist in developing stronger policies for social development. SADC was initially structured in such a way that each member state was responsible for a particular sector or issue portfolio. In order to address national priorities through regional action, member states were tasked with coordinating these sectors by proposing policies, strategies and priorities and "processing" projects for inclusion in the sectoral programme, by monitoring and reporting progress to the Council of Ministers (Cawthra, 2010). For example, South Africa was responsible for finance and investment, and health. Zambia was responsible for employment and labour, and mining. The sectoral/portfolio approach was in place until 2001. As such, SADC was viewed initially as an organisation that provided services to the region (Ostergaard's now dated description of SADC as a "service organisation" providing sectoral services for the region was accurate until 2001 (Ostergaard, 1990)).

The "sectoral responsibility approach" was ineffective and resulted in decentralisation of the structure. SADC operations were cut off from the member state Sector Coordinating Units (SCUs) that coordinated the 21 sectors of regional integration. This approach had as a consequence individual governments trying to promote their own national goals rather than thinking regionally (Söderbaum 2004). The Secretariat's establishment in Gaborone,

Botswana in 2001 (Schoeman, 2002; Ostergaard, 1990) was intended to improve effectiveness. It allowed SADC operations to be centralised at the SADC Secretariat in Gaborone (SADC, 2014b). By operations, this means the Secretariat provides "operational facilitators support", as the executive arm of the eight organisational directorates (which replaced the SCUs)[2] (SADC, 2014b); the Secretariat was not a decision-maker.

SADC became more focused on creating social development programmes to address socio-economic imbalances in the region, at the same time promoting a trade and regional economic integration agenda (Amaya et al, 2015).

4. The Poverty Reduction and Regional Integration (PRARI) project

In this project we are particularly interested in how health impacts on or is impacted by this nexus of regional political, economic, and security interests. There are few areas of study that are more demonstrably and directly concerned with issues of life and death than *health*. Given the severe burden that ill health (particularly the AIDS pandemic, malaria and tuberculosis) place on the governments and people of Southern Africa, we are interested in two questions:

1. Does SADC have a committed pro-poor focus in its health policy regarding access to healthcare, as indicated by policy agendas, policy development processes and resourcing?
2. What can national, regional and international actors do to promote pro-poor practices and methods for access to healthcare and medicines in the SADC region?

The investigation of SADC as a regional organisation also asks whether there is an focus on poverty in SADC's policy-making process.

Based on primary research, the project reflects on the role of the SADC Secretariat in Southern Africa, as a regional organisation and as a policy-making institution. The project also reflects on how policy addresses the need for increased access to healthcare and medicines in Southern Africa. What efforts have been made historically for improved access to

[2] These directorates are: the Directorate of the Organ on Politics, Defence and Security Cooperation; the Directorate of Trade, Industry, Finance and Investment, the Directorate of Infrastructure and Services, the Directorate of Food, Agriculture and Natural Resources, the Directorate of Social and Human Development and Special Programmes, the Directorate of Policy, Planning and Resource Mobilisation, the Directorate of Budget and Finance and the Directorate of Human Resources and Administration (SADC, 2014b).

healthcare and medicines? Which current initiatives have shown progress in promoting an increased focus on regional access to healthcare and medicines?

The promotion of regional health policies provides insight into the objectives of regional social policy and public organisational commitment to the values of development. An analytical focus on health may reveal how Southern regionalism engages institutional and ideological positioning on health and social welfare. Southern regionalism refers to the specific characteristics of Southern regional organisations and Southern regional concerns (for example, high levels of poverty and governance challenges) (Khadiagala, 2008). Northern regionalism refers to the structuring of regionalism in Northern regional economic communities (for example the EU), which are differentiated by higher-income brackets and different socio-economic challenges. Southern vs Northern regionalism is also understood in terms of the Global South and the Global North, which have different development challenges.

Regionness has traditionally been used to explain the role of the European Union as an international political and economic actor, but has overlooked how Southern regionalism works differently to address the socio-economic and political concerns of Southern regional bodies (Hettne, 2008). Riggirozzi and Yeates (2015) provide an explanation of Southern regionalism or "non-European" regionalism in Latin America which is a useful frame, considering the limited discourse on Southern regionalism in Southern Africa.

In defining the ideological and geostrategic notion of Southern regionalism, we move away from the view of Southern regionalism as a reactionary response to the role of the Global North and the market-driven rules of the global economy. Southern regionalism sets out to recreate power relations, inequality and development in a manner that is more fitting to the concerns of Southern regional blocs. Southern regionalism redefines how socio-political agendas are addressed, which organisations are responsible for this and how Southern regional organisations have become a more autonomous force in determining a Southern regional outlook to social policy concerns (Riggirozzi and Yeates, 2015; Yeates 2014a, 2014b, 2014c, 2014d). Southern regionalism looks beyond market-driven objectives in the Global South and integrates socio-economic needs in the region with policies and practices befitting Southern regional economic and development communities (Riggirozzi and Yeates 2015). Southern regionalism restructures the role of Southern regional organisations from regional structures capable of decision making and acting capacity, to global actors

(Yeates and Riggirozzi 2017). Southern regional governing bodies, policies and practices are geared towards Southern regional concerns, instead of being determined by Northern economic imperatives (Riggirozzi, 2015). Southern regionalism echoes the "will to renew (regional) politics" (Arditi, 2008) by moving to socio-political, ideational and institutional transformation (Riggirozzi, 2015), as a redefinition of regional consent on issues of social and economic regulation, planning and financial cooperation (Yeates and Riggirozzi, 2017).

The project explores how health and its intersections with poverty enter the regional policy discourses and practices of SADC. Tracing the institutional foundations and contours of the health/poverty nexus in SADC regional policy from the inception of the SADC Protocol on Health in 1999 to the present day can frame how regional processes work to create access to healthcare and medicines. It also addresses and engages with key analytical themes, including how the policy process operates in defining health priorities, whether these policies are embedded at a national level, and what progress SADC has made with regard to access to healthcare, reflecting regional norms within the organisation.

The project also questions whether regional institutional practices are conducive to promoting the embeddedness of a "pro-poor" policy. This regards poverty and healthcare within the framework of a pro-poor discourse. Tracking pro-poor discourse and development in the SADC region is a difficult task, considering the vast economic imbalances, political tension, and varying levels of poverty and donor assistance in the region (Hurt, 2012). Our research indicated that the use of the term "pro-poor" was not an adequate reflection of how policies are developed by SADC member states. Southern Africa is a poor region and SADC policies are mandated to focus on poverty reduction.

The term is used in the development industry as a concept to address a wide number of policies that are "pro-poor" and/or "pro-growth". However, the concept and the way it is used could mean different things in different contexts. The SADC Secretariat has mentioned specifically that they do not use this concept as representative of regional policies, particularly with regard to health policy (Cord, Lopez, Page, 2003).

References to "pro-poor" initiatives are used in diverse ways across the world and the concept does not have a single and specific definition. Nevertheless, the use of the term is advocated by some bilateral and multilateral donors as an important part of public policy in low-income countries (Cord, Lopez, Page, 2003; OECD, 2008). That said, given the resistance/objections to this term, it might not be a useful guide or help to provide a

normative framework for the region. The SADC region uses the poverty benchmark of a population living on less than $1 a day (using data from the International Council on Social Welfare).

5. Methodology

Using the broad method of purposive sampling (as primarily used in qualitative studies, defined as selecting units – individuals, focus groups and institutes – based on specific purposes associated with answering the research questions), we made use of desktop research, in-country information and snowball techniques to identify interviewees. We firstly identified potential key informants through Internet searches. Subsequently, a workshop was held as a means of identifying specific stakeholders who could link us to additional key informants to interview (Teddlie, Yu, 2007).

The purpose of the sampling methods was to generate a selection of people who could answer the research questions, using a questionnaire that built a narrative for the research questions. The rationale for selecting the interviewees was to address specific purposes relating to the research questions. The samples were selected before and during the fieldwork phase of the research.

We (Penfold and Fourie) visited three countries. We conducted face-to-face interviews three times in Swaziland, once in Zambia and three times at the SADC Secretariat in Gaborone, Botswana. We also conducted interviews with organisations in South Africa. We interviewed three categories of organisations, namely government agencies, multilateral organisations and civil society organisations. These included project officers, researchers and senior government officials amongst others.

