UKDS ReShare number: #852133

UKDS ReShare title: Poverty Reduction and Regional Integration (PRARI) 2014-2015

UKDS ReShare number: #852133

Full title: Poverty Reduction and Regional Integration: A Comparative analysis of SADC and UNASUR health policies

This work was carried out with support from the Economic and Social Research Council (ESRC), Grant Ref. ES/L005336/1, and does not necessarily reflect the opinions of the ESRC. For all enquiries please contact: n.yeates@open.ac.uk

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Introduction

This User Guide is intended to facilitate users to navigate the deposited data which consists of interview transcripts with interviewees and analytical data used in the construction of the Toolkits. The User Guide provides contextualises this data in relation to the study's research, ethics and data assurance processes, and signposts key project documentation for further understanding the data and the processes by which it was collected and analysed. Information relevant to the eventual outcome, such as unplanned deviations or intentional alterations to the planned research, is included in this guide. While every effort has been taken to ensure the dataset is fully compliant with expected standards, the Principal Investigator will be pleased to be contacted in the unlikely event that there are any perceived or actual shortfalls on this front and the dataset will be reviewed as soon as is reasonably possible in order to make necessary amendments to it.

Data access and usage statement

The project does not seek to embargo or place other restrictive access conditions on the archived data. All data deposited is subject to acceptable use protocols. It is strongly advised that secondary users contact the PI, Nicola Yeates, to discuss appropriate re-uses and practical anonymity for any derived output. She should also be contacted about acceptable re-usage of the Toolkits data.

Abstract to Dataset

The data collection consists of a comprehensive User Guide, 48 transcripts (non-annotated) from individual interviews and workshops, background and other project documents, and Decoders for the interview and workshop transcript series. A total of 63 documents constitute this dataset The interviews and workshops were conducted with a diverse range of participants drawn from policy and practitioner fields in two geographical areas of the world: the SADC region in Southern Africa, and the UNASUR region in South America. The research data includes senior policy and statistical officials from government ministries and international organisations, members of health and poverty-focused civil society organisations (service and advocacy non-governmental organisations, and health practitioners). The deposited data is organised into two principal file strands: Interviews and Regional Indicators-based Monitoring Toolkits. Each of these strands is further divided into South America (UNASUR) and Southern Africa (SADC) components. Each of these contains the anonymised decoder for the 'chapter' or strand of the research plus qualitative data, while the Toolkits file also contains regional indicators and the Toolkits documents themselves. Transcripts relating to the UNASUR regional health governance component of the project are in the Spanish language; all other transcripts are in English. This may limit access for some users. The User Guide contains further information about the organisation of the research within the project, including the analytical methods framing the cross-regional comparative analysis and the Toolkits, and project documents (sample project information sheets, consent forms, interview guides, and workshop schedules).

Abstract to Study

The growing presence of multilateral regional organisations in public policy making is increasingly the subject of North-South and South-South development agendas. It is also generating development initiatives and research into the benefits of regional economic integration for public goods provision and for people living in poverty. There is growing recognition that regional integration ambitions and initiatives extend beyond commercial trade and investment to embrace health and welfare policy. However, little is known about whether and how regional commitments on poverty are being implemented in these domains, and what kinds of regional policy development processes are conducive to the emergence of embedded 'pro-poor' approaches in regional and national spheres.

This project examined Southern multilateral regional organisations' approaches to poverty reduction through regional health policy. It was guided by the following

questions: what regional institutional practices and methods of regional policy formation are conducive to the emergence of embedded 'pro-poor' health strategies, and what can national, regional and international partners do to promote such practices and methods? The project investigated regional agendas and ambitions, regional programmes of action and regional processes of policy development in relation to access to health and medicines in relation to the Southern African Development Community (SADC) and the Union of South American Nations (UNASUR). It undertook in-depth fieldwork in relation to SADC and UNASUR as regional organisations and in relation to low-income member states of SADC (Zambia, Swaziland) and UNASUR (Bolivia and Paraguay) which are confronted with serious socio-economic challenges, low levels of service delivery and immense public health challenges.

In addition, the project gave separate attention to the application of indicators for the purpose of monitoring and tracking pro-poor policy change and success in regional health policy. These have been previously developed for monitoring regional integration policies in the economic sphere but had not given proper attention to the regional social sphere. To this end, in collaboration with stakeholders from policy and practitioner communities in SADC and UNASUR regions, the project developed indicator-based systems ('Toolkits') for monitoring regional health policies (including tracking policy change and poverty focus).

The research design was informed by international comparative research methodology in relation to the study of SADC and UNASUR regional health governance, policy and programming, and by collaborative modes of Participatory Action Research in relation to the PRARI Monitoring Toolkits. Data was collected using available datasets and official documents plus interviews, practitioner workshops and consultations with purposively sampled members of policy and practitioner communities in the SADC and UNASUR regions. These methods generate evidence and analytical perspectives capable of informing processes of political regionalisation as they relate to health policy, and in particular the health-poverty nexus.

Research Topic

Multilateral regional organisations are of substantial and growing significance in international integration and development cooperation (UNU-CRIS 2008; Deacon, Macovei, Van Langenhove and Yeates 2010). To varying extents, they act as knowledge brokers, training hubs, industrial coordinators and global players (Van Langenhove 2012; Riggirozzi 2012), and invest substantial resources in regional

health and other social programmes. The Southern African Development community (SADC) and Union of South American Nations (UNASUR), the focus of this study, in particular lead regional themed networks and country-based working groups to implement health projects; initiatives referring patients between member states; research and communication technologies for practitioners and policy-makers; health surveillance activities; and regional strategies for medicine production and commercialisation (UNASUR 2009; SADC 1999, 2003, 2011). Poverty reduction is a stated goal of regional integration of many regional integration projects, yet little is known about whether poverty reduction agendas and goals are in practice being progressed through regional health cooperation and if so, how (Yeates 2014a, 2014c).

Research on the regional integration-poverty nexus funded by the World Bank (Schiff and Winters 1996) and UK Department for International Development (DFID) (Te Velde 2006) has focused on the liberalisation of foreign trade, foreign direct investment, and labour migration. DFID (Te Velde 2006) recognised the importance of active regional public policies in ensuring a fair distribution of benefits from economic integration, but it did not investigate this further. Policy research on regional public goods, for its part, had not specifically examined health, while there was significant scope for examining whether and how regional organisations' policy commitments are being implemented and embedded in domestic social institutions and policy formation (Deacon et al 2007, Deacon, Macovei, Van Langenhove and Yeates 2010; SELA 2010; UNDP 2011; Yeates and Deacon 2006, 2010; Yeates 2014a, 2014b).

Prior fieldwork highlights the absence of a reliable basis for measuring the outcomes of regional institutional processes as a significant obstacle in regional policy makers' prospective innovation in approaches to tackling structural inequalities and poverty. Evaluation of policy monitoring in the context of regional integration similarly drew attention to the importance of external actors (e.g. donors) and the necessity of local/regional ownership for improved provision of monitoring systems and their institutional embeddedness (De Lombaerde 2005, 2006; De Lombaerde et al 2005, 2008a, 2008b, 2010, 2011). It also highlighted the potential of metrics and indicators in monitoring to provide additional precision, transparency and policy-relevance, as well as measuring the characteristics and effects of 'positive' regional integration policies, such as health policies.

In this context, the aims of this project were, first, to substantiate the relation between 'positive' regional integration measures and poverty reduction, and,

second, to address the issue of whether and how regional integration processes can be harnessed in the interests of health-related poverty reduction. An aim of the project was to contribute to policy-facing debates about how regional interventions can be strengthened in the interests of health equity and access to health care in low-income contexts.

The project gave particular attention to the application of indicators, previously developed for monitoring regional integration policies in the economic sphere, in ways that give proper attention to the regional social sphere. To this end, in collaboration with stakeholders, indicator-based systems ('Toolkits') were developed to monitor regional health policies (including tracking policy change and poverty focus) that we anticipated will be of tangible use to diverse actors within SADC and UNASUR, and beyond. In doing so, the project aimed to inject a Southern regional focus into contemporary policy initiatives and debates on global governance, social policy and health equity.

The scope for enhancing Southern multilateral regional organisations' contributions to poverty reduction in low-income contexts was guided by asking, in the relation to the regional organisations of the SADC and UNASUR, what regional institutional practices and methods of regional policy formation are conducive to the emergence of embedded pro-poor health strategies, and what can national, regional and international actors do to promote such practices and methods? Underpinning this question was the idea that there are unexplored synergies between regional institutions and poverty reduction; that regional integration processes have potentially significant impacts on health equity and access to health care, and that there is scope for effective policy intervention.

