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REPORT OF THE INTERNATIONAL CONFERENCE ON

Exploring Areas of Cooperation in Digital and Preventive Healthcare: India-Africa Partnership for Sustainable Development

DAKSHIN - GLOBAL SOUTH CENTRE OF EXCELLENCE

RESEARCH AND INFORMATION SYSTEM FOR DEVELOPING COUNTRIES (RIS)

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Concept Note



Africa is emerging as one of the most important regions in the evolving global economic and strategic landscape. With a rapidly growing population, expanding consumer markets, increasing urbanisation, abundant natural resources, and ongoing regional integration efforts under the African Continental Free Trade Area (AfCFTA), the continent is expected to play a defining role in shaping future global growth and development. At the same time, African countries continue to face important developmental challenges relating to healthcare access, industrialisation, food security, infrastructure gaps, and employment generation. These realities underline the importance of stronger and development-oriented international partnerships.

India and Africa share historically rooted ties based on solidarity, mutual respect, anti-colonial cooperation, and South-South partnership. Over the years, India-Africa relations have evolved into a broad-based and multidimensional engagement covering trade and investment, development cooperation, capacity building, healthcare, pharmaceuticals, education, digitalisation, agriculture, and technology partnerships. India has emerged as a trusted and reliable development partner for African countries through demand-driven initiatives, affordable technologies, concessional financing, and people-centric cooperation programmes.

The forthcoming India-Africa Forum Summit provides an important opportunity to reimagine India-Africa cooperation in light of evolving global realities. In an increasingly uncertain global environment marked by geopolitical tensions, supply chain disruptions, healthcare vulnerabilities, and the growing search for resilient and sustainable development pathways, India and Africa have strong complementarities that can support deeper strategic and economic cooperation. Trade and investment remain central pillars of India-Africa engagement. Bilateral trade has expanded substantially over the last two decades, with cooperation spanning sectors such as pharmaceuticals, agriculture, automobiles, energy, digital technologies, and services. However, the full potential of economic cooperation remains underutilised. There is significant scope for strengthening regional value chains, MSME partnerships, investment facilitation, digital connectivity, and industrial collaboration, particularly in the context of AfCFTA and evolving global production networks.

Healthcare and health innovation have emerged as important pillars of future India-Africa cooperation. India's experience in affordable telemedicine, digital public infrastructure for health, and economical medical innovation offers significant potential for supporting Africa's evolving healthcare priorities. Initiatives such as Ayushman Bharat Digital Mission (ABDM) and eSanjeevani demonstrate how scalable and cost-effective digital health solutions can strengthen healthcare accessibility, service delivery, and system efficiency. At the same time, India's traditional systems of medicine, alongside Africa's rich indigenous medicinal knowledge systems, provide a strong foundation for collaboration in preventive healthcare, wellness, research, capacity building, and sustainable healthcare practices. Strengthening cooperation in healthcare innovation, digital health, and traditional medicine can contribute significantly towards building resilient, inclusive, and people-centred health systems across African countries while advancing broader South-South cooperation in health and development.

Against this backdrop, the proposed International Seminar seeks to provide a platform for policymakers, scholars, industry representatives, healthcare experts, and practitioners from India and Africa to deliberate on emerging opportunities and practical pathways for strengthening cooperation. The seminar aims to contribute to policy discussions leading up to the India-Africa Forum Summit and generate actionable recommendations for advancing India-Africa partnership in trade, health, and innovation. Specifically, seminar will have following technical sessions.

Session I: Deepening India-Africa Trade and Investment Partnership

This session will examine the evolving landscape of India-Africa economic relations and explore strategies for enhancing trade and investment cooperation. Discussions will focus on trade diversification, regional and global value chains, MSME partnerships, digital trade, infrastructure and connectivity, investment facilitation, and opportunities emerging from AfCFTA. The session will also deliberate on ways to address existing bottlenecks and strengthen institutional and business-to-business engagement between India and Africa.