The project methodology carefully considers actors involved in addressing the health burden in Southern Africa. The next section highlights the key challenges of the health burden in the region.

6. The characteristics of the health burden in Southern Africa

The health burden in Southern Africa is characterised by high levels of HIV and AIDS, tuberculosis, and malaria. HIV and AIDS, TB and malaria are the three most prominent diseases in Southern Africa and are significant in the overall burden as the numbers of

affected citizens make up the bulk of the disease burden. SADC continues to be the 'global epicentre of HIV and AIDS. Nevertheless, the 2015/16 SADC annual report indicates a decline in new HIV infections from 880,000 in 2010 to 763,000 in 2015, or a drop of 13.3%. The biggest decline (64.2%) was noted among children in the age group 0-14 and is attributed to the success of the PMTCT programmes in the SADC member states. Among adults the decline was only 5.3% (SADC, 2017). . Furthermore, Southern Africa continues to experience high rates of new HIV infections, despite the scaling up of treatment and interventions (Delva, Karim, 2014).

Figure 1: Development Indicators SADC

	Population 2015 (000)	Birth Rate 2015 (per 1,000 women of reproductive age)	Death Rate 2015 (per 1,000 population per year)	Life Expectancy at birth 2015	Infant Mortality (No. of deaths per 1,000 live births) 2015	Number of reported cases of TB (2013)	HIV Prevalence (2013) (% of people tested who were found to be infected with HIV)	Number of reported cases of malaria (2013)
Angola	26,682	36.9	8.4	61.2	63.4	58,607	2.0	1,999,868
Botswana	2,195	22.8	7.9	68.0	17.0	6,834	24.8	456
Democratic Republic of Congo	71,386	n.a.	n.a.	59.1	74.5	112,439	1.1	6,715,223
Lesotho	1,924	29.5	19.9	45.0	80.9	9,555	23.0	…
Madagascar	23,041	n.a.	n.a.	65.5	35.9	26,569	0.2	387,045
Malawi	16,311	42.8	11.3	56.8	42.0	17,779	11.0	1,280,892
Mauritius	1,263	10.1	7.7	74.5	13.6	130	1.0	…
Mozambique	25,728	39.3	12.4	53.8	79.2	53,272	11.4	2,998,874
Namibia	2,281	n.a.	n.a.	n.a.	32.8	9,597	13.1	4,911
Seychelles	93	17.0	7.5	74.2	10.7	24	…	…
South Africa	54,012	22.2	9.8	62.1	34.4	312,380	17.8	8,645
Swaziland	1,119	30.1	17.3	45.7	98.8	6,641	25.78	402
United Republic of Tanzania	48,776	35.2	12.3	61.8	43.0	64,053	5.6	1,552,444
Zambia	15,474	43.4	13.1	53.3	74.2	40,638	13.5	0
Zimbabwe	13,944	32.0	n.a.	n.a.	50.0	32,899	14.3	422,633

Source: SADC Statistical Yearbook, 2015, World Bank Population Data 2015, World Health Statistics 2015

South Africa itself has the world's largest epidemic. In 2016 South Africa accounted for one third of East and Southern Africa's new HIV infections. HIV and AIDS rates in East and Southern Africa stand at 7% prevalence in the adult population (Avert, 2017). The region has 50% of the total number of people living with Aids in the world. In 2016 it had 43% of total new infections and women accounted for 56% of adults living with HIV (Avert from UNAIDS).

Malaria incidence has decreased overall in Southern Africa, as a result of the progress of programmes such as the E8 consortium (see below), but the disease remains a challenge in certain countries such as Zambia and Zimbabwe (Interviewee C1, 2015; Braack, 2015; WHO, 2015a).

TB continues to pose significant problems, particularly among mineworkers, with incidence levels of 2 500 to 3 000 cases for every 100 000 people. This rate is ten times the level that is classed as a health emergency (World Bank, 2014).

The World Health Organisation has documented existing problems, including disruptions to nutritional, water, energy and medical services, identifying the need for national health ministries to develop improved health systems. Common challenges include the complexities of HIV and AIDS in relation to other diseases (primarily TB), weather conditions, the brain drain of healthcare workers, increasing socio-economic decline and inadequate health policies to address these challenges (WHO, 2015a; SADC, 2014d).

Regional organisations have stepped up in recent years to shoulder some of the health burden. The health burden has been a driver for social policy change in SADC. Member states have worked together to address health challenges from SADC's inception, with particular focus on policy making for health concerns. However, efforts to mitigate challenges to healthcare and poverty in Southern Africa are directly linked to the region's economic strength (including at a national level), as well as the role of donors and their related financial capacity (Handley et al., 2009). Gray (2013) argues that SADC is an example of an organisation that attracts, and is reliant on, development aid.

Donors influence the political economy of development and the political economy of health in the region. Aid organisations are responsible for coordinating, amongst other things, HIV/AIDS plans and projects. The overall SADC 2015 budget of $79 million is mostly funded by donors (ENCA, 2015). Overall donor spending for the region in 2015 was projected to be about 61% of the total budget (Adebajo, 2014). External finance and foreign aid have encouraged institutional transformation within SADC, with support in particular from the

European Union (EU), Finland, the United Kingdom, Germany and Switzerland, in order for SADC countries to increasingly address socio-economic concerns (Gray, 2013 Tjonneland, 2006).

Table 1: GDP, Gini co-efficient and Overseas Development Assistance per Member State

Country	Year	GDP (Market Price) millions	Year	Gini-coefficient	Year	Net official development assistance received (constant) (US$)
Angola	2015	115,114	2015	55	2014	418,930,000
Botswana	2015	14,384	2015	64.5	2014	67,500,000
DRC	2015	37,587	2006	44.4	2014	2,828,780,000
Lesotho	2015	2,280	2010	53.8	2014	90,300,000
Madagascar	2015	8,920	2013	41..3	2014	750,680,000
Malawi	2015	6,430	2010	45.2	2014	1,155,270,000
Mauritius	2015	11,681	2012	41.4	2014	90,230,000
Mozambique	2015	15,466	-	n.a.	2014	2,024,560,000
Namibia	2015	11,545	2010	59.7	2014	155,310,000
Seychelles	2015	1,380	2013	45.9	2014	7,720,000
South Africa	2015	314,792	2011	65	2014	1,592,970
Swaziland	2015	3,946	2013	51.5	2014	101,230,000
Tanzania	2015	45,772	2007	35.0	2014	2,844,140,000
Zambia	2015	21,274	2015	69.0	2014	872,770,000
Zimbabwe	2015	14,419	2010	n.a.	2014	867,660

Source: SADC Statistics Yearbook, 2015, World Bank https://data.worldbank.org/indicator/DT.ODA.ODAT.KD?locations=AO-ZW&name_desc=true

7. Project findings

Using regional and national evidence and interview data, we were able to assess how SADC operates at a regional policy level, how this process fits in the narrative of regionalisation and whether SADC has been successful in this path.

7.1 Policy framing in SADC – how does health reflect on regionalism?

Initially, SADC defined "health" as a discrete area of attention, and allocated each such issue area to a specific member country. However, this has changed, and in more recent years the SADC Secretariat has done away with such a portfolio approach and replaced it with a more generic, mainstreaming approach. Instead of a top-down course where SADC identifies, introduces, develops and implements policy initiatives, it is up to individual member states to bring an issue to the Secretariat, and to then consult with other member countries before mandating the Secretariat to develop policy initiatives. Instead of a specific country being responsible for health in its entirety as when there were sectoral coordinating units, every country has the right to bring a health issue to the Secretariat.

7.2 Policy frameworks and protocols

SADC has developed a corpus of policy frameworks and protocols that speak to health horizontally (collectively, generically); it also has vertical policy frameworks and protocols, which suggest regional interventions targeting specific diseases or health issues (e.g. HIV). "Frameworks" and 'protocols" do not, however, imply great regional and institutional capacity for policy initiation and implementation. Instead, our research exposed a number of at times surprising and counter-intuitive findings.

Firstly, the SADC Secretariat serves at the pleasure of its member states. It follows a bottom-up protocol for policy agenda setting, development, and implementation. In fact, the SADC Secretariat does not implement policies on its own; instead it acts as a locus of (limited) policy development and technical assistance. Individual member countries have to identify issues for policy development in the first place, and then implement those policies themselves (with some technical assistance from the Secretariat – at most).