The regional integration-poverty nexus was examined in relation to access to health care and medicines for two principal reasons. First, poor health and poverty coincide and are mutually-reinforcing. Inadequate access to health care and medicines is a social determinant of ill-health (Marmot 2005; Maclean et al., 2009) and is disproportionately borne by women and girls. Access is an issue in peri-urban informal settlements and in rural areas, many of which are often border areas where there is scope for innovation in cross-border regional policy coordination in support of universal access to healthcare. Second, health and poverty have emerged as distinctive hubs of attention in regional integration. SADC and UNASUR have developed institutional competences in health policy and poverty reduction, although their policy development practices and methods take quite different forms.

The SADC and UNASUR regions exhibit very high burdens of poverty and insufficient health care (Barreto et al. 2012; PAHO 2012; Maclean et al., 2009), and are comparable in terms of inequality. Comparing UNASUR and SADC regional health policy would enabled the project to identify and distil context-specific policy and analytical lessons capable of galvanising and underscoring their mandates on poverty reduction.

To this end, project addressed the following specific questions:

1. Do UNASUR and SADC have a committed pro-poor focus in their health policy regarding access to health care and medicines, as indicated by sustained policy agendas, policy development processes, and resourcing?

2. How do regional health policy development processes mobilise diverse actors in the interests of very impoverished populations in relation to health care and medicines – or fail to do so, and why?

3. What input, process, output and outcome indicators effectively capture regional policy change and especially pro-poor regional health policy success and failure?

Methods of data collection and analysis

The research adopted a case study approach, exploring the project's central questions across political regions in Southern Africa (SADC) and South America (UNASUR). Both these regions have developed mandates on poverty and development. The policy sectors of health and medicines were the focus of study because: a) they form significant areas of the regional organisations' activities and b) health is an important field in addressing social inequity.

The project undertook primary data collection as available data did not provide the necessary depth and insight into regional health policy and policy development processes as they operate in practice. It used qualitative methods of data collection involving in-depth interviews, workshops and consultations with members of policy and practitioner communities within selected SADC and UNASUR member states as well as at the level of SADC and UNASUR as regional organisations. This qualitative data was supplemented by consulting available national and international datasets as well as official documents from member states and regional organisations. This additional data provided further contextual and interpretive information about the nature of regional pro-poor health policy in the cases concerned. In addition, primary and secondary data were used to inform the selection of participants for interviews and the design of interview schedules (see below).

Two principal methodological approaches were used in the project: comparative analysis and participatory action research. Furthermore, the totality of the project fieldwork was organised around two principal investigative strands carried out over the project's 22 month lifecycle (See Figure 1).

Strands of the research

Strand 1: this comprised two research teams embedded in Southern Africa (SAIIA) and South America (FLACSO) conducting the fieldwork on SADC and UNASUR, respectively, and focusing on questions 1 and 2 above. They used qualitative data collection and analytical methods supplemented by occasional consultations of quantitative datasets. The methodological framework for the international (cross-regional) comparative segment of the project, covering data generation and data analysis (see below), was jointly developed by The Open University and Southampton University.

Strand 2: this was led by UNU-CRIS, addressing question 3, above. Its purpose was to develop pro-poor indicators of policy success and change (so-called 'scoreboard' indicators), constituting regional monitoring systems (Toolkits) capable of assessing regional policy change and success in relation to impoverished populations' access to health care. Two such Toolkits were developed during the project, one in the SADC context in collaboration with SADC-based participants, and the other in the UNASUR context in collaboration with UNASUR-based participants. The UNASUR Toolkit is available in English as well as in Spanish.

The Toolkits were developed using collaborative modes of Participatory Action Research. This affirms stakeholders as agents (co-researchers) bringing diverse knowledge and techniques and a commitment to the process and outputs of the research, in a project designed, initiated and managed by the project researchers. The SADC and UNASUR Toolkits were thus co-produced in a collaborative partnership process involving professional researchers, policy makers and practitioners drawn from governmental and non-governmental sectors. No cross-regional comparative element was involved in the production of these Toolkits.

Figure 1 Summary of research design by strand and phase

Strand and site	**Method**	**Phase 1 (5 months)**	**Phase 2 (12 months)**	**Phase 3 (5 months)**
1.**Comparative health regionalism**: within and between SADC and UNASUR	Comparative	Baseline mapping, stakeholder engagement, two stakeholder workshops (one per region)	Interviews with Key Informants from two countries per region, and the relevant regional organisation. SADC countries: Swaziland, Zambia. UNASUR countries: Bolivia, Paraguay	Analysis, writing, intra-regional and global dissemination SADC Stakeholder workshop; UNASUR Stakeholder workshop. International Project conference
2. **Indicators-based Toolkits** for the SADC and UNASUR regions	Participatory Action Research	Finalisation of methodological approach, participant (co-researcher) recruitment	Indicators Development workshops – three per region (six in total), supplemented by one SADC consultation between workshops.	

Figure 2: Schedule of Indicators Development Workshops and consultation

	Region	Location	Purpose
10/11/2014	1st UNASUR Workshop	ISAGS, Rio de Janeiro, Brazil	Discuss regional priorities; assess the need for a regional health policy monitoring system; identify key actors
08/12/2014	1st SADC Workshop	BIDPA, Gaborone, Botswana	Discuss regional priorities; assess the need for a regional health policy monitoring system; identify key actors
16/03/2015	SADC Consultation	Health Systems Trust, Johannesburg, South Africa	Finalize key agreements from 1st SADC workshop
23/06/2015	2nd SADC Workshop	SADC Secretariat, Gaborone, Botswana	Develop toolkit conceptual framework; define indicators
09/07/2015	2nd UNASUR Workshop	UNASUR Secretariat, Quito, Ecuador	Develop toolkit conceptual framework; define indicators
14/09/2015	3rd SADC Workshop	SAIIA, Johannesburg, South Africa	Discuss final toolkit draft
05/10/2015	3rd UNASUR Workshop	FLACSO-Argentina, Buenos Aires, Argentina	Discuss final toolkit draft

Phases of the research

In **Stage 1** baseline documentation was prepared to deepen understandings of: (i) the regional political economy of health and medicine in Southern Africa and South America, with regard to interfaces with poverty, gender, age, ethnicity and locality, drawing on datasets, academic and policy literatures; (ii) secondary and grey

literatures on UNASUR and SADC mandates, action plans, regulatory frameworks, policies and resourcing relating to access to medicines and health care; (iii) conceptual and methodological issues, and design options, for data collection and the monitoring indicators Toolkits. These were not published but informed the refinement of research methodology and the comparative framework for the Stage 2 fieldwork. They also informed the two stakeholder engagement workshops (one per region) as part of the SADC-UNASUR comparative strand of the project, held during Stage 1. These workshops 'reality-checked' project plans against stakeholder feedback, plans for key informant interviews (KIIs), and elicited awareness of and support for the project from stakeholders that proved most useful for the Toolkits strand of the project.

The baseline documentation are not archived (they do not create a stand-alone dataset or enhance an existing data set) but the information gathered from this phase enhanced better understanding of the context-specific data collection challenges and strategies and it informed the following publications:

- Contextual and policy briefings for the two regional stakeholder workshops (Policy Briefs, freely available from the project website).
- A guest-edited peer-reviewed special issue (Open Access) of the journal of *Global Social Policy: a journal of international development and public policy* (Sage) December 2015, volume 15, issue 3 (Full citations are contained within the Data Deposition Summary).
- Working Papers (available from the project website and other online sources)

Stage 2. Informed by prior analytical and documentary research of available sources and contacts, and guided by a snowball method of identifying interviewees, we anticipated strand 1 teams undertaking 15-20 semi-structured Key Informant Interviews (KIIs), tested in Spanish (as appropriate) and English, in each regional country, plus interviews with 5-8 with officials in each of the SADC and UNASUR secretariats (and closely affiliated) health units, working groups, and institutes. The team anticipated undertaking 35-48 in-person interviews in each region.

Key Informant Interviews (KIIs) explored (i) the nature of health need and access to health services among impoverished populations in relation to specific diseases, identified through a context-specific disease burden approach; (ii) approaches, processes and practices of regional governance and policy making, including the synergies between regional and national policymaking and how they create opportunities for actors to influence and advance pro-poor health policies (see

Interview schedule design, Annex). The KIIs were wholly carried out by the research assistant and sometimes also the co-Investigator responsible for undertaking and assuring the fieldwork within the country and regional contexts. Interviews took place with Key Informants (KIs) employed by or associated with organisations operating at national and regional scale. The fieldwork teams investigating either SADC or UNASUR generated three tranches of interview data, one for each of the two countries in which they undertook in-depth interviews, and one for the regional level. The teams interviewed each KI once.