Session II: Exploring Areas of Cooperation in Digital and Preventive Healthcare

This session aims to strengthen India-Africa cooperation in health through dialogue, knowledge exchange, and identification of practical collaboration opportunities. The session will focus on scalable and affordable healthcare innovations relevant to the Global South, particularly in areas such as digital public infrastructure, telemedicine, preventive healthcare, and traditional systems of medicine. Drawing on India's experience with initiatives such as Ayushman Bharat Digital Mission (ABDM) and eSanjeevani, the conference seeks to facilitate discussions on strengthening resilient and inclusive health systems across Africa. It will also assess the interest, institutional readiness, and priority areas of participating African countries for future collaboration, technical assistance, capacity building, and policy partnerships in the health sector.

Agenda

9:30 AM – 10:00 AM	Registration
10:00 AM– 11:15 AM	Inaugural Session Welcome Remarks • Professor Sachin Kumar Sharma, Director General, RIS Initial Remarks • Professor Amitabh Mattoo, Dean, School of International Studies, Jawaharlal Nehru University Special Remarks • Dr Angela Lusigi, Resident Representative, UNDP India Vote of Thanks • Professor J.M. Moosa, Professor, Centre for African Studies, School of International Studies, Jawaharlal Nehru University
11:15 AM– 11:20 AM	MoU Signing
11:20 AM–11:45 AM	Tea / Coffee Break

11:45 AM – 13:00 PM	Session I: Deepening India-Africa Trade and Investment Partnership Chair: • Professor Rajat Kathuria, Dean, School of Humanities and Social Sciences, Shiv Nadar University Speakers: • Dr Deepak Pareek, Founder, Hny BTech-Incubations Pvt. Ltd. • Mr Tarun Sharma, Deputy Managing Director, EXIM Bank • Amb. Abdoulie M. Touray, Chairman and Chief Executive Officer, SaHel Invest Management International (SIMI) • Mr Moustafa Hiridjee, CEO, VISEO Group and Managing Director, Ocean Trade • Dr Priyadarshi Dash, Associate Professor, RIS • Dr Pankaj Vashisht, Associate Professor, RIS
13:00 PM – 14:00 PM	Lunch Break
14:00 PM – 16:00 PM	Session II: Exploring Areas of Cooperation in Digital and Preventive Healthcare
14:00 PM – 14:20 PM	Setting the context • Dr Rajan Sudesh Ratna, Coordinator, DAKSHIN, RIS

14:20 PM – 15:00 PM	Sharing of India's experience Chair: • Ms Geetu Joshi, Economic Adviser, Department of Health & Family Welfare, Ministry of Health & Family Welfare (MoHFW), Government of India Moderator: • Dr Monika Kochar, Advisor-Health, DAKSHIN, RIS India's Digital Public Infrastructure for Health • Mr Vikram Pagaria, Director, ABDM, National Health Authority (NHA), Ministry of Health & Family Welfare (MoHFW), Government of India Telemedicine and Digital Access to Care • Mr Madhukar Kumar Bhagat, Joint Secretary (ehealth), Ministry of Health & Family Welfare (MoHFW), Government of India Traditional and Preventive Health Innovations • Dr Charu Lata, Principal Scientist, CSIR-National Institute of Science Communication and Policy Research (CSIR-NIScPR), New Delhi
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15:00 PM – 15:45 PM	Sharing of African experiences and exploring areas of cooperation • Dr Franck Arnaud Ndurukwigira, Head of Digital Governance, Artificial Intelligence, and Technology, Centre For Development and Enterprises Great Lakes (CDE), Burundi • Mr Robert Mwale, Lead Public Finance Researcher, Centre for Trade Policy and Development (CTPD), Zambia • Mr Mohamed Abdullahi Ali, Researcher, Somali Institute for Development Research & Analysis (SIDRA), Somalia • Dr Christian Pout, Chairman, Centre for International, Diplomatic and Strategic Studies (CEIDES), Cameroon • Prof John Huston Stanfield, Director, Advanced Study of African Renaissance Policies Ideas (ASARPI), Mauritius • Ms Harshitha Nayar, Research Associate, Advanced Study of African Renaissance Policies Ideas (ASARPI), Mauritius • Ms Zambwe Shingwele, Acting Research Fellow, Zambia Institute for Policy Analysis and Research (ZIPAR), Zambia • Dr Nouzha Chekrouni, Senior Fellow, Policy Center For The New South (PCNS), Morocco • Mr Michael Owuor, Research Fellow, The Global Centre for Policy and Strategy (GLOCEPS), Kenya • Mr Philemon Okillong, Research Analyst, Economic Policy Research Centre (EPRC), Uganda • Dr Sadek Aly Abdelaal, Member of the Egyptian Council of Foreign Affairs (ECFA), Egypt
15:45 PM– 16:00 PM	Open discussion on possible areas of cooperation
16:00 PM– 16:30 PM	Closing Remarks and Way Forward • Dr Pankaj Vashisht, Associate Professor, RIS • Dr Monika Kochar, Advisor-Health, DAKSHIN, RIS