Secondly, individual member states often identify health and other policy issues in tandem with and/or at the suggestion of international donors or multilateral development organisations. The latter typically make technical expertise and funds available for the development and eventual implementation of policies. When member states lack the

capacity to implement such policies themselves, they outsource the implementation function to national NGOs and CBOs, who apply for funding in dedicated 'rounds', and then roll out specific national health programmes.

Stated differently: donors and multilateral aid organisations work together in national health policy agenda setting, then facilitate some consultation with national governments, and provide the means (funds) for governments to then contract civil society in implementation. The SADC Secretariat has a very limited role in health policy agenda setting, development, and implementation – nationally and regionally. In fact, the SADC Secretariat is now actively cutting back its involvement in regional and/or national health programmes. This cutback is largely attributed to budgetary constraints, with more money being spent on security and less on health. Donors in the North are also reducing or redirecting development funding. SADC policy initiatives are framed in the context of the health burden in Southern Africa.

7.3 SADC policy documents and developments

Poverty reduction and regional integration are written into the SADC mandate, vision, mission and goals. The SADC Treaty identifies sustainable development and poverty reduction as priorities for the region (SADC 2014a; SADC Treaty, 1992; Giuffrida, Muller-Glohde, 2008).

At a regional level, policy making for access to healthcare and medicines is a partnership between the SADC Secretariat, national governments and their respective Ministries of Health, and donor agencies. These partners cooperate on issues of poverty reduction, and access to healthcare and medicines. The Protocol on Health (1999) focuses on two main aspects of healthcare, namely health and pharmaceuticals, and HIV and AIDS. The Protocol notes that member states under the SADC mandate work together to attain acceptable standards of health for all SADC citizens. Member states must implement the SADC Health Protocol (1999). The SADC Health Protocol also commits member states to focus on reducing the number of people living with HIV and AIDS in the region (SADC, 1999). The HIV and AIDS Strategic Framework (2007-2015) is the legal document which establishes these goals (SADC, 2014d).

Interviewees from the SADC Secretariat confirmed that poverty reduction and eradication are primary objectives for the region, echoing SADC's mandate:

It is, I would say, poverty eradication actually is the over-ranking objective for SADC. Even all the programmes that SADC has are expected to impact on poverty or to contribute to the reduction of poverty in the region. That is the over-ranking objective (Interviewee B3b).

Harmonisation and domestication are the processes of integrating SADC policies and ensuring member states implement them at a national level. National policies focusing on specific aspects of health, for example, or economics, are synthesised and developed into SADC strategies and protocols, (always reflective of the poverty reduction mandate (RISDP, 2001)). Policy developed must harmonise national plans (Interviewee D3).

The Health Directorate focuses specifically on the facilitation and coordination of health care policies and standards proposed and agreed upon by SADC member states. The primary focus for the directorate is HIV and AIDS, tuberculosis (TB) and malaria (SADC, 2014). SADC works in partnership with international cooperation partners (ICPs), depending on what policy process is being facilitated: for example, SADC partners with the Global Fund for the cross-border HIV and AIDS initiative (Interviewee D3).

The directorate is limited in its activities, considering the varying country priorities within the region. Health priorities are outlined in SADC regional health policy documents (predominantly focusing on HIV and AIDS, TB and malaria).

Below we briefly set out what is contained in the Health Protocol (1999) which forms the overarching framework for regional health priorities, and the RISDP (2001-2015), which is SADC's strategic plan for economic integration and development.

7.3.1 The SADC Protocol on Health (1999)

The SADC Protocol on Health was signed on 18 August 1999 to coordinate regional efforts on epidemic preparedness, mapping prevention control and the eradication of communicable and non-communicable diseases in the region (Padarath et al., 2003; SADC, 1999). Education, training, laboratory services and strategies to address health needs of women, children and vulnerable groups are also included in the protocol. SADC recognises that "a healthy population is a pre-requisite for the sustainable human development and increased productivity in a country" (SADC, 1999). Member states acknowledge that regional cooperation for health is indispensable for controlling communicable and non-communicable diseases, to address common concerns in the region (SADC, 2014b). The Protocol encourages

the establishment of institutional mechanisms within the health sector of the region to effectively implement the Protocol.

7.3.2 The Regional Indicative Strategic Development Plan (2001-2015) and revised RISDP (2015-2020)

The RISDP objectives are to review the main SADC cooperation and integration areas, define priority integration areas over a fifteen-year period and develop an implementation programme of the main activities needed to achieve the broader SADC goals. In addition, the plan aims to ensure sectoral linkages and synergies, and to provide member states, the Secretariat and other institutions, regional and international stakeholders with a long-term implementation agenda (SADC RISDP, 2001; RISDP Summary, 2001; TRALAC, 2012; SARDC, 2014). The RISDP intervention areas are poverty eradication, combating HIV/AIDS, gender equality and development, science and technology, information and communications technology, environmental and sustainable development, and private sector development (SADC RISDP, 2001; RISDP Summary, 2001; TRALAC, 2012).

The RISDP prioritises poverty reduction in relation to health issues (RISDP, 2001:14) and as a key objective to ensuring redress for all other intervention areas in the SADC region (SADC RISDP, 2001; TRALAC, 2012).

A key strategy in eradicating poverty is facilitating the empowerment of poor people by laying the political and legal basis for inclusive development, promoting public administrations that foster economic growth and equity, promoting inclusive decentralisation and community development, promoting gender equity, addressing social barriers and supporting poor people's social capital (RISDP, 2001:70)

This refers specifically to the empowerment of poor people, with reference to social development, inclusive of health. The document also makes specific reference to the SADC mandate of poverty reduction and the HIV and AIDS pandemic, acknowledging how the health-poverty nexus is reflective of ill health and poverty burdens (SARDC, 2014).

Realising that the RISDP priorities set out in the 2001-2015 framework were beyond member state capacity and would result in the need for an increased SADC budget, in August 2007 the Council of Ministers approved the “reprioritisation of SADC programmes”, with a framework for reallocation of resources, to improve overall efficiency and effectiveness. The revised priorities included trade and economic liberalisation and development, infrastructure in support of regional integration, peace and security cooperation, and special programmes

of a regional dimension, which include health, education, food security and gender equality amongst others.

The revised RISDP for the period 2015-2020 was approved in April 2015. The main pillars that had been adopted in 2007 remained relevant but were reorganised as follows (SADC, 2015): priority A – industrial development and market integration; priority B – infrastructure in support of regional integration; priority C – peace and security cooperation; and priority D – special programmes of a regional dimension (which includes health initiatives). On the specific areas of health, the revised RISDP identifies the pooled procurement and regional production of essential medicines and health commodities as essential outputs during this period, as well as the development of a monitoring and evaluation framework. Combating HIV/Aids is again highlighted as a key objective, with cross border initiatives recognised as important (SADC 2015).

SADC policy documents act as legal instruments which establish guidelines and imperatives for health priorities in the region. There are six key documents which address health in SADC (Amaya et al, 2015). The two major policies we have discussed are the SADC Protocol on Health (1999) and the Regional Indicative Strategic Development Plan (RISDP, 2001). The additional four documents are the Maseru Declaration (2003), the SADC Declaration on Poverty Eradication and Sustainable Development (2008), the Sexual and Reproductive Health business plan for the SADC region (2011-2015), and the SADC Strategy for Pooled Procurement of Medicines and Health Commodities (2013-2017), which are subsidiaries to the SADC Protocol on Health (1999) and the RISDP (2001).

The policy-making process is an integral part of understanding how these documents are developed. When policies are created, the process follows a specific trajectory, leading down from decisions made by member states, through to the SADC Secretariat, for final implementation by external partners facilitated by the SADC Secretariat. However, there are certain constraints to policy making.

7.4 Policy-making processes

To contextualise how policies address health, we look at how SADC is firstly structured. SADC works on regional cooperation and coordination of four specific areas: trade, peace and security, industrialisation, and social development (SADC Think Tank Conference, 2012). The SADC Secretariat functions as the organisation's "secretary" (Interviewee D2).

The Secretariat Executive is responsible for acting on behalf of SADC member states to develop legal instruments (protocols), agreed upon by member states, for member states to work on the four areas identified. Member states remain sovereign and do not put matters to the vote, preferring decisions by consensus only (Saurombe, 2012; SADC Secretariat; SADC, 2015b).