Focusing on two countries within each region allowed exploration of how regional health policy and practice played out nationally and was designed to capture variation in how regional policy development is refracted through different country contexts, including the nature of regional-national interactions in the making of regional policy. This approach added insights into significance of domestic policy regimes in the making of regional health policy. Zambia and Swaziland were chosen as they are dissimilar in regime type and size, but roughly similar in terms of disease burden and colonial legacy (Maclean, Brown and Fourie 2009). Bolivia and Paraguay, both democracies, are otherwise similar in terms of overall disease burden, but their markedly different ethnic composition impacts on poverty-health profiles and are embarking on distinctive health policy reforms.

The strand 2 fieldwork team responsible for the PRARI Toolkits investigated specific data requirements needed to inform pro-poor regional health policies, including measures of policy change, as part of the Toolkits design. It organised and conducted three indicators development workshops in the UNASUR region and three such workshops plus one consultation in the SADC region (Figure 2). These workshops worked with identified stakeholder/co-researchers to progress the development of the two planned Toolkits (one for each region). The remaining two workshops took place during project's third phase, during when the Toolkit draft was finalised. In all, 31 participants attended one or more of the Indicators Development Workshops: 15 participants attended one or more of three Indicators Development Workshops held in South America; 16 participants attended one or more of four Southern African Indicators Development Workshops and consultations.

Users are directed to the appendices to this document for the sample Project Information Sheet, Consent Form. These also contain sample question schedules used in the interviews and the early phase of the Toolkits development. The main archive contains a sample guidance document that was provided to attendees of the second workshops in advance of the workshop.

During the final phase of the project, **Stage 3**, the two Toolkits were finalised (see above, and Figure 2). The Southern African team undertook further KIIs to supplement their regional dataset. The Southern African and South American teams organised a stakeholder engagement workshop each to communicate their research to stakeholders. The project international conference held at The Open University in the UK was a further opportunity for the strand teams to present and discuss the research to international academic, policy and practitioner delegates.

Participant identification and selection

Participant identification processes for both the individual in-depth interviews and Toolkits workshops were guided by snowball and purposive sampling methods. These substantially built on the project team's prior knowledge and understanding of the research field in context. The ranking of potential participants for the interviews and workshops was based on the investigators' assessment of the project's data aims and needs and of resourcing constraints. Individual participants identified for KIIs were those that have expert working knowledge of technical (bio-statistical) data, the policy position(s) of their organization or wider understanding of the issues that were the subject of this study. Established public officials and representatives - policy analysts, bio-statistical analysts, monitoring and evaluation experts, decision makers and agenda-setters – were identified and included in the field of potential research participants. The final selection of interviewees and participants was designed to enable a focus on the health-poverty nexus, and issues of social (in)equalities of gender, ethnicity, age, and place to surface in relation to the subject of study. This selection did not achieve full representation across the range but it balanced coverage with resources available.

The research participants were drawn from public officials from government ministries and international organisations) and representatives of health and poverty-focused civil society organisations (service and advocacy non-governmental organisations, and health practitioners). Impoverished or vulnerable people were excluded from the research participant population.

Participatory Action Research and the Toolkits

No specific design was imposed ex ante on the indicators Toolkits, in line with the principles of Participatory Action Research that the purpose and content should maximally respond to the needs of the stakeholders and be defined in collaboration with them during the research.

Collaborative modes of PAR were used to produce two Toolkits for use by governmental and non-governmental actors. These Toolkits consisted of a indicators-based monitoring system of input, process, output and outcome indicators. However, instead of the anticipated template of an indicator-application for use by local stakeholders, and a template of an indicator-application for use by regional stakeholders, two region-specific templates (Toolkits) that integrated usage for local, regional and international stakeholders were produced. This strand of the project worked within local stakeholder structures and with equivalently powerful actors (public officials, technical experts, advocacy and service NGOs). The plan to pay specific attention to trans-border regional health problems was achieved. There was general (but not universal) agreement that the SADC Toolkit was capable of capturing regional-level policy change and success with regard to 'pro-poor' health policy.

The role of the UNU-CRIS researchers remained as anticipated, namely that in the interactions with the stakeholders, the role of the project team consisted of offering options and solutions for the construction of indicator-systems, identifying existing data sources, and bringing in a wider, international perspective where it was needed.

The Policy Briefs, Working Papers and the Toolkits themselves are the outcome of the participatory data production process. They were collaboratively produced and co-authored by members of the project team and the Toolkit co-researcher/stakeholders. They are additional sources of useful metadata about the methodological and practice processes of data generation and analysis in this strand of the project.

Comparative analysis and interview schedules (design and analysis)

The comparative dimensions of project strand 1 relating to SADC (conducted by SAIIA) and UNASUR (conducted by FLACSO took two forms.

First, cross-national analysis *within* the SADC and UNASUR regions (Zambia-Swaziland; Paraguay-Bolivia) aimed to locate and identify how regional policy making in the health poverty nexus intersects with, and is refracted through, distinctive features of the national political, social or economic 'landscapes', and with what consequences and effects for poverty-reduction strategies and policies. An overview of the analytical method and processes in published in Herrero and Loza (2015) in relation to South America and Penfold (2016) in relation to Southern Africa.

Second, cross-regional analysis *between* SADC and UNASUR aimed to locate and explain what distinctive features of institutional design and practice in SADC and

UNASUR are conducive to the emergence and implementation of embedded pro-poor health strategies. Riggirozzi was responsible for leading the comparative regional research design, fieldwork and analysis project strand. An overview description of the inter-regional comparative analysis method used by Riggirozzi together with aspects of the results is published by Riggirozzi in 2015a, 2015b and 2017 (see Data Deposition Summary for full publication details). These publications frame and explain the substantive research topic, and are useful documents to enable better understanding of UNASUR and SADC as political institutions. Interested users are encouraged to refer to these publications. However as they do not elucidate the specificities of the methodological context or method of analysis underpinning the findings these are described below.

Analytically, the principal comparative dimension of the project aimed to elucidate how the two regional organisations' pursuit of their intersecting health mandates and poverty reduction commitments is mediated by institutional traditions, practices and methods of regional policy formation operating in situated contexts. The project did not aim to demonstrate causal relationships but to develop multifaceted observations of the institutional features and dynamics of regional policy making in practice in relation to the specified countries, policy sectors and poverty-specific focus of the project. It used methods of 'agreement and difference' (see Mahone 2007: 134) to observe commonalities and differences to observations based on data from interviews and documentary sources. The methodological rationale underpinning comparison aimed to avoid 'misjudgements of transplantation', a problem often attributed to comparative regional studies which tend to take the European Union as comparator for other regional projects (see De Lombaerde et al 2010). In this case, the analysis was sensitive to each context in order to draw findings based on the specificities of each region; that is in terms of the context, nuances and complexities of different systems, ethos, processes, engagements, modalities of impact in diverse scenarios. Methodologically, it aimed to identify context-specific, path-dependent and policy-contingent trajectories and outcomes, and to develop theoretical explanations and explanatory variables related to the outcomes observed in the two regional cases, combining deductive and inductive approaches to do so.

Operationalising the project comparative method

To these ends, a set of variables was identified that depicted the context-specific, path-dependent and policy contingency trajectories and outcomes of SADC and UNASUR regional health policy in terms of whether these policies have embedded

poverty reduction objectives, together with how they play out in the context of the country case studies (Bolivia, Paraguay, Swaziland, Zambia). The specific variables and their operationalisation for each research question were as follows:

RQ1: do UNASUR and SADC have a committed pro-poor focus in their health policy regarding access to health care and medicines, as indicated by policy agendas, policy development processes, and resourcing?

VARIABLES

(a) Health;
(b) Regional health policy: the institutional scope of regional health policy overall, and in relation to access to health care and medicines in particular;
(c) A *committed* 'pro-poor' (or proxy) *focus* in regional health policy

Categorisation of health and regional health policy

- What defines disease-burden and poverty profiles in each country case study and in relation to the SADC and UNASUR region as a whole?
- how UNASUR and SADC discourses, initiatives and programmes manifest different understandings of ill-health disease?
- how do UNASUR and SADC's regional health policy demonstrably link to poverty (in terms of discourse, and incidence/burden/distribution of poverty/ill-health)?
- the extent of commitment by UNASUR and SADC to focusing on health (ill-health/disease)
- mandates of UNASUR and SADC in relation to health
- number and sort of initiatives and programmes addressing health
- extent of alignment of ROs' mandates, policy objectives and agendas in relation to the health/poverty profile and context of the region

Categorisation of '*committed* pro-poor focus of each RO'

According to Policy agendas

- normative framework and policy objectives
- characteristics of a pro-poor (or proxy) *focus* in regional health policy
    - is there attention to issues of impoverishment, exclusion, marginalisation, poverty? And how is this evidenced?