Executive Summary

The International Conference on “Exploring Areas of Cooperation in Digital and Preventive Healthcare: India-Africa Partnership for Sustainable Development,” organised by DAKSHIN-Global South Centre of Excellence, Research and Information System for Developing Countries (RIS), brought together policymakers, researchers, healthcare professionals, diplomats, and representatives from African think tanks and institutions. The conference was convened as part of the preparatory process for the Fourth India-Africa Forum Summit (IAFS-IV).

The conference was structured around two complementary objectives. The first was to present India’s digital public infrastructure (DPI) models in health, specifically the Ayushman Bharat Digital Mission (ABDM), the eSanjeevani telemedicine platform, and the AYUSH and Traditional Knowledge Digital Library (TKDL) frameworks. The second was to document, through structured country presentations, the healthcare system priorities of African nations and the extent to which Indian DPI models address those priorities.

The evidence from African country presentations was unambiguous. Eleven representatives from nine countries, covering Burundi, Zambia, Cameroon, Mauritius, Morocco, Kenya, Somalia, Uganda, and Egypt, identified fragmented health information systems, shortages of healthcare professionals, weak interoperability, and limited access to specialist services as their most pressing systemic constraints. Across these presentations, Indian DPI models, particularly ABDM and eSanjeevani, were consistently cited as directly relevant responses to these constraints.

Demand for ABDM’s architectural model, encompassing unique health identities, interoperability frameworks, health facility and professional registries, and consent-based data sharing, was the broadest and most recurrent signal across country presentations. Burundi, Kenya, Somalia, Cameroon, Morocco and Uganda each identified one or more components of this architecture as a priority cooperation area. Demand for eSanjeevani’s telemedicine service delivery model was the second strongest signal, raised by six countries as a practical mechanism for addressing workforce distribution gaps and extending specialist access to remote populations.

Demand for cooperation in traditional medicine and AYUSH frameworks was more limited in scope, raised substantively only by Egypt and Kenya, and focused primarily on documentation, scientific validation, and medicinal plant research rather than on DPI deployment as such.

The conference also surfaced an important distinction in cooperation modalities. Countries such as Morocco and Kenya expressed interest in peer-level adaptation of India's DPI architecture to their own national contexts. Countries such as Somalia and Uganda articulated a need for technical assistance, capacity building, and implementation support. This distinction carries practical implications for how IAFS-IV structures cooperation frameworks.

The conference concluded that India's DPI models in health represent a documented, evidence-based response to the most commonly cited structural weaknesses in African health systems. The findings provide a strong foundation for IAFS-IV to move from dialogue to implementation, with ABDM-linked digital health architecture and eSanjeevani-modelled telemedicine emerging as the two areas of highest and most broadly distributed African demand.

Introduction

Healthcare has emerged as one of the most important pillars of cooperation between India and Africa. Both regions face common challenges in ensuring equitable access to healthcare services, strengthening health system resilience, managing growing disease burdens, and achieving the health-related Sustainable Development Goals (SDGs). At the same time, both possess valuable experiences, innovations, and institutional strengths that can contribute to mutually beneficial partnerships.

The COVID-19 pandemic exposed vulnerabilities in health systems worldwide while demonstrating the critical importance of digital technologies, resilient supply chains, local manufacturing capacity, and community-based health interventions. For many African countries, the pandemic accelerated efforts to strengthen digital health systems, improve disease surveillance, and expand access to healthcare services through technology-enabled approaches. India's experience in deploying digital public infrastructure, telemedicine platforms, large-scale health insurance programmes, and vaccine delivery systems attracted considerable global attention during this period.