The Secretariat plays a coordinating role for SADC to ensure that SADC decisions are implemented. The Secretariat monitors how member states function and acts as an information hub for the region. It uses information provided by member states to achieve its objectives. Information facilitates processes and the Secretariat facilitates signing of agreements, informed by knowledge produced by member states, independent consultants and civil society (SADC Think Tank Conference, 2012).

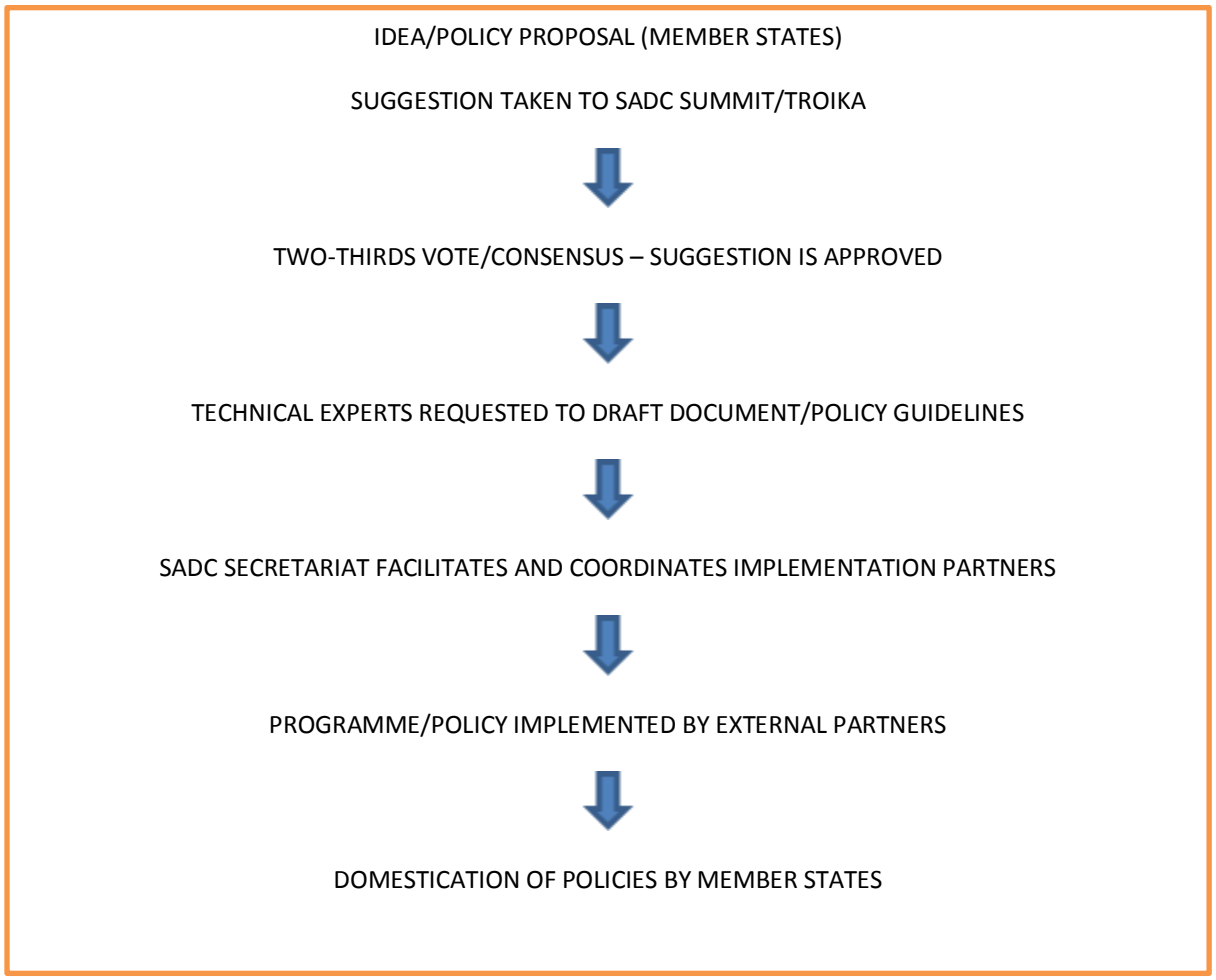
Procedures within SADC depend on the individual unit in SADC. For example, peace, security and defence have more influence and greater investment (Interviewee B3a, Interviewee B3b). The Secretariat facilitates harmonisation of member state policies. Article 5 of the SADC Treaty stipulates that SADC shall "harmonise political and socio-economic policies and plans of Member States (SADC, 1992). Harmonisation is the process of identifying mutual priorities in national plans of member states and compiling these into treaties and protocols. Harmonisation requires both give and take from member states. Certain states, such as South Africa, dominate in the region, however, which complicates the harmonisation process (Kalenga, 2012; SADC Think Tank Conference, 2012; Saurombe, 2012).

The health directorate is housed within the Directorate of Social and Human Development and Special Programmes. It is managed by a minimum number of staff and works closely with the HIV and AIDS unit. Health decisions and policy processes require input from member states, who propose programmes and policies to the SADC Council of Ministers or the SADC Troika. The SADC Council oversees the functioning and development of SADC and ensures that policies are properly implemented. The Council is made up of Ministers from each Member State. It meets once a year before the SADC Summit (SADC, 2014). The SADC Troika manages the Directorate of the Organ on Politics, Defence and Security Cooperation. It is mandated to steer and provide Member states with direction regarding matters that threaten peace, security and stability in the region. It consists of a Chairperson, Incoming Chairperson and Outgoing Chairperson, and reports to the SADC Summit Chairperson (SADC, 2014)

As indicated above, the health directorate is not growing and has no capacity to implement policies and agreements or to monitor outcomes.

The policy-making process is important. Member states table proposals for social development and consider poverty reduction and sustainable development goals. The proposal process works as outlined in Box 1.

Box 1: SADC regional policy process



Source: The Author

The following section provides an analysis of policy making constraints, to show how SADC is limited in its actions.

7.5 Policy making constraints

Regional protocols should technically be included as part of national policy, to integrate policies for greater cross border collaboration. (Riggirozzi, Yeates, 2015). For states to

integrate as part of social policy development, it would be beneficial for national and regional policy to be integrative. This is not necessarily so in the case of SADC.

Regional health policy in SADC is constrained. National policy remains the key determinant of health policy targets and donor funds at a member state level, as opposed to a top-down regional approach. There is no regional-national crossover between SADC mechanisms and national policy-making mechanisms. States are responsible for domesticating SADC policies at a national level and national policies are harmonised in regional frameworks – arguably a one-way process. There is no inter-connectivity between national policy processes (made by national ministries) and regional policy processes developed by SADC, other than harmonisation of certain aspects (Nzewi, Zakwe, 2009).

The SADC Treaty makes provision for sanctions against states (article 33). The SADC Summit can enforce compliance by placing sanctions on member states. Sanctions can be restrictions on access to documents, restrictions on contributions to meetings, or suspension of membership. However, in practice SADC states have always been loathe to apply sanctions against a member. Sanctions have never been used to enforce compliance on health matters. (SADC, 2014b). While sanctions may not always be politically palatable, the fact is that they are an instrument to ensure compliance. In their absence there is no way to keep member states in check in terms of protocol obeisance, apart from perhaps peer pressure in cases where compliance is largely adhered to and one or two states may be the exception.[3]

We analysed the role of SADC at a national level to interrogate these policy constraints, to determine whether SADC has a scope of influence at a national level, and to ascertain the ways in which regional policy could be said to be embedded in spheres of domestic governance. Considering the role of SADC in the region and in individual countries, the research evidence indicates that as there is no mandate for national intervention, there is no real need for a regional office representative at an individual country level. SADC's broad project interventions are targeted at priorities which benefit the region as a whole and are not intended to target national programmes (USAID, 2011).

In Swaziland and Zambia, for example, health programmes at a national level are guided by the respective regional offices of international organisations: for example, UNAIDS

[3] The SADC Ministerial Retreat in March 2017 directed the Secretariat to develop 'effective compliance, monitoring and assurance mechanisms to track progress in implementation of SADC programmes and compliance to Protocols and legal instruments' (SADC 2017).

has a regional office, as does the World Health Organisation. There is no real role for SADC at a national level. Swaziland and Zambia each have a SADC representative, employed by SADC and based in each country. For example, the SADC representative in Swaziland is situated at the Department of Foreign Affairs. For health, if a policy idea is tabled, the issue will be debated by the Ministers of Health from each country (Nzewi, Zakwe, 2009). The next section provides case study evidence for these arguments.