- range of programmes, actions and initiatives pertaining to health
- ways in which conceptions of the poverty/health nexus are evident in institutional and policy responses of UNASUR and SADC

According to policy development

- institutional characteristics of SADC and UNASUR overall and in relation to health specifically:
    - governance framework
    - regulatory frameworks and powers
    - institutional structures and processes of policy development (from inception or generation to development, to review)
    - actors in SADC/UNASUR policy making
- SADC and UNASUR programmes, actions and initiatives pertaining to health (including medicines) overall;
- ways in which conceptions of the poverty/health nexus are evident in institutional and policy responses of UNASUR and SADC.

According to Resourcing: where do the resources for UNASUR/SADC action on health-poverty come from and how are they allocated:

- Domestic health expenditure for each of the Member States - data on public expenditure and health-related household expenditures
- Health expenditure as a proportion of all public expenditure for each of the Member States
- Overall (annual) expenditure budget for each of SADC and UNASUR as regional entitles
- Aggregate (annual) regional health expenditure of SADC and UNASUR - raw numbers
- Non-health social expenditure (social protection, education, labour, social development etc) of SADC and UNASUR as regional entities
- Breakdown of totality of regional health expenditure by activities, programmes, projects
- Sources of regional financial budget - who gives what (how much): by
    Member State (showing amount per member state)
    Non-state sources (showing amount per type of non-state entity)

Extra-regional (multilateral organisations, bilateral donors, non-state donors)

- Where resourcing occurs e.g. technical assistance
- Formulae/principles guiding Member States financing of UNASUR/SADC entities
- Do UNASUR/SADC undertake monitoring/effectiveness/evaluation reviews of spending or other outcomes of programme actions?

RQ 2: how do regional health policy formation and implementation processes mobilise diverse actors in the public, private and NGO sectors in the interests of impoverished populations in relation to health care and medicines – or fail to do so and why?

VARIABLES

(a) regional health policy formation
(b) implementation (and take up) processes
(c) mobilisation of and engagement by actors in the public, private and NGO sectors
(d) influence of those actors in relation to processes of policy development (formation and implementation)

Categorisation of regional health policy formation

According to policy development

- Institutional structures and processes framing policy
  - How policies and/or projects are formulated by ROs address the health/poverty
  - Institutionalised and/or ad hoc mechanisms through which SADC and UNASUR identify and formulate policies and / or projects for countries in relation to access to healthcare and access to medicines
  - how key actors advocate their agendas towards or within SADC/UNASUR
  - Actors involved in SADC/UNASUR health policy making in relation to access to medicines and access to healthcare
  - the differential place that national, NGOs, donors occupy in regional policy making, shaping and affecting policy agendas and resources in relation to access to healthcare and medicines in general

Categorisation of implementation and policy take up processes

- which regional projects have been implemented in the areas of healthcare and medicines – general overview and in country cases – and how
- How UNASUR and SADC pursue their regional health/poverty agendas in practice in the region and in the country cases
    - formal and informal institutional processes for engagement with state, non state and multilateral actors for the formulation of policies regarding healthcare and medicines
- Institutional basis on which the regional-national process rests (for example, constitution-based, treaty-based integration processes; regulatory, ad hoc)
- the differential place that SADC and UNASUR occupy in national policy process in relation to access to healthcare and access to medicines
    - How ROs advance and help / support changes at national policy-making, and regulations (governance) in support of health care and medicines
    - reform institutions in support of health care and medicines
    - political and/or advocacy behaviour
- How ROs facilitate the allocation of resources (Explain in relation to the country cases and in relation to access to health care and medicines)
- Presence and significance of actors (including donors) shaping and affecting formation, implementation and take up of regional policies and resources in relation to access to healthcare and medicines

Categorisation of influence of actors

- actors that participated in the *formulation* and *implementation* of health policies in relation to healthcare and medicines in the countries
    - what health-poverty agendas are they advocating
    - what are the proposed initiatives, programmes, policies
    - at which level of policy making (regional, national) and
    - what are the effects of these actors agendas in relation to regional health policy
- Mechanisms that enable UNASUR and SADC's engagement with state, non state and donors for the coordination and implementation of the policies/projects identified
    - different modalities, vehicles/mechanisms of mobilisation (ie formal, established, ad hoc)

- are there different interests between these actors in relation to the two policy areas and the projects implemented on the ground?
- Which ones prevailed?

The data was collected using semi-structured interviews based on questionnaires (see Annex) designed in alignment with the above categorisation. Other methods of data collection involved official and grey literature. Preliminary structured analysis of fieldwork data was based on textual analysis of all the transcripts of interviews (recorded) and of the secondary sources. This was led by the Southern African and South American researchers. As part of this qualitative data analysis, a process of coding identified and grouped interviewees' responses into the variables and categories mentioned above to single out similar ideas, concepts, patterns and themes in response to the RQs.

Operationalising the comparative framework into interview schedules

Semi-structured in-depth KIIs were carried out with, for example, officials in ministries of health and welfare, other national and international organisations embedded within the regional context, 'technical' and working groups affiliated with the regional organisations, and policy makers and practitioners in non-governmental organisations). These KIs were working on health policies and policy making at the country and regional levels. This data was supplemented and contextualised by documentary sources in 'grey' literature and official documents.

The interview schedules were designed on the basis of the variables and categories identified and were to be used by the Southern African and South American research teams during in-depth interviews with key informants in the case study countries and in the regional organisations' headquarters (see Annex). In-depth interviews at the two levels were designed to elicit (a) data about the scope and nature of regional policy making in practice (b) contextualised perspectives on how regional organisations engage with poverty issues (and/or fail or miss opportunities to do so) through policy formation processes; actors mobilised, disease-burden and poverty profiles, and actual policy responses and specific initiatives; and (c) elicit contacts for additional interviews (as per the snowball sampling method used by the Southern African and South American research teams).

Each research team worked with the same semi-structured interview schedule in order to secure comparable data collection within the comparative methodological framework. The interview schedules covered themes of institutional characteristics,

health programmes and interventions, policy formation, actors and modes of political and policy engagement, reflecting the key variables identified (see above). There was an element of flexibility in the semi-structured interview schedules, permissive of capturing context-specificity and emergent (but unanticipated) information and insights.

Interpreting the qualitative data through the comparative lens

The comparative analysis was based on the observed, descriptive dimensions provided by each regional chapter, and the variables and categories described above framed the inter-regional aspect of the comparative analytical framework. Following the methodology of content analysis approach and process chasing, the data for each regional chapter were presented side by side and systematically compared to identify significant commonalities and differences, anomalies, patterns, policy dynamics, relationships in each regional case study. This analysis was also contextualised using secondary sources and systematised in PRARI Working Papers. Inductive methods of interpretation helped venture some categorisations and hypothesis that transpired from comparing each regional analysis. The comparative analysis was then organised by:

- Context defining regional organisations mandates and profiles
- Health and social development objectives in UNASUR and SADC
- Institutionalisation of Health in UNASUR and SADC
- Scope and nature of regional health governance: approaches to, and commitments on, health
- Regional responses to health
- Categorisation of UNASUR and SADC in relation to their mandates and distinctive roles advancing health policies in South America and Southern Africa respectively.
- Overview of SADC and UNASUR health governance and policy

Ethics

The research was submitted to and received full ethical approval at The Open University.

The project worked in the primary language of participants which is a key feature of the conditions for authentic consent. Potential participants were contacted for interview in either English or in Spanish, whichever was the most appropriate. Initial contact with identified participants was made through written means (email, letter) with telephone contact and face-to-face contact supplementing this as necessary. Initial contact with prospective participants was followed up, but the fieldwork teams ceased all further contact at the point it became apparent that further approaches would be unwelcome. Contact with potential participants was accompanied by the project Information Sheet and Consent form (see appendices). Broad topics that the interview or consultation covered were sent to participants in the first instance (at the initial point of contact). Closer to the interview or consultation, the participants were sent indicative interview questions closely tailored to the organisational context for which the individual works. Again, these were in either English or Spanish. Interviews (and workshops) took place in either English (Southern Africa) or in Spanish (South America). It was not assumed that prospective participants were speaking in an official capacity on behalf of the organisation concerned and the researchers verified whether they were empowered to do so (none were). As such, it must not be assumed that the views expressed by KIs in the interviews (or workshops) are those of the organisations which employed the KIs.

Interviews and workshops were audio-recorded or from notes. Whereas 93 interviews were undertaken a total of 41 KIs gave their full *written* informed consent which incorporated recording of interviews, the anonymised use of selected sections of transcripts in publications, and data archiving at The Open University *and* the UKDS. The lack of written consent by interviewees for their anonymised data to be made publicly available on UKDS proved to be the single most important reason explaining why not all transcripts could be included in this deposition.