Against this backdrop, DAKSHIN-Global South Centre of Excellence at RIS convened the International Conference on "Exploring Areas of Cooperation in Digital and Preventive Healthcare: India-Africa Partnership for Sustainable Development" as part of the preparatory process for the Fourth India-Africa Forum Summit. The conference focused on three broad themes: digital health and digital public infrastructure, including electronic health records, interoperability, and health data governance; telemedicine and technology-enabled healthcare delivery; and preventive healthcare, traditional medicine, and community-based approaches to health promotion.

Opening Session

Welcome Remarks



Professor Sachin Kumar Sharma

Director General, RIS

Professor Sachin Kumar Sharma emphasised that healthcare has become a strategic dimension of India-Africa relations and a central priority within the agenda of South-South cooperation. He observed that both India and African countries face interconnected challenges arising from demographic transitions, climate change, food insecurity, emerging diseases, and persistent inequalities in healthcare access, and that addressing these requires collaborative approaches combining policy innovation, technological advancement, and institutional capacity building.

Professor Sharma highlighted DAKSHIN's role in facilitating dialogue among countries of the Global South and generating evidence-based policy recommendations. He stressed that the objective of the conference was not merely to exchange experiences but to identify practical pathways for collaboration grounded in mutual respect, shared learning, and co-development. He noted that India's experience in digital public infrastructure, telemedicine, preventive healthcare, pharmaceutical manufacturing, and traditional medicine offers valuable lessons that can be adapted to African contexts, and equally that African countries possess innovative experiences from which India can learn.

Opening Address



Professor Amitabh Mattoo

Dean, School of International Studies, Jawaharlal Nehru University

Professor Amitabh Mattoo situated the conference within the historical trajectory of India-Africa relations, emphasising solidarity, shared development aspirations, and common experiences of colonialism and underdevelopment. He argued that contemporary global challenges require countries of the Global South to play a more active role in shaping development pathways and global governance structures. He noted that the COVID-19 pandemic demonstrated that health security is now inseparable from economic security, social stability, and sustainable development, and that digital public infrastructure and healthcare technologies have the potential to transform health service delivery while contributing to inclusive growth.

Special Remarks



Dr. Angela Lusigi

Resident Representative, UNDP India

Dr. Angela Lusigi emphasised the importance of building partnerships that move beyond traditional donor-recipient relationships toward co-creation and shared ownership. She highlighted the interconnected nature of health, education, livelihoods, gender equality, and climate resilience, arguing that effective healthcare systems must be embedded within broader development frameworks. She pointed to India's contributions through Vaccine Maitri and other South-South solidarity initiatives as evidence of the value of peer-based cooperation, and called for deeper collaboration in digital governance, workforce development, and inclusive health system strengthening.

Context Setting Remarks



Dr. Rajan Sudesh Ratna

Coordinator, DAKSHIN-Global South Centre of Excellence

Dr. Rajan Sudesh Ratna set the analytical frame for the conference by identifying healthcare as a critical pillar of South-South cooperation in which many Global South countries share common structural challenges: inadequate healthcare infrastructure, shortages of skilled health professionals, rising burdens of communicable and non-communicable diseases, and unequal access to quality healthcare services, challenges further compounded by climate change and demographic transitions.

He emphasised that the conference aimed to identify practical, demand-driven areas of cooperation in digital and preventive healthcare as part of IAFS-IV preparations, and highlighted DAKSHIN's role in fostering research, policy dialogue, and knowledge exchange among Global South nations. Drawing on lessons from COVID-19, he underscored the importance of resilient health systems, digital technologies, and local manufacturing, pointing to ABDM and eSanjeevani as examples of how technology can improve healthcare access and governance at scale.

Concluding his remarks, Dr. Ratna emphasised that future India-Africa cooperation must be demand-driven, context-specific, and focused on implementation, identifying digital public infrastructure, telemedicine, workforce development, pharmaceutical manufacturing, traditional medicine, and health research as the most promising areas for partnership.

Remarks by the Session Chair



Ms. Geetu Joshi

Economic Adviser, Department of Health & Family Welfare, Ministry of Health & Family Welfare (MoHFW), Government of India

Ms. Geetu Joshi welcomed participants and situated the conference within the broader context of India-Africa relations, describing the partnership as one rooted in long-standing historical ties, mutual trust, and shared developmental aspirations. She noted that healthcare has increasingly emerged as one of the most important pillars of India's engagement with African countries and a critical area for future South-South cooperation.