7.6 National level case studies

The researchers identified Swaziland and Zambia as the country cases studies to test the arguments and research questions. The following section provides key findings on how SADC functions at a national level within each case study context.

7.6.1 Swaziland

Health policy in Swaziland is dominated by national health ministry priorities for eradicating HIV and AIDS. Swaziland has the highest HIV/AIDS prevalence in the world. Some 26% of people aged 15-49 are infected with HIV. In addition, 80% of TB patients are co-infected with HIV (CDC, 2015). In 2016, 210,000 people lived with Aids in Swaziland, of whom 200,000 were adults (Avert, 2017). The epidemic defines the country's disease burden and the poverty-health nexus, considering the country's weak economic position and the impact of the epidemic on the country's socio-economic profile. The government has committed to strengthening health financing and health investment. In the budget speech for 2014/2015, for example, 300 million Emalangeni is committed for medication and an additional 28 million Emalangeni for TB health care providers (Dlamini, 2014). Donors continue to support preventative health programmes for HIV/AIDS, STIs, TB and malaria, as the Swazi government is unable to meet these needs. Heavy reliance on donor funding is unsustainable for health financing in the long term. The 2008-13 National Health Sector Strategic Plan (NHSSP) set out to eliminate cost and improve affordability for health care by mobilising additional resources for the health sector although what these may be is not spelt out (NHSSP, 2008-2013:1). The country is in the process of developing the NHSSP 2014-2018. At the time of writing the paper, no final strategic plan was publicly available. Table 2 provides information on the health burden in Swaziland.

Table 2: WHO Statistical Profile (Swaziland)

Millennium Development Goals (MDGS) **Statistics**		
Indicators	**Baseline***	**Latest****
Under-five mortality rate (per live 1 000 births)	74	80
Maternal mortality ratio (per 100 000 live births)	550	310
Deaths due to HIV/AIDS (per 100 000 population)	603.5	441.1
Deaths due to malaria (per 100 000 population)	0.7	0.2
Deaths due to tuberculosis among HIV-negative people (per 100 000 population)	39	91
*1990 for under-five mortality and maternal mortality; 2000 for other indicators **2012 for deaths due to HIV/AIDS and malaria; 2013 for other indicators		

Source: WHO (2013a)

SADC has not had any direct impact on driving change in domestic policy embeddedness in Swaziland. Regional policy has been expanded, with SADC member states as participants, but there is no policy embeddedness at a national level. The US government has taken the lead in supporting the strengthening of health promotion and health systems in Swaziland. At a national level there is no connection with SADC. In 2009, the USA and Swaziland signed the Partnership Framework Agreement (2009-2013) under the President's Emergency Plan for AIDS Relief (PEPFAR) to strengthen the HIV/AIDS response and overall health sector capacity. PEPFAR support has enabled ARTs to reach 75% of those in need (Vandome et al., 2013, PEPFAR, 2009). In 2014 PEPFAR funding amounted to $43.8 million. Swaziland also partners with the European Union. EU funding for health amounted to 16.5 million euros, with the support of the World Bank (EU Commission, 2014).

The government has not been systematic in its response to development and health challenges. Poverty reduction through the social protection window has been progressive, but budgeting has remained fragmented. There has been an increase in free education and food assistance, but there is scepticism about the sustainability of social protection programmes in a stunted growth economy. Swaziland does not have adequate strategies and planning to generate revenue and the economy is over-reliant on revenue from the Southern African Customs Union (McCarthy, 2003). The system of taxation is punishing for the poor and the cash transfers intended for the poor are taxed, creating further poverty. In addition, the ministries are overwhelmed and understaffed and therefore constrained in their activities for poverty reduction and health.

There is limited interaction with SADC at a multilateral, non-governmental and civil society level. A SADC secretariat officer is assigned to be present at government meetings but that is the extent of interaction on many levels. International organisations have limited engagement with SADC and do not receive financial support from it, rather relying on their own regional offices for assistance. This is not to say that there is no interaction whatsoever, but the Swazi government only engages with SADC on specific issues, for example, contributing to a cross-border initiative. The Regional Indicative Strategic Development Plan requires that member states implement regional plans according to their own national priorities, but policy is led by a bottom-up approach, beginning at national level and then is communicated to SADC, but is not necessarily informed by SADC input. Domestication of SADC policies requires follow-through and implementation by member states, but there is no crossover into national policy embeddedness. SADC does not have the mandate to dictate policy to member states, nor does it provide funding for individual member state initiatives. There is only collaboration when the issue tabled is regional, proposed by a SADC member state and agreed on at the SADC Summit level. Swaziland has not individually tabled a health proposal for SADC. National-level organisations, including civil society, church groups, multilateral organisations and government employees suggest revisions to SADC's role in Swaziland in order for it to become more relevant.

Countries could regularly inform SADC about health priorities and needs in the country and the need for monitoring and evaluation specialists to ensure that SADC involvement, implementation and influence are regularly followed up so that the draft policies ratified become actionable pieces of legislation for all countries involved. However, the limited SADC

presence at a national level (and its limited mandate) means challenges of coordination and capacity for SADC at a national level.

SADC's presence in Zambia displays similar characteristics to those of Swaziland. The following section provides an overview of Zambia's health burden, national policy making and the role of SADC in Zambia at a national level.

7.6.2 Zambia

The country has a high prevalence of communicable diseases, including HIV/AIDS, malaria, STIs and TB. In addition, the country has high maternal, neonatal and child morbidities and mortalities. Non-communicable diseases such as diabetes, cardio-vascular disease, mental health and violence, are also on the rise. (NHSP, 2011-2015). In Zambia in 2016, 1.2 million people lived with Aids, of whom 1.1 million were adults (Avert, 2017). Table 3 provides information on the health burden in Zambia.

Table 3: WHO Statistical Profile (Zambia)

Millennium Development Goals (MDGS) **Statistics**		
Indicators	**Baseline***	**Latest****
Under-five mortality rate (per live 1 000 births)	193	87
Maternal mortality ratio (per 100 000 live births)	580	280
Deaths due to HIV/AIDS (per 100 000 population)	749.1	255.7
Deaths due to malaria (per 100 000 population)	160	76.3
Deaths due to tuberculosis among HIV-negative people (per 100 000 population)	35	25
*1990 for under-five mortality and maternal mortality; 2000 for other indicators **2012 for deaths due to HIV/AIDS and malaria; 2013 for other indicators		

Source: WHO (2013)

Zambia's national health policy is contained in the National Health Strategic Plan (2011-2015). (In 2017 a new plan was approved for the period 2017-2021.) . The 2011-2015 plan set out how the government will address health priorities in the country and it is working

to achieve its targets. It highlights how poverty is creating further health problems, considering the high levels of unemployment and the weak socio-economic status of the population. The plan acknowledges that little research has been conducted on how health challenges are affecting the poor. Health services, facilities and workers are concentrated in urban areas and favour the rich and urban populations (NHSP, 2011-2015). The SADC Secretariat did not play a part in developing the National Health Strategic Plan, which reflects key Zambian health initiatives rather than more regional ones. Significantly, regional policy is not embedded in national policy (Interviewee C1, Interviewee C14). The new plan for the period to 2021 makes no mention of SADC.

The government has implemented measures to distribute health resources equitably, including resource allocation criteria for health grants and a retention scheme for health workers. The government introduced the User Fees Removal Policy in 2006, for rural and peri-urban areas to increase access to health services. This has resulted in increased use of health services (Carasso et al., 2012). This policy is described in the National Health Strategic Plan as a "pro-poor" policy inclusion. However, it has not benefitted the urban poor, who have to pay fees to access health services. There are targeted pro-poor initiatives, including participatory and action method pilots and the Social Cash Transfer Scheme administered by the Public Welfare Assistance Scheme (NHSP, 2011-2015).

The 2017-21 plan places greater emphasis on primary health care. Prevention and treatment of non-communicable diseases, health promotion, the social determinants of health and disease surveillance will be given more attention in this phase. The objective is also to revitalise Neighbourhood Health Committees to bring health closer to the people (Republic of Zambia, 2017).