The Co-Is (Tussie, Riggirozzi in South America; and Fourie and Kingah in Southern Africa), the Toolkit advisor (de Lombaerde – South America and Southern Africa) and the Research Fellows were fluent in the main language in which interviews and workshops were conducted. Yeates is not a fluent professional Spanish language speaker, but Riggirozzi, who was co-responsible for data quality and management assurance (as per grant application) is. When the regional teams, led by Tussie,

Kingah and Fourie, returned interview transcripts to individual participants for validation, they offered participants the opportunity to amend the transcript or remove statements they did not wish to be made public via the UKDS. Further rounds of transcript anonymization and checking were undertaken, as described below.

Data Protection and Anonymisation

This project is registered with the Open University under the UK's Data Protection Act and all project data storage and disposal is handled securely and in full compliance with the Act. The project partner organisations which gained ethics approval through The Open University are also duty-bound by this provision. The Consent framework ensured that anyone taking part is aware that data may be transferred to the UK and that they consented to this.

Informed consent was obtained prior to any data gathering interviews conducted as part of the fieldwork, and recorded data from all interviews and workshops undertaken during the project conforms with the confidentiality principle embedded in the project's ethical framework. Storage of interview data, whether at partner institutions or at the OU, was based on the principle that information from interview transcripts that could identify the Key Informants (KIs) would be anonymised to conceal their identities as far as it is possible to do so. KIs were however informed that there would remain a small risk that they may be able to be identified even after the anonymization process.

Where interviewees were more comfortable if some sections of their interview were not recorded or made public, recording was paused or sections of text were erased from interview transcripts. Where this happened, this is reflected in the transcript and the archived data. Some interviewees did not give consent for the interview to be recorded, and where this happened in relation to interviews involving one research participant, the regional research teams wrote up notes from the interview and checked these with the interviewee. This occurred in SADC KI interview transcripts C16, C17, and D3, and UNASUR KI interview transcripts PY15 and PY25. Where interviews involved two (or more) research participants or interviewees but the fieldwork team was unable to secure full consent (such as for transmission of data to the UK and deposition in a public archive) of all KIs concerned, then the transcript was redacted to remove all contributions of the non fully-consenting participant or interviewee. This occurs in SADC KI interview transcripts A10b, C4a, C12b, and D1b.

Otherwise, workshops and interviews were transcribed and anonymised using agreed formats and standards of handling the issue of multiple voices, interruptions, and labelling. The quality of audio-recordings were not always of the standard that enabled full and complete transcription. In such cases, the affected fragment of the transcript is marked [inaudible]. In the case of workshops, involving a dozen or more people, it was not always possible to retrace the identity of individuals due to the recording quality issues. In such cases this is marked [unidentifiable male/female]. In other cases, the audio-recording was started after the beginning of the interview or workshop event, or there was a gap in recording arising from the audio-recording equipment needed to be reset. This accounts for some interruptions to the fluency of the workshop proceedings.

It was not possible to preserve anonymity of the Toolkits workshop participants viz a viz each other. This was made clear on initial contact and in the tailored Consent form that participants would sign and return to the team responsible for the work strand (in this case UNU-CRIS, Kingah). Workshop transcripts have been anonymised for the purpose of archiving to ensure that participants' identities are not fully revealed and that they are not linked to specific statements made during the workshops.

Each transcript was assigned a unique identifier, corresponding to its reference on the relevant file decoder for each of the two principal fieldwork sites (SADC or UNASUR). The same arrangements were made for the PRARI Toolkits project strand. Workshops transcripts are labelled in the order in which they took place. Note that one of the SADC Toolkit transcripts, labelled WS0X, took the form of a consultation between some Toolkit participants in preparation for the second SADC workshop.

Due to the participants being recruited from a relatively small total population and the nature of the observation unit, the datasets do not contain a description of the participants' demographic or other personal characteristics. Such aspects were not the focus of the investigation or relevant to it, and the inclusion of these descriptions would have presented an unacceptable risk to the anonymity of the participants.

File list of archived documents

Interviews

SADC region

Decoder

001 Decoder Interview Transcripts SADC.pdf

Transcripts

A4, A5, A7, A10, B3, B6, B8, C1, C2, C4, C10, C12, C14, C16, C17, D1, D3 [all in pdf format]

UNASUR region

Decoder

001 Decoder Interview Transcripts UNASUR.pdf

Transcripts

AL01, AL02, AL03, AL04, AL07, AL08, BO01, BO07, BO10, PY01, PY02, PY04, PY05, PY06, PY08, PY09, PY11, PY13, PY14, PY15, PY17, PY18, PY19, PY25 [all in pdf format]

Toolkits

SADC region

Data files

Background documents

Harmonised Surveillance Framework for HIV and AIDS, Tuberculosis and Malaria in the SADC region.pdf
SDG Targets for Health.pdf
UNU SADC Second Workshop Guidance Document.pdf
WHO 2015 Global Reference List of Core Health Indicators.pdf

Transcripts

WS01, WS02, WS03, WS0X [all in pdf format]

Decoder

001 Decoder Workshop Transcripts SADC.pdf

Toolkit document

Indicator_toolkit_1_eng_dec_2015.pdf

UNASUR region

Data files

Background documents

Documento Guia – segunder talker de indicadores para la region de UNASUR.pdf
Inequidades en salud y sus determinantes sociales en Uruguay.pdf
SDG Targets for Health.pdf
WHO 2015 Global Reference List of Core Health Indicators.pdf

Transcripts

WU01, WU02, WU03 [all in pdf format]

Decoder

001 Decoder Workshop Transcripts UNASUR.pdf

Toolkit document

Indicator_toolkit_2_english_dec_2015.pdf
Indicator_toolkit_2_spanish_dec_2015.pdf

User Guide

PRARI User Guide.pdf
Deposition Summary.pdf
Data Deposit Form.pdf

Please note that some files are intentionally absent. This could have arisen either because participants withdrew from the study after being assigned a personal identifier, or because they did not agree to some aspect of the consent agreement. The most common reason for the latter concerned their non-consent for their data to be published in anonymised format in the UKDS. Intentionally-absent files number 52. This explains the non-sequential listing of interview transcripts.

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Common Acronyms and Abbreviations in Dataset

(a) English-language

ACT	Accelerating Children's HIV/AIDS Treatment
ACTO	Amazon Cooperation Treaty Organization
ASEAN	Association of South-East Asian Nations
AFDB	African Development Bank
AFRO	African Regional Office of the WHO
ART	Antiretroviral therapy
CAN	Andean Community
CDC	Centers for Disease Control and Prevention
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
COMESA	Common Market for Eastern and Southern Africa
DOTS	Directly Observed Treatment, Short-Course
DRC	Democratic Republic of Congo
ECLAC	Economic Commission for Latin America and the Caribbean
ERT	Empowered Reinforced Therapy
ESRC	Economic Science and Research Council
EU	European Union
FTA	Free Trade Agreement
FTAA	Free Trade Area of the Americas
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HDI	Human Development Index
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HPIC	Highly Indebted Poor Countries
IHR	International Health Regulations

ILO	International Labour Organisation
MDR-TB	Multi-drug resistant TB
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio
NAFTA	North American Free Trade Agreement
NGO	Non-Governmental Organisation
NHSSP	National Health Sector Strategic Plan
NTDs	Neglected Tropical Diseases
OAG	Old Age Grant
OECD	Organisation for Economic Co-operation and Development
OSF	Open Society Foundation
OVC	Orphans and Vulnerable Children
PAHO	Pan American Health Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission of HIV
Post-2015 (agenda)	The agenda on the successor to the MDGs
PRARI	Poverty Reduction and Regional Integration project
PRSP	Poverty Reduction Strategy Paper
RISDP	Regional Indicative Strategic Development Plan
SACU	Southern African Customs Union
SADC	Southern African Development Community
SAIIA	South African Institute of International Affairs
SDGs	Sustainable Development Goals
SEARO	WHO's Regional Office for South-East Asia
STI	Sexually Transmitted Infections

TB	Tuberculosis
TRIPS	Trade-Related Aspects of Intellectual Property Rights)
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNASUR	Union of South American Nations
UNDP	United Nations Development Programme
UNECA	UN Economic Commission for Africa
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WFP	World Food Program
WHO	World Health Organisation
XDR-TB	Extensively Drug Resistant TB

(b) Spanish or Portuguese Language

ABC	Agência Brasileira de Cooperação
ADPIC	Aspectos de los Derechos de Propiedad Intelectual relacionados con el Comercio
AIEPI	Atención Integrada a las Enfermedades Prevalentes de la Infancia (Comprehensive Care for Diseases Prevalent in Childhood)
ALADI	Asociación Latinoamericana de Integración
ALAMES	Asociación Latinoamericana de Medicina Social
ALBA	Alianza Bolivariana para las Américas (Bolivarian Alliance for the Americas)
ALBA – TCP	Alternativa Bolivariana para América Latina y el Caribe - Tratado de Comercio de los Pueblos
AleSat	AleSat Combustíveis
ANDE	Administración Nacional de Electricidad
ANEAES	Agencia Nacional de Evaluación y Acreditación de la Educación Superior
ANVISA	Agência Nacional de Vigilância Sanitária