Highlighting the institutional foundations of this partnership, Ms. Joshi referred to the Memorandum of Understanding on India-Africa Health Sciences Cooperation between the Indian Council of Medical Research (ICMR) and the African Union, which seeks to promote joint research, pharmaceutical cooperation, scientific collaboration, and capacity building. She also noted that India has concluded bilateral health cooperation agreements with several African countries, including Angola, Zambia, Burundi, Malawi, and Mozambique, demonstrating the growing breadth of health diplomacy between India and the continent.

Ms. Joshi highlighted the expansion of Ayushman Arogya Mandirs (formerly Health and Wellness Centres) as a cornerstone of India's primary healthcare strategy, with more than 185,000 Ayushman Arogya Mandirs established across the country. She framed these investments as evidence of the importance of building resilient, people-centred health systems capable of responding to both routine health needs and future crises.

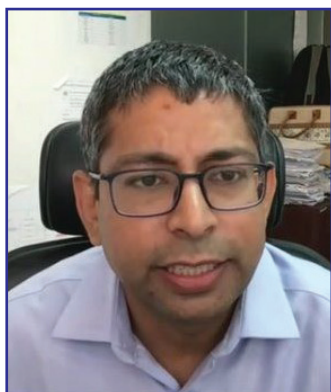
On global health solidarity, she noted that India supplied approximately 300 million vaccine doses to nearly 100 countries during the COVID-19 pandemic through the Vaccine Maitri initiative. She also highlighted India's support to Africa during the Ebola public health emergency through the provision of essential medical supplies and protective

equipment to Africa CDC, reflecting India's broader commitment to health technologies and pharmaceutical capabilities as global public goods.

Turning to pharmaceutical access, Ms. Joshi described India as the pharmacy of the world and highlighted the Pradhan Mantri Bhartiya Janaushadhi Pariyojana, under which more than 15,000 Jan Aushadhi Kendras had been established by March 2025. She also discussed the Arogya Maitri initiative and the deployment of BHISHM Cubes, portable hospital-in-a-box systems equipped with medicines, surgical supplies, and emergency response capabilities, as examples of how humanitarian assistance and health security can be strengthened through technology-enabled solutions rapidly deployable during disasters and public health emergencies.

Concluding her remarks, Ms. Joshi identified digital health systems, health research, vaccines, medical devices, pharmaceutical manufacturing, and traditional medicine as priority areas for future India-Africa cooperation. She emphasised that Africa occupies a special place in India's development partnership vision, and called for stronger collaboration to translate shared aspirations into concrete outcomes grounded in solidarity, innovation, capacity building, and mutual learning.

India's Experience in Digital and Preventive Healthcare



Mr. Vikram Pagaria

Director, National Health Authority, Government of India

Mr. Vikram Pagaria presented India's digital health transformation through the Ayushman Bharat Digital Mission (ABDM), describing it as a foundational digital architecture that enables seamless exchange of health information while ensuring privacy, security, and user control over personal health data. He explained that ABDM is built on the principles of interoperability, inclusivity, accessibility, and consent-based data sharing.

At the core of the system is the Ayushman Bharat Health Account (ABHA), which provides every individual with a unique digital health identity usable across healthcare providers and services. The platform also includes a Health Facility Registry and a Healthcare Professionals Registry, enabling patients to identify and access providers while ensuring transparency and accountability within the health system. Interoperability standards allow health records generated at different facilities and through different software platforms to be securely accessed across the continuum of care.

Mr. Pagaria highlighted that beyond improving patient care, digital platforms can support health financing, disease surveillance, public health planning, and resource allocation. He drew attention to the broader significance of digital transformation as an institutional reform process rather than merely a technology adoption exercise, requiring supportive policy frameworks, infrastructure investment, capacity building, and stakeholder engagement.