There is limited interaction with SADC, although SADC representatives are sometimes present at government meetings. Many interviewees were actively interested or involved in the question of how regional organisations can be rejuvenated. Part of such a rejuvenation strategy could include greater SADC interaction with CSOs and with multilateral organisations. Similarly to Swaziland, SADC does not play a role in national policy (Edwards, 2012). Nevertheless, Zambia participates in some cross-border initiatives that have shown some progress, including the cross-border malaria and HIV initiatives (UNDP, 2013) (see below).

SADC has a representative in the Zambian government. Health governance programmes are either led by government, donors or both in partnership with each other.

SADC has some representation within the government but does not interact with CSOs and faith based organisations. There is some negotiation with multilaterals, but generally multilateral organisations operate within national boundaries rather than regionally. There is no conflicting health governance within Zambia between multilaterals and SADC, as SADC has no health governance presence at a national level (Interviewee C1, Interviewee C2a and 2b).

Interviewees emphasised the importance of focusing more on the delivery of action plans in different countries, with a specific focus on the pharmaceutical directorate (considering the problems with access to medicines in Zambia (Interviewee C1). Member states must hold SADC accountable for supplying human resources for health, in conjunction with national planning documents, for example, the National Plan for Health Workers in Zambia. Harmonising the health sector, was argued to be a great opportunity for civil society to advocate how policies are implemented and how action plans are monitored.

Considering the limited interaction of SADC with national policy initiatives, the following section identifies regional healthcare initiatives to which all SADC states are signatories, and which ideally should be domesticated into national frameworks. The regional healthcare initiatives described represent progress in SADC's regional healthcare agenda in addressing the health burden in SADC states.

8. Regional progress on health policy and programmes

SADC initiates regional health programmes at the proposal of one or more member states. These programmes are examples of SADC's regional progress on access to healthcare and medicines (Penfold, 2015). Despite there being no SADC presence at a national level, the cross-border initiatives have shown that, with dedicated funding and political commitment, there is regional capacity to facilitate implementation of these initiatives. The following examples provide an indication of how these regional initiatives function, the policy processes involved and some of the procedures followed to ensure implementation of the programmes.

8.1 The SADC Cross-Border HIV and AIDS Initiative

The policy-making process for the cross-border initiative for HIV/AIDS engages the SADC Secretariat, multilaterals, and NGO and civil society partners. Increased movement across borders has increased the risk of HIV transmission in key populations, including commercial sex workers and long-distance truck drivers (SAMP, 2005). Migrant populations are at risk, as

are communities within close distance of border-crossing sites and communities with increased levels of migration. Younger working-age adults are also at risk, considering their mobility and the involvement of young women in transactional sex (SAMP, 2005).

The SADC HIV and AIDS Cross-Border Initiative aims to address these particular challenges. The Initiative is supported by an HIV Cross-Border Initiative Global Fund grant, with the outcomes of improving the effectiveness of the regional response to HIV and AIDS, with particular emphasis on mobile populations, to reduce HIV infections in the SADC region (SADC, 2012a; SADC HIV and AIDS Cross-Border Initiative Summary Document, 2011; ILOAIDS, 2005).

SADC developed the Initiative in 2011 in consultation with member state Ministers of Health, relevant technical advisers, stakeholders and civil society partners. The two main implementing partners are the North Star Alliance and the Walvis Bay Corridor.[4] The policy process was started in 2010. As a preceding condition for the Global Fund grant, each SADC member state was required to sign a Memorandum of Understanding (MoU), which describes the commitments between SADC, its sub-recipients and member states. The MoUs also outline the member state commitments to the provision of pharmaceuticals, medical supplies, work permits and exemption from custom duties (SADC, 2012a). The MoU process required the SADC HIV Unit to visit member state signatories to introduce the project, agree on project logistics (including location of mobile wellness clinics at border posts) and obtain member state commitments to further support the resourcing and functioning of the Initiative. Twelve MoUs were signed by July 2012 with Angola, Botswana, the Democratic Republic of Congo, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

The SADC HIV/AIDS Unit was responsible for visiting member states and mobile site units in 2011 with relevant partners from the North Star Alliance, the Walvis Bay Corridor Group and relevant representatives from Ministry Departments (including Ministries of Health and Transport). The MoU process facilitated participation and buy-in from member states. Additional issues discussed as part of the MoU and document-planning process

[4] The North Star Alliance is a group of organisations dedicated to providing healthcare throughout Africa to hard-to-reach populations in particular, including long-distance truck drivers and commercial sex workers in migrant corridors. The Walvis Bay Corridor is a private-public partnership established to facilitate the use of the Walvis Bay Corridor transport routes, including the Trans-Kalahari, Trans-Kunene, Trans-Caprivi and Trans-Oranje corridors, effectively acting as a transport hub for the SADC region (North Star Alliance, 2014).

involved discussion of practical implementation, including provision of land for mobile clinics, work permits and government approval processes for the cross-border staff, import duty exemptions, staff recruitment, provision of clinic HIV-testing kits and STI drugs by member states and primary health activity expansion (SADC, 2012a).

Following the signing of the MoUs, the SADC Secretariat facilitated the drafting of a planning and policy document, the SADC HIV and AIDS Cross-Border Initiative. All member states have now agreed to provide access without charge to clinics at cross-border sites. The Initiative has been implemented in 12 member states. The Initiative's objectives are to harmonise policies, frameworks, plans and strategies for mobile populations and affected communities and improve coordination and collaboration for a regional response to HIV and AIDS, to strengthen HIV and AIDS mainstreaming across sectors and programmes for mobile populations and affected communities, to strengthen monitoring and evaluation systems for mobile populations affected by HIV and AIDS and to coordinate and enable sub-regional interventions for regional response commitments (SADC, 2012a; SADC HIV and AIDS Cross-Border Initiative Summary Document, 2011).

The implementation partners for the initiative are responsible for the rollout of the project. The initiative will see the rollout of a fleet of mobile clinics or "Wellness Centres" to provide basic health services, HIV prevention, STI treatment, HIV counselling and testing, condom distribution and community health referrals as needed (Jones, Hellevik, 2012).

The project has a multi-country approach to provide border communities and mobile populations with access to STI treatment and HIV prevention, with the additional outcomes of lowering HIV prevalence in the region. Technical advisers facilitate the initiative at the regional level to create further benefits for access to healthcare and medicine in the region. The project has established and is creating a sustainable system for 29 vehicle-based mobile clinics which employ medical staff (Interviewee D2, 2015).

The policy implementation of the initiative is facilitated by the SADC Secretariat, Ministries of Health and SADC member states. Operations are undertaken by the abovementioned partners with donor support. The project is being extended through to 2017, when the operational side of it will be taken on by ministries and other sustainable regional coordinating committees (Interviewee D2, 2015).

The policy process details each step of engagement with different national, regional and international partners, together with project funders and SADC. Clinics are free and

primary healthcare is free. The HIV and AIDS unit at SADC (funded by SADC member states) is the chief coordinator of the initiative and employs a project coordinator, who works together with relevant specialists to ensure facilitation of the project (Interviewee D1a, 2015).

The initiative is rolled out in partnership with national governments, Ministries of Health and the implementing partners who work on the cross-border mobile sites. The SADC Secretariat acts as a facilitator and support structure for the process. The donors provide funding and technical support. In practical terms, the project works with a bottom-up approach, as national implementation partners are responsible for enacting initiative goals and outcomes. At a regional level the Secretariat, donors and regional health partners offer technical support and administrative assistance (Interviewee D2, 2015). The link with poverty is evident in these initiatives; about half of the SADC population lives on less than $1 a day, and is dependent on this programmatic support for healthcare. These initiatives address the question of national domestication of regional initiatives. Domestication cannot outrightly be regarded as leading to implementation, as this is procedural and highly case-dependent. Each member state involved has had to implement the terms required by the policy.

8.2 The SADC Pharmaceutical Business Plan

The SADC Pharmaceutical Business Plan sets out a regional framework for regional access to pharmaceuticals for all member states. This Plan was initiated in 2007. SADC identified the need to develop a pharmaceutical programme to match the health protocol and health policy objectives to enhance member state capacity to prevent and treat diseases across the region. The focus was mainly on addressing access to quality medicines, with the goal of ensuring availability of medicines to decrease the regional disease burden (Box 2).