AP	Atención Primaria
APS	Atención Primaria de la Salud (PHC — Primary Health Care)
BID	Banco Interamericano de Desarrollo
BNDES	Banco Nacional de Desenvolvimento Econômico e Social
CAF	Banco de Desarrollo de América Latina
CAN	Comunidad Andina de Naciones
CDC	Centros para el Control y la Prevención de Enfermedades
CDS	Consejo de Defensa Suramericano
CELAC	Comunidad de Estados Latinoamericanos y Caribeños
CEPAL	Comisión Económica para América Latina y el Caribe
CEPEP	Centro Paraguayo de Estudios de Población (Paraguayan Center for Population Studies)
CLACSO	Consejo Latinoamericano de Ciencias Sociales
CNE	Centro Nacional de Enlace (National Link Center)
CONACyT	Consejo Nacional de Ciencia y Tecnología (National Science and Technology Council)
CONES	Consejo Nacional de Educación Superior
COPROSAL	Consorcio Productivo del [Río] Salado
CSDS	Consejo suramericano de desarrollo social
CSS	Cooperación Sur-Sur
DGEEC	Dirección General de Estadísticas, Encuestas y Censos (Directorate General of Statistics, Surveys and Censuses)
DGVS	Dirección Nacional de Vigilancia Sanitaria
DIGIES	Dirección de Gestión de Insumos Estratégicos en Salud (Directorate of Strategic Inputs)
DILOS	Directorio Local de Salud (Local Health Board)
DNERHS	Dirección Nacional Estratégica de Recursos Humanos en Salud
DSS	Determinantes Sociales de la Salud Social (SDH — Social Determinants of Health)
EIH	Encuesta Integrada de Hogares (Integrated Household Surveys)
EPH	Encuesta Permanente de Hogares (Continuous Household Surveys)

FAO	Organización de las Naciones Unidas para la Agricultura y la Alimentación
FESP	Funciones Esenciales y Programa de Salud Pública
FIC	Fondo de Iniciativa Comunes
Fiocruz	Fundação Oswaldo Cruz
FLACSO	Facultad Latinoamericana de Ciencias Sociales
FMI	Fondo Monetario Internacional
FOCEM	Fondo para la Convergencia Estructural del MERCOSUR
FONACIDE	Fondo Nacional de Inversión Pública y Desarrollo
GMC	Grupo del Mercado Común
GRULAC	Iniciativa América Latina y el Caribe sin Hambre
H1N1	GRIPE A (H1N1) - Minsa (see also Minsa)
IDH	Indice de Desarrollo Humano
INASES	Instituto Nacional de Seguros de Salud (National Health Insurance Institute)
INDES	Instituto de Desarrollo Social y Promoción Humana
INS	Instituto Nacional de Salud (National Health Institute)
INSO	Instituto Nacional de Salud Ocupacional (National Occupational Health Institute)
IPG	Índice de Priorización Geográfica
IPS	Instituto de Previsión Social (Social Insurance Institute)
ISAGS	Instituto Sul-Americano de Governo em Saúde
MEC	Ministerio de Educación y Cultura
MECIP	Modelo Estándar de Control Interno del Paraguay
MERCOSUR	Mercado Común del Sur
Minsa	Reunión de Ministros de Salud del Área Andina (see also H1N1)
MSBPS	Ministerio de Salud Pública y Bienestar Social (Ministry of Public Health and Social Welfare)
MSD	Ministerio de Salud y Deportes (Ministry of Health and Sports)
MSPyBS	Ministerio de Salud Pública y Bienestar Social
MST	Movimiento Nuestra América

ODM	Objetivos de Desarrollo del Milenio
OEA	Organización de los Estados Americanos
OMC	Organizacion Mundial del Comercio
OMPI / OMPIC	Organización Mundial de la Propiedad Intelectual
OMS	Organización Mundial de la Salud
ONG	Organizacion No Gubernamental
ONT	Organización Nacional de Trasplantes
ONU	Organización de las Naciones Unidas
OPS	Organización Panamericana de la Salud
ORAS	Organismo Andino de Salud
ORAS CONHU	Organismo Andino de Salud - Convenio Hipólito Unanue (Andean Health Organism – Hipolito Unanue Covenant
OTCA	Organización del Tratado de Cooperación Amazónica
PBI / PIB	Producto Bruto Interno / Producto Interno Bruto
PND	Plan Nacional de Desarrollo (National Development Plan)
PNUD / UNDP	Programa de las Naciones Unidas para el Desarrollo
POA	Plan Operativo Annual
PPP	Presidencia Pro Tempore
PRONASIDA	Programa Nacional de Control de Sida-ITS (National Program for the Control of AIDS-STI)
PSD	Plan Sectorial de Desarrollo (Sectoral Development Plan)
PT	Partido de los Trabajadores
RBC	Rehabilitación basada en la comunidad
RESP	Red de Escuelas de Salud Pública
RePIR	Reducción de la pobreza e integración regional [PRARI – Poverty Reduction and Regional Integration project).
RIBS	Red Integral de Bienestar Social
RIMPS	Red Iberoamericana de Migración de Profesionales de la Salud
RISS	Red Integrada de Servicios de Salud (Integrated Healthcare Service Network)

RSI	Reglamento Sanitario Internacional
SAFCI	Salud Familiar Comunitaria Intercultural (Family, Community and Intercultural Health)
SAI	Sistema Andino de Integración
SAS	Secretaría de Acción Social
SELA	Sistema Económico Latinoamericano y del Caribe
SEDES	Servicio Departamental de Salud (Departmental Health Service)
SENASA	Servicio Nacional de Sanidad y Calidad Agroalimentaria
SENEPA	Servicio Nacional de Erradicación del Paludismo (National Malaria Eradication Service)
SGT11	Sub Grupo de Trabajo N° 11 - Salud
SIDAR	Seminario Iberoamericano sobre Diversidad y Accesibilidad en la Red
SINAIS	Sistema Nacional de Información en Salud (National Health Information System)
SIPLIS	Sistema Plurinacional de Investigación en Salud (Plurinational Health Research System)
SISVAN	Sistema de Vigilancia Alimentaria y Nutricional (Food and Nutrition Surveillance System)
SNIS	Servicio Nacional de Información en Salud (National Health Information Service)
SSIEV	Subsistema de Información de las Estadísticas vitales (Vital Statistics Information Subsystem)
SSPAM	Seguro de Salud para el Adulto Mayor (Social Health Insurance for the Elderly)
SUMI	Seguro Universal Materno Infantil (Maternal and Child Health Insurance Program)
SUS	Sistema Universales de Salud (Universal Health System)
TAES	Tratamiento Acortado Estrictamente Supervisado
TEKOPORA	Programa Social implementado por la Secretaría de Acción Social de Paraguay
teleSUR	Canal de televisión multiestatal de noticias con sede central en Caracas, Venezuela
UE	Unión Europea
UNASUR	Unión de Naciones Suramericanas
UOM	Unión de Obreros Municipales

USF	Unidades de Salud de la Familia (Family Health Units)
VIH	Virus de la Inmunodeficiencia Humana
VPH	Virus del Papiloma Humano

Appendix 1: Sample Project Information Sheet [Eng]

Insert FLACSO or UNU-CRIS

or SAIIA logo here

Research jointly supported by the ESRC and DFID

Research Project Information Sheet

Poverty Reduction and Regional Integration: a comparative analysis of SADC and UNASUR health policies (PRARI)

Inadequate access to health care and medicines is a persistent issue among impoverished populations in Southern Africa and South America and beyond. This project examines the scope for enhancing Southern multilateral regional organisations' contributions to poverty reduction through regional health policy. We aim to understand better how the commitments of the Southern African Development Community (SADC) and the Union of South American Nations (UNASUR) on poverty and health are being implemented. We are interested in what kinds of regional policy development processes are conducive to the emergence of embedded pro-poor approaches within SADC and UNASUR and nationally (we are focusing on Zambia, Swaziland, Bolivia and Paraguay). We are seeking to develop policy 'Toolkits' that assess what progress is being made towards pro-poor regional health policies.

PRARI will contribute to the fleshing out of appropriately targeted recommendations for SADC and UNASUR decision-makers, governments, civil society organisations, health professionals, businesses and international organisations as to how they may better support regional health policies having a demonstrably positive impact on poverty reduction among vulnerable populations. It will also contribute to publications for teaching and research purposes.