Mr. Madhukar Bhagat

Joint Secretary, eHealth, Ministry of Health and Family Welfare, Government of India

Mr. Madhukar Bhagat presented India's eSanjeevani telemedicine platform, which has emerged as one of the largest digital health initiatives globally. The platform was designed to connect patients with healthcare providers through virtual consultations, reducing barriers associated with distance, travel costs, and specialist shortages. It operates through two models: doctor-to-doctor consultations and patient-to-doctor consultations, enabling primary care providers to seek specialist advice while allowing patients to access healthcare professionals directly from community health facilities.

Mr. Bhagat noted that eSanjeevani has facilitated hundreds of millions of consultations across India. The platform gained critical significance during the COVID-19 pandemic when movement restrictions disrupted conventional

services, demonstrating the value of digital technologies in maintaining health system resilience during public health emergencies. He emphasised that telemedicine enables healthcare systems to leverage limited specialist resources more effectively by extending their reach beyond physical facilities, contributing to reduced out-of-pocket expenditures and improved access to timely consultations.

He stressed that telemedicine should be understood as a complementary mechanism that strengthens healthcare access and quality rather than a replacement for conventional services, and that its effectiveness depends on integration with digital health records, electronic prescriptions, and clinical decision-support systems.



Dr. Charulata

Principal Scientist, CSIR-National Institute of Science Communication and Policy Research (CSIR-NIScPR)

Dr. Charulata focused on the role of traditional medicine, indigenous knowledge systems, and preventive healthcare in strengthening health systems. She emphasised that India and Africa possess rich traditions of medical knowledge that have evolved over centuries and remain relevant in contemporary healthcare contexts. She highlighted India's efforts to systematically document, preserve, validate, and promote traditional knowledge through the Traditional Knowledge Digital Library (TKDL), which protects traditional formulations and practices from misappropriation while making them accessible for research and innovation.

She described the broader institutional ecosystem supporting traditional medicine in India, including the National Medicinal Plants Board, the Botanical Survey of India, and the AYUSH framework, which integrates traditional medicine into the health system through practitioner training, regulatory mechanisms, and digital platforms such as the WHO-supported mYoga application. Dr. Charulata argued that traditional medicine and

preventive healthcare should be viewed as integral components of resilient, people-centred health systems, particularly relevant in addressing the growing burden of non-communicable diseases through lifestyle approaches, nutrition, and holistic well-being.

African Perspectives on Healthcare Priorities



Dr. Franck Arnaud Ndorukwigira

Head of Digital Governance, Artificial Intelligence, and Technology, Centre For Development and Enterprises Great Lakes (CDE), Burundi

Dr. Ndorukwigira highlighted the transformative potential of digital health technologies in addressing long-standing healthcare access challenges across Africa. Despite improvements in health outcomes over recent decades, he noted that many African countries continue to face persistent constraints related to shortages of healthcare professionals, weak health information systems, inadequate infrastructure, and fragmented systems that operate in isolation and fail to support integrated care.

He expressed strong interest in ABDM's model of interoperable digital infrastructure, identifying specific areas where cooperation with India would be most valuable: national digital health databases, unique patient identification systems, digital supply chain management platforms, AI-enabled diagnostic solutions, and teleconsultation services. He also highlighted India's health technology startup ecosystem as a potential source of innovation and called for partnerships between startups, research institutions, and governments to foster domestic innovation ecosystems across Africa.



Mr. Robert Mwale

Lead Public Finance Management Researcher, Centre for Trade Policy and Development (CTPD), Zambia

Mr. Mwale focused on the growing burden of non-communicable diseases across Africa and the urgent need to shift healthcare systems from treatment-oriented to prevention-focused approaches. He identified tobacco use, alcohol consumption, unhealthy diets, and physical inactivity as major drivers of the NCD epidemic and highlighted Zambia's Tobacco Control Data Initiative as an example of how digital technologies can support data collection, surveillance, monitoring, and public accountability for health policy.

He advocated the use of health taxes on tobacco, alcohol, and sugary beverages as cost-effective strategies for reducing harmful consumption while generating resources for healthcare. Drawing on India's experience, he identified cooperation opportunities in digital health infrastructure, telemedicine, epidemiological surveillance, health policy analytics, and pharmaceutical manufacturing.