Box 2: Major challenges for pharmaceuticals in the SADC region

- Outdated medicine laws and IP laws not TRIPS compliant
- Government expenditure on pharmaceuticals below 15% of national budget although the Abuja Declaration target is above 15% of budget. Weak regulatory systems and lack of regulatory capacity to ensure quality, safety and efficacy of medicines
- Predominance of private sector spending on medicines (implications for affordability by the poor)
- Inadequate medicine quality control laboratories in the region
- Over dependence on imports – 85% of ARVs imported from India and only 15% manufactured in the SADC region
- No research and development of medicines
- Unreliable supply chain management of medicines
- Lack of trained personnel

The Business Plan is the implementing mechanism of the programme. The policy process was initiated in line with the SADC Protocol on Health, the Implementation Plan for the Protocol on Health and the SADC Health Policy Framework. The SADC Pharmaceutical Business Plan was coordinated and implemented through SADC-approved structures, delineating clear roles and responsibilities for all implementation stakeholders. The plan was monitored by a SADC institutional framework, comprising a subcommittee made up of the SADC Ministers of Health.

As an Integrated Committee of Ministers, the subcommittee reviewed, approved and proposed the Implementation Plan and was responsible for monitoring its implementation. Ministerial meetings were supported by senior officials from member state health departments. Technical subcommittees and supporting organisations, particularly the Southern African Regional Programme on Medicines and Diagnostics (SARPAM) were engaged for programmatic support (SARPAM, 2015). The SADC Directorate was made responsible for overseeing SADC's engagement with social and developmental issues. The Health Desk at the SADC Secretariat was tasked with coordinating Plan implementation, including development of yearly plans, technical subcommittee meetings, terms of reference, information for stakeholders and progress reports (Avafia et al., 2009; WHO, 2011; SADC, 2014d).

The Plan was tabled and accepted for the years 2007 to 2013. The pharmaceutical plan focuses on a pooled procurement of medicine programme, with the intention of promoting regional medicine production and health commodities. This is still happening in phases, with the beginning phase currently focusing on information sharing between countries. With the assistance of SARPAM, a sharing database has been established, with the intention of countries sharing information on access to medicines, national pharmaceutical policies and procurement. The objective is work out a way to develop a cross-regional pharmaceutical policy, to allow migrant populations to access medicine or a kind of regional medical access card, which would allow regional access to hospitals and pharmacy stores. Further collaboration is envisioned with generic producers in India and Brazil so as to increase use and/or production of local generics (Avafia et al., 2009; WHOc, 2011; SADC, 2014d).

In August 2017 the new plan for the period 2015-19 was launched during the SADC Industrialisation Week. The plan is estimated to cost $10m. The plan focuses on three areas:

regional production, rational use of medicine, and pooled procurement with regard to trade. It identifies eight strategic objectives (Southern African Trust 2017):

- Review existing member state standard treatment guidelines and essential medicine lists;
- Create an enabling environment that will maximise the research into production capacity of local and regional pharmaceutical industry in terms of generic essential medicines;
- Strengthen regulatory capacity;
- Strengthen supply chain management systems;
- Establish a regional databank of African traditional medicines, and medicinal plants in order to ensure their protection in accordance with regimes and related intellectual property rights governing genetic resources, plant varieties and biotechnology;
- Develop and retain competent human resources for the pharmaceutical programme;
- Facilitate trade in pharmaceuticals in the region; and
- Create an enabling environment that will promote operational research into pharmaceutical issues.

8.3 Additional cross-border initiatives

Two other important initiatives are the E8 initiative and SADC Declaration on Tuberculosis in the Mines. These initiatives were established under the same policy conditions as the previous two and have shown progress in their efforts to combat malaria and TB respectively.

8.4 E8 and regional elimination of malaria

The Africa Malaria Elimination Campaign launched by the African Union in 2007 committed African states to transition from malaria control to elimination. SADC followed by committing to eliminate malaria from the SADC region. SADC Ministers of Health approved the SADC Malaria Elimination Strategic Framework in 2007, which was conceptualised as a means to regional elimination of malaria in the SADC region. The Malaria Elimination 8 (E8) brings together 8 states[5] in Southern Africa to work together to eliminate malaria. This is a key

[5] These states are Botswana, Namibia, South Africa, Swaziland, Angola, Mozambique, Zambia and Zimbabwe.

example of a cross-border regional initiative, requiring the input of national and regional strategies (SADC, 2008; Feachem, Chaka Chaka, 2013).

Malaria transmission in these eight countries extends across the "front-line countries", with increased transmission towards the northern borders. Cross-border collaboration is essential to achieving zero transmission (GHS, 2015). Countries on either side of transmission boundaries have to assist other countries by increasing control on either side of the borders. Cross-border interventions for insecticide control, medication, treatment, diagnosis and surveillance must be harmonised across the borders of each of the countries to ensure that minimum standards of control are upheld (Tambo et al., 2012, Feachem, Chaka Chaka, 2013). Each member state has to employ key interventions to reduce malaria transmissions, based on what the framework stipulates. Member states have to employ integrated vector management (insecticide nets and indoor spraying) and case management (medication combination therapy and preventive treatment during pregnancy in high prevalence malaria endemic areas) (SADC, 2012b).

8.5 The SADC Declaration on Tuberculosis in the Mining Sector

Malaria elimination is progressing in Southern Africa. The TB epidemic in the mining sector especially continues to be a challenge. Mineworkers in Southern Africa are susceptible to TB. They are exposed to risks because of the work, living conditions and migrant lifestyles.[6] Crowded living spaces and poor, informal housing can also spread the disease, as well as increased levels of HIV. As mining in Southern Africa has historically drawn workers from across the region rather than only from the home country of the mine, such migration across borders has also been a factor in the spread of the disease. Health systems are not aligned across borders so it is difficult to track infected patients.

The SADC Declaration on Tuberculosis in the Mining Sector is the legal document which establishes the regional framework to address the problem of TB in the mines. The Declaration lays out a five-year strategy for SADC to eliminate TB in Southern Africa by improving environmental, health and safety standards in the regional mining sector. TB is one of the major health complaints in the region (increasingly so, considering the high levels of HIV and AIDS)[7]. Since TB is highly infectious, the commitment to eliminating the disease is a

[6] Silica dust in inadequately ventilated mine shafts can result in silicosis which can lead to pulmonary TB.
[7] The SADC Mining protocol also confirms the regional commitment to addressing safety concerns for the health of miners..

regional imperative, considering the cross-migration patterns of miners across borders as well (SADC, 2012).

The Declaration commits states to strengthening accountability, coordination and collaboration to tackle TB, HIV and AIDS, silicosis and other occupational diseases (SADC, 2012). SADC action in this regard is constrained, as many mines provide healthcare for their staff, so it is not always the state which provides healthcare for miners. Although the region does not make use of "pro-poor" terminology to describe its promotion of access to healthcare and medicines, with regard to TB in particular, the majority of people who work in the mines are from poor and vulnerable populations. The Declaration thus addresses poorer populations. All efforts made by SADC and its supportive organisations are geared towards supporting people in the mines to access affordable healthcare and medicines for diseases related to working in the mining sector (Stuckler, Basu, McKee, 2010). Policymakers have not adequately addressed the risks to the mining sector populations. Further action is needed by regional organisations working in partnership with international organisations to create improved healthcare responses for TB in the mines (Stuckler, Basu, McKee, 2010).

With this evidence, we can assess that certain specific regional programmes are able to secure buy-in from member states, which have operationalised them. In the absence of effective monitoring and evaluation systems regionally and nationally it is difficult however to assess whether these initiatives have met their objectives. Regional programmes are the example of how SADC addresses regional health issues. The regional cross border initiatives are additional to national health policies.

9. Response to research questions

With these findings in mind, this study's response to our two initial research questions can be summarised as follows.

Regarding SADC's pro-poor focus in its health policy, SADC is loath to separate a socio-economic developmental focus from any putative focus on health. The bidirectional causal links between health and poverty are presented as a given, with socio-economic development, prosperity, and social justice on the whole viewed as the ultimate and appropriate response to health deficits and inequalities. The Secretariat itself does not initiate policy making, but responds to the demands and instructions of member states; it then

provides technical assistance in policy development – if requested to do so. All policy implementation is left to individual governments.