We are speaking to a range of policy stakeholders from policy, practice and end-beneficiary communities. These consultations complement analysis of statistical sources, policy documents and research literatures. We need written consent from participants to progress these consultations.

Collation, storage and use of information generated through this research are strictly governed by social research ethics codes and the UK Data Protection Act (1998), which assure anonymity, security and confidentiality of research data across all stages of the research during the lifetime of the project. This sesearch data will be held securely at ***[FLACSO/SAIIA/UNU-CRIS [delete as applicable]*** and the Open University in the UK for 5 years after the completion of the research project. It will be desposited in a publicly accessible archive in the UK so that other researchers can undertake secondary analysis if they so wish

Interviews and consultations either on a one-to-one basis or in focus groups will take place in English/Spanish ***[delete as applicable]*** with [Dr Ana Amaya or Dr Stephen Kingah/Dr Belen Herrero or Dr Diana Tussie/Dr Erica Penfold or Professor Pieter Fourie] [***delete as applicable***] at a mutually agreed day, time and venue to be arranged. When arranging these, we will let you know in advance of these what the format for these will be

(e.g. via Skype or teleconference; or personal (face-to-face)). We anticipate that the duration of these interviews and consultations will be 60 minutes, and they will be recorded. Participants will be sent an interview schedule prior to the interview indicating the topics to be covered. During the discussion, you will be asked to clarify between statements that reflect a personal perspective and those that reflect an organisational perspective. Subject to agreement, there may be scope for follow-up contact with you after the interview, including the possibility of a second interview, subject to agreement. We will will send you a copy of the interview transcript to review and you will have an opportunity to further clarify yourr statements.

We are unable to offer any recompense for participating in the research. We do not anticipate that participants will incur any travel and subsistence costs but if this is the case we will reimburse you to an agreed amount if this has been agreed in advance with the research team (Dr Ana Amaya or Dr Stephen Kingah/Dr Belen Herrero or Dr Diana Tussie/Dr Erica Penfold or Professor Pieter Fourie) **[*delete as applicable*]**.

We would like to use relevant quotations from the consultations in presenting our research findings to the research team and to wider academic and policy audiences. We will make every effort to remove all information that can personally identify you. However, there remains a risk that using quotations may personally identify individuals, even after we have removed identifiers. If this is a cause of discomfort to you we undertake not to use quotations them.

Your participation in this study is voluntary and you are free to withdraw from the project at any point and without prejudice. In such cases, all relevant data pertaining to your participation in the project will be securely destroyed.

Participants may elect to receive project updates during the lifetime of the project and a copy of the final report following the completion of the research in December 2015. If this is the case please let us know by emailing PRARI@open.ac.uk. The website address for the project is http://www.open.ac.uk/socialsciences/prari

[below – delete as applicable depending on which team this PI Sheet is sending this out to prospective participants]

The Southern African strand of the research is led by **Professor Pieter Fourie** (Co-Investigator) in collaboration with **Dr. Erica Penfold** (PRARI Researcher) at the South African Institute for International Affairs (SAIIA). [insert PF and EP emails).

or

The South American strand of the research is led by **Dr Diana Tussie** (Co-Investigator) in collaboration with **Dr. Belen Herrero** (PRARI Researcher) at FLACSO, Argentina. [insert DT and BH emails).

or

The policy Toolkits research is led by **Dr Stephen Kingah** (Co-Investigator) in collaboration with Dr. Phillippe de Lombaerde (Consultant) in collaboration with **Dr. Ana Amaya** (PRARI Researcher) at the United Nations University Institute for Comparative Regional Integration Studies, Belgium. [insert SK and AA emails).

The Principal Investigator for the project overall is Professor Nicola Yeates, Department of Social Policy and Criminology, Faculty of Social Sciences, the Open University, UK (PRARI@open.ac.uk) The project is funded by the UK Economic and Social Research Council, Grant No. ES/L005336/1, and does not necessarily reflect the opinions of the ESRC.

Appendix 2: Sample Consent form [Eng]

Insert FLACSO or UNU-CRIS or SAIIA logo as appropriate		

Consent form

Poverty Reduction and Regional Integration: a comparative analysis of SADC and UNASUR health policies (PRARI)

I, [insert name] _____

of_[organisation and address] _____

Agree to take part in this study as a research participant in [a policy consultation/interview/ group discussion; Toolkit consultation/stakeholder meeting/workshop] focused on poverty reduction through regional health policies. ***[delete/amend as applicable according to specific circumstances]*** I confirm I have:

- had the purposes of the research project and my participation in it explained to me.
- been informed that I may refuse to participate at any point without penalty.
- been informed that once I have given my consent, I may withdraw at any time during the project, without penalty, up until the point that data archiving is finalised (October 2015).
- ***[for individual consultations and interviews:]*** been assured that my privacy will be protected as specified in the Project Information Sheet.
- ***[insert this for focus groups involving several participants:]*** Been informed that it will not be possible for my privacy to be fully protected from other participants but that the project will protect this in all other ways as specified in the Project Information Sheet
- agreed that the information that I provide can be used for educational or research purposes, including publication.
- Been informed that data including recordings and transcriptions may be securely transferred to the UK.
- Consented for my anonymised data to be deposited in a publicly accessible archive in the UK

I would like to be personally acknowledged in research publications (*Please delete as applicable*). **Yes** **No**

I understand that if I have any concerns or difficulties I can contact: ***[insert name of relevant Co-Investigator Fourie/Tussie/Kingah as appropriate;contact address, email [PF, DT or SK] and telephone and fax numbers]. Insert project email address (PRARI@open.ac.uk].***

Signed: _____ Date_____

Appendix 3: Interview schedules

3.1 SADC and UNASUR policy KIIs

A. Regional governance structures and policy-making

1. Could you explain the work of your organisation/unit/section in the making of regional (SADC/UNASUR) policy?
    - Prompt for health policy example/s if not already given
2. Could you explain the institutional processes by which regional (SADC/UNASUR) policies are made and change? For example, what are the processes of consultation, decision-making, resourcing, evaluation and accountability?
    - Prompt for (health-related) recent examples – this could be structured around an example of a specific identified regional initiative or policy document]
3. Which organisations and groups do you regard as principal stakeholders when it comes to regional policy-making?
    - Prompt for multilateral, donor, governmental, commercial, non-profit, civil society, professional groups, citizens.
    - Follow-up to ascertain specifically identified (named) groups.
    - Follow-up: why these?
4. How are these organisations/groups actually involved in practice?
    - Follow-up: Are some organisations/stakeholders easier to engage than others? Which ones – and why is this? Conversely, which are most difficult to engage – and why?
    - How do they shape policy making and the setting of priorities?
        - Prompt: agenda-setting, advocacy, expert (scientific or political) knowledge, wider influence among communities of interest and constituencies..?
        - Prompt for specific examples
        - Prompt for variation in contributions/involvement of different groups in the policy process and over time
        - Follow-up: would you characterise SADC/UNASUR policy making as democratic? Prompt: If so, why? Prompt: If not, how would you characterise it [possible alternative descriptors - elitist, technocratic, undemocratic] – and why?
5. How do you work with other stakeholders in regional policy-making? Is SADC/UNASUR directly involved in implementation or is its role more normative and regulatory?
    - Prompt for health and health-related examples
    - Follow-up: does this depend on specific policy issues, countries and circumstances, such as epidemics, disasters, risks? Prompt for how and why
6. Which official documentation or reference material relating regional governance in SADC/UNASUR should we be aware of?

B. Health priorities

1. How does SADC/UNASUR determine health needs and health priorities within the region?
    - Prompt: what sources of information (data, evidence) do you use to inform this assessment? Where does it come from – who generates it.
    - Follow-up: what issues are there with this data? Prompt for gaps in information (data, evidence) on regional health, and comparability
    - How do these data issues impact on determining *regional* assessments of health needs and priorities?
2. What role does SADC/UNASUR play in the setting of health priorities of these countries?
    a. Follow-up: does SADC/UNASUR as a regional organisation play any role in health resource allocation? Prompt for what and how.
3. Follow-up as appropriate, how could SADC/UNASUR as regional organisations play a more effective role in developing regional health policy? Could this be done within existing competencies or would some more fundamental reforms need to happen? If so, what?
4. Who would you recommend we should be in contact with in your organisation or others regarding regional health policies?

C. Poverty

1. How does your organisation/unit define poverty? How do you see it as being related to health issues?
2. Which are the principal regional policies of SADC/UNASUR having an impact on poverty and poverty-related ill-health that our project be aware of?
3. How does SADC/UNASUR as a regional organisation engage with issues of poverty?
    - Prompt: through concrete programmes of action or provision, flagship/statement reports, shaping political discourse, awareness raising…
    - Follow-up: does SADC/UNASUR take every opportunity to address issues of poverty and how does it do this?
        - Prompt for specific examples
4. How could SADC/UNASUR engage with issues of poverty more effectively, in your view?
    - Follow-up: what, in your opinion, would pro-poor health policy ‘look’ like?
    - Follow-up: in your view, what are the exemplary pro-poor health policies in the member states of SADC/UNASUR?
        - Prompt for specific examples,
    - Follow-up: what are the upcoming promising policy initiatives in member states that we should be aware of?
5. What kinds of changes to the ways in which SADC/UNASUR is constituted or how it functions in practice might help a more pro-poor health policy to emerge [or be consolidated]?

- Prompt: More/different consultative or democratic structures and practices? Better resourcing? More responsive/rational policy-making? Better/more coherent/coordinated national/regional collaboration? Better leadership, improved skills/professional base?
- Follow-up: clarify whether these are changes within SADC/UNASUR and/or at the level of member states – or both? Why?

D. Regional-national engagement

1. Which actors/stakeholders are mobilized in national policy processes in health?
    - Prompt for examples to draw out who (specifically) and how
    - Follow-up: are region-wide/regional actors present and/or a significant force in national health systems and policy-making?
        - Prompt: who, how and why?
        - Follow-up: Have you found this engagement to be useful, regarding advocacy or policy change?
2. Does your organisation routinely engage with health policymakers in SADC/UNASUR?
    - Follow-up: How and over what issues? What issues arise from this, from your perspective?
3. What are the challenges you /your organisation has faced in trying to generate and steer policy change?
    - Follow-up: what opportunities are available that could be harnessed by those seeking *pro-poor* policy change?
    - Follow-up: are there any additional observations you would wish to add to what you've just raised if we were to focus specifically on pro-poor *health* policy change?

<u>3.2 Toolkit Indicators KIIs (SADC/UNASUR secretariats)</u>

1. Could you please tell me a bit about your background?
2. Do you think health is a priority in your country/region? Why? Can you give some examples?
3. How does the country/regional body determine health priorities? Why?
4. How are health and poverty related?
5. Can this link be measured? Why/how?
6. Do you use (health and/or poverty) data in your daily work? Why/how?
7. Who is responsible (actor) for data generation? Management? Distribution?
8. Have there been any (significant) changes to your health information system? What factors prompted these – How did these come about?

9. How would you rate your reporting/monitoring system on a scale of 1-10? Why?

10. Which do you consider are your main reporting/monitoring strengths?

11. Which do you consider are your main reporting/monitoring weaknesses?

12. What are the main gaps in information for health/sanitation in your country/region?

13. How is information shared from the local to the national/regional level? Does this work well? Is it effective? What are the issues/difficulties/obstacles?

14. How would you rate the capacity to process this information at each of these levels?

15. Do you collaborate on data issues with the member states? How? Why/Why not?

16. What is your relationship with other regional bodies (Africa: AU/NEPAD; South America: Mercosur/CAN/ALBA) regarding data? Do you share information? Why/Why not? How? Is there an attempt to address comparability and data gaps on a regional/cross-national scale? If not, what are the obstacles to doing so?

17. Do you share data with any other organisations or stakeholders? Which ones? Why?

18. Do you use data from other organisations? Why/which data?

19. Is this information reported back to you? Why/how?

20. Is there anything else you would like to add?

3.3 Toolkit Indicators KIIs (in-country)

1. Could you please tell me a bit about your background?
   - Have you been trained in data management?
2. How do you use data in your daily work?
   - What does this entail?
   - Who do you work with in this process?
     - within your organisation? outwith your organisation?
3. How are decisions on data selection and management made?
   - Who does this involve?
   - Who has ultimate say on how data is used?
   - How is this process reviewed?
4. What are the drivers of changes made to the information system?
   - Was this brought about by external or internal factors?
   - How often do these changes occur? [in response to specific drivers/crises, or scheduled intervals]
5. How do you monitor and evaluate your information system?
   - How often does this take place?
   - Who does this?
   - How does this promote (or hinder) change?
   - What are some constraints for change?

6. How are data gaps filled?
    - Could you please explain why?
    - Can you give some specific examples?

7. How many databases do you use for health?
    - Who manages these?
    - How can we access this information?
    - Are these available online?
    - What is your relationship with these other statistical bodies/ministries?
    - Who do you communicate with?

8. Regarding this data, how is it reported?
    - To what degree is it disaggregated? Can you give me some examples?
    - At what level does this disaggregation take place?
    - What do you consider vulnerable populations in your data?

9. Following up on the last question, what data can illuminate issues of access to services for populations living in poverty? Can you give me some specific examples of indicators?
    - Is this data readily available? Where?
    - What about access to medications?
    - How do you disaggregate this?
    - Can it be disaggregated by sex, age, locality, ethnicity?

10. How are multisectoral health policies monitored?
    - Can you explain why?
    - Please give me some specific examples
    - What makes this easy/difficult?

11. What data is not readily available to the public?
    - Can you please explain why?
    - Is this temporary/permanent?
    - How do you decide this?

12. What is the main way of calculating data that is not directly available?
    - How do you decide this?
    - Who does this?
    - How often does this change?

13. What are the main strengths and weaknesses of your health information system?
    - Can you tell me why?
    - What about data quality?
    - Whose responsibility is this?
    - Are there any political/social/international implications?
    - What is the role of international bodies/regulations in this?

14. What data captures poverty and health – and the intersection between them?
    - Could you explain why?
    - Can you think of any specific indicators?
    - Input, process, output, outcome indicators?
    - Can you rank these in order of importance?
    - Can you give some specific examples?
    - Where is this data found?

- What is the capacity at local/regional/national level to compile/manage and report this data?

15. Is this link already being explored?
    - Can you explain why/how/where?

16. How are regional policies tracked and evaluated?
    - Who tracks them?
    - How are they evaluated?
    - Is this effective? Why?/Why not?
    - Have you received any guidelines about this?
    - Who do you liaise with? Who sends you this information?
    - Is the information used nationally the same as that which is reported internationally? Why?/Why not?

17. How do you measure cross-country (regional) health issues/diseases?
    - Can you tell me about any agreements with these other countries?
    - How does this data sharing take place?
    - Are these processes institutionalized or based on person-person interaction?

18. Is there anything else you would like to add that I haven't asked?
    - Any recommendations for our project about who I should talk to or databases I should consult?

3.4 Group discussion (workshop) guide (Indicators)

1. What do you think is the link between health and poverty?

2. According to you, what is more important, improving the health of the poor or improving equity? Please explain.
    - Is this already being discussed at the policy level? Where, how?
    - For example, are regional level health policy recommendations/negotiations being developed to support the creation of poverty strategy reduction papers (PRSPs) in the countries? Why?
    - Can you think of other examples?

3. How do you think the link between poverty and health can be measured?
    - Can you think of any specific indicators? [Prompt: input, process, output, outcome indicators]
    - Can you rank these in order of importance?

4. Are there any limitations to compiling data needed to measure this relationship?
    - How can these limitations be addressed?

5. How do you bridge the divide between political and technical processes in your institution? Please explain.
    - How are these policies operationalized?
    - Do you provide regional guidelines or leave it to countries?
    - Does this work? Why? Why not?

6. What is your interaction with the countries?
    - Is there continuous interaction or does it take place periodically?
    - How often?
    - At what level? Who do you interact with?

7. What is your interaction with other actors? What is their level of influence on how you conduct your work?
    - Global actors? Donors? Other regional actors? Other (national) actors in the region?

8. What is the quality of the data that you receive from the countries? Please explain.
    - How do you address this?
    - How do you fill any possible data gaps?

9. In your institution, who makes decisions on which data to use and report?
    - How are these decisions made?
    - Is this useful? For whom?

10. How do you monitor regional health agreements
    - Do you have mechanisms of accountability in place? Do they work? Why?
    - Do these activities/policies reach their objectives? Please explain

11. Do you monitor other regional agreements in terms of their health impacts?
    - Do you have mechanisms of accountability in place? Do they work? Why?
    - Do these monitoring activities/policies work? Please explain

12. Are there any contributions by regional bodies to national policy-making that cannot be measured quantitatively? Please explain.
    - How do these contribute to health improvements and the reduction of poverty?
    - Thinking specifically about access to medicines and vulnerable populations, can you give me examples of policies that contribute to this?
    - How are these monitored?
    - What is their degree of success?

13. Have you thought of any ways of bridging the gap from regional (supra-national) policy-making to local data collection? Please explain.
    - What are the opportunities and threats involved in this?
    - What can be done from the regional level to improve this gap?

14. Let's summarise some of the key points from our discussion […] Am I missing anything?

15. Do you have any questions?