Ms. Zambwe Shingwele

Acting Research Fellow, Zambia Institute for Policy Analysis and Research (ZIPAR), Zambia

Ms. Shingwele focused on Zambia's efforts to strengthen primary healthcare and advance universal health coverage. She acknowledged significant progress while noting persistent challenges: shortages of doctors, nurses, and specialists, particularly in rural and remote areas, and gaps in connectivity, electricity, and equipment that constrain the effectiveness of digital health tools. She expressed strong interest in India's experience in telemedicine, digital public infrastructure, and healthcare workforce development, and also highlighted opportunities for cooperation in vaccine production and pharmaceutical manufacturing.

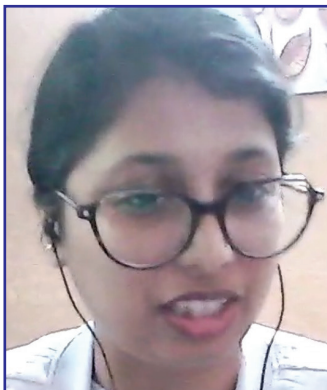


Dr. Christian Pout

Chairman, Centre for International, Diplomatic and Strategic Studies (CEIDES), Cameroon

Dr. Pout provided a comprehensive overview of the challenges facing Cameroon's healthcare system, including a complex burden of communicable and non-communicable diseases, climate-related health risks, conflict-related disruptions, inadequate health financing with high out-of-pocket expenditures, workforce shortages, infrastructure deficits, and regional inequalities. He described Cameroon's National Digital Health Strategy (2026-2030), which seeks to establish an integrated digital health ecosystem capable of strengthening service delivery, improving data quality, and supporting evidence-based policymaking.

He emphasised telemedicine as a particularly promising solution for addressing geographical barriers and specialist shortages, and linked Cameroon's priorities to cooperation opportunities with India in digital health architecture, telemedicine implementation, health workforce training, pharmaceutical production, and health financing innovations. He stressed throughout that future cooperation must focus on strengthening national capacities rather than creating external dependency.



Ms. Harshitha Nayar

Research Associate and Prof. John Huston Stanfield II, Director, Advanced Study of African Renaissance Policies Ideas (ASARPI), Mauritius

The Mauritius speakers focused on tobacco control, behavioural change, and the role of digital technologies in preventive healthcare. They highlighted the ongoing health and economic burden of tobacco-related diseases and emphasised that effective public health interventions require community engagement and culturally sensitive programme design. They explored the potential of artificial intelligence, telemedicine, and digital communication tools, including social media platforms, to expand access to health information and facilitate behaviour change at scale, and identified cooperation opportunities with India in digital

health communication, public health education, and research partnerships.



Mr. Michael Owuor

Research Fellow, the Global Centre for Policy and Strategy (GLOCEPS), Kenya

Mr. Owuor discussed Kenya's ongoing efforts to achieve universal health coverage through the Taifa Care Programme and broader health sector reforms. He highlighted the growing burden of non-communicable diseases, which account for a significant proportion of mortality, and the importance of digital health systems in improving service delivery, strengthening accountability, and supporting evidence-based decision-making. Kenya's Digital Health Act and related reforms aim to create interoperable systems capable of supporting continuity of care and efficient resource management. He identified cooperation opportunities with India in digital health architecture, telemedicine, interoperability frameworks, health information exchange, workforce development, and primary healthcare strengthening. Mr. Owuor also noted the relevance of India's traditional medicine systems and wellness approaches in addressing the growing burden of non-communicable diseases, identifying this as a potential area for future collaboration.



Dr. Nouzha Chekrouni

Senior Fellow, Policy Centre for The New South (PCNS), Morocco

Dr. Chekrouni situated Morocco's health reforms within the broader context of social protection and human development, arguing that health inequities cannot be addressed solely through healthcare infrastructure investment but require integrated approaches that address social determinants of health. She described Morocco's transition from fragmented insurance and assistance programmes toward a more integrated system of universal coverage, drawing lessons on the importance of strong governance structures, digital systems, and coordinated implementation mechanisms.

A central theme of her intervention was the role of digital public infrastructure in supporting both health and social protection objectives. She explained how digital identity systems, beneficiary registries, and electronic payment mechanisms enabled Morocco to deliver social assistance rapidly and efficiently during the COVID-19 pandemic, improving targeting, reducing administrative inefficiencies, and enhancing transparency. Drawing