International actors are already quite active in the regional health environment, providing most of the funding for projects (not only in health, but in other SADC initiatives). National, regional and international actors should continue to consult each other in policy innovation, development, implementation, and evaluation. The SADC Secretariat can make itself available as a useful interface for such consultation, and we have a number of suggestions for such policy and process innovations. International actors active in health policy at a national level include the US government, the EU and UN agencies amongst others.

10. Suggested policy and process recommendations and innovations

The current RISDP ends in 2020 and indicates that work on the development of the SADC Vision 2050 should commence with the intention to develop a single long-term strategy for the SADC regional cooperation and integration agenda (SADC 2015). With the above in mind the suggestions below are intended to contribute to this process.

10.1 Cross border initiatives: HIV and AIDS and Malaria

The SADC Cross Border Initiatives for both HIV and AIDS and Malaria are cornerstones of regional health policy. They need strengthened monitoring and evaluation strategies to ensure that member states can take over the initiatives in the future. A SADC-led monitoring and evaluation plan would allow states to see whether cross border populations are benefitting from these interventions in the long run, allowing all partners to ascertain what can be done for sustainability of these projects in the future.

The two initiatives are still in their early stages. SADC member states have committed to taking responsibility for the initiatives after a certain period of time. However, SADC member states may not have the financial and human resources to sustain the projects M&E and a strengthened strategy for continuation of the initiatives would demonstrate their effectiveness and create impetus to extend these projects at the country level. It is important to extend these projects as primary care for migrant populations and border communities is essential and areas in which regional initiatives are the only means of combatting disease.

10.2 Access to pharmaceuticals

SADC would benefit from more efficient regional regulatory procedures for medicines. The launch of the 2015-19 plan and its successful implementation is crucial to improved access to medicines.

The SADC region has a number of issues regarding pharmaceutical access, including poor supply chain management, irregular procurement of essential pharmaceuticals and national coordination of stocks, resulting in nationwide stockouts in a number of SADC states (SARPAM, 2014, Stop Stockouts Consortium, 2015, WHO, 2014). As a result millions of people needing medicines do not access them when they need them, exacerbating illness and infection rates.

Member states need to buy into the Business Plan to ensure its implementation and domestication. In addition, In addition, there needs to be a whole of society effort (government, civil society, the public, private and pharmaceutical sectors) for the ambitious commitments to be realised, including harmonisation. Civil society must be consulted on plan submissions, and pharmaceutical companies should be consulted on an ongoing basis as technical advisers.

10.3 Civil society coordination

SADC's health policy, the Secretariat and health directorate would benefit from engaging further with civil society in general. Individuals and communities that use health services contribute to health services, provide care and should play an important role in developing policies and systems. SADC would benefit from considering civil society for public accountability and input. SADC could also be considered as a civil society champion in the region, by acting through the Secretariat, as a coordinating mechanism for a civil society advisory desk for health organisations. This desk could promote civil society agendas, for addressing concerns at a ministerial level and on government agendas (Interviewee A4, Interviewee A7).

Civil society plays a fundamental role in the policy making, decision making and implementation process. Whether this is acknowledged at a regional level is unclear, considering the different reporting mechanisms in SADC. All actors need to be considered in policy processes to ensure adequate interaction with all stakeholders. Regional policy making must be an inclusive process to consider all perspectives (Interviewee C1). However, it is also important to note the often fraught relations between government and civil society in many

Southern African countries, where civil society is often the most vocal on government accountability amongst other things.

10.4 Health personnel training for SADC and other southern regional organisations

SADC policy and SADC as a regional organisation would benefit from liaising with other developing countries in the Global South. SADC could lead as a facilitator for promoting South-South cooperation amongst regions in the Global South and lead training of health personnel to perform this task (Penfold and Fourie, 2015).

A training programme could be a solution for Southern health policy management and diplomacy. Training for SADC country representatives could take place at inter-ministerial meetings and elected diplomatic representatives could benefit from advanced health diplomacy training to "prepare professionals" to better manage regional global health challenges. If such a programme were established and successful, SADC could potentially offer these services to other regional organisations to learn from other countries' challenges as well.

Training programmes of this nature could establish some important parameters for regional health diplomacy and regionalism in SADC and help develop more effective responses and capacity building. Health diplomacy is beneficial to the region as it provides resources for the negotiation of health policy needs nationally and regionally. By providing training, this would help to fill the gap needed for health diplomacy. Current global health agendas reflect the importance of health diplomacy – Southern Africa needs to engage with these trends.

10.5 Horizontal vs vertical healthcare in SADC

SADC must generate funds and resources for integrated universal healthcare systems. The SADC region has experienced vertical responses to HIV and AIDS, TB and Malaria. Vertical systems target specific health issues with interventions that are not fully integrated into health systems. Vertical systems have shown success in eliminating smallpox and controlling vaccine-preventable diseases. However, vertical programmes are difficult to integrate in country health systems. People who are ill most often need to be treated holistically (Eisinga, 2005). SADC member states can fundraise for better quality, integrated healthcare for all member states in the region (Penfold and Fourie, 2014).

Horizontal approaches are resourced by publicly financed healthcare systems (or comprehensive primary care). Horizontal approaches, including provision of routine immunization, community directed treatment strategies (for example, the control programs for African onchocerciasis, also known as river blindness, or Robles disease) focus on prevention and care for prevailing health problems (SADC, 2014).

Horizontal systems are essential for sustainable, effective health care. They can deliver preventive services to poorer people who can't afford private healthcare, are cost effective and sustainable in the long term. In addition, if financed by government revenue and a broader, sustainable health plan, horizontal healthcare systems can be integrated into the public sector. The difficulty with horizontal systems is that states require a level of stability, reasonably stable infrastructure and resources (Penfold and Fourie, 2014).

These recommendations form part of what could be a greater push to strengthening regionalism in Southern Africa, with a view to integrating regional social policy and health policy objectives in the future.

11 Conclusion

Regionalisation does not have significant precedent in Southern Africa. Given the relative youth and dynamism of regional integration and approaches in the last two decades, this implies opportunity and potential for greater regional integration and cooperation, rather than indicating or suggesting their abandonment.

Regionalism, as understood through a health policy lens, reflects on regional efforts for poverty reduction, as outlined in the SADC Treaty, Health Protocol and RISDP. SADC is not comfortable with the term “pro-poor” and uses the term “poverty reduction” in its treaties. This is also evident in policy agendas, policy development processes and resourcing, as SADC states collaborate on policies, setting policy agendas and committing to resourcing for the poor. Health is a member state project. Overall our findings have indicated that health at a regional level is in retreat and regional health policies face significant constraints in implementation. SADC, as a development community, has an integrated mandate of poverty reduction and addresses its causes through its frameworks, but in practice regionalism is not embraced as a panacea to developmental poverty challenges. National level policy embeddedness of regional frameworks is largely absent and there is no particular concrete commitment to poverty reduction through health.

SADC does, however, interact with a wide range of national, regional and international actors to promote what are colloquially referred to as “pro-poor” practices. National, regional and international actors work very closely with SADC to promote cross-border initiatives, which are designed to promote pro-poor access to healthcare and medicines in the SADC region. This is evident in the cross-border initiatives detailed in the paper. Some key recommendations for the global health community would be to increase assistance for implementation of these programmes, further interaction with civil society and increased collaboration on domestication of policies, enabling regional autonomy of these programmes, instead of regional dependence on donors.

SADC most certainly has a number of development policies, but as a development community it needs continued support to realise the purported promise of regionalisation. Development goals may become a reality if SADC can continue to grow as an economic community, but this can only be achieved with time and effort from SADC member states, with the support of the SADC Secretariat, the donor community and other stakeholders, including civil society. A key element of this is the extent to which member states in the future intend to give the SADC Secretariat more authority on such matters, and the requisite resources. SADC has a committed normative and policy focus on poverty reduction, which extends to health policy, access to healthcare and medicines. SADC also interacts with a wider range of national, regional and international actors, who are instrumental in promoting poverty reduction policies and methods for access to healthcare and medicines. These actors can advance their agendas by assisting the SADC Secretariat in becoming more autonomous, in building its policy-making and implementation capacity, and by providing increased support for SADC to work more in-country, in order to assist civil society and national governments in advancing health policy goals.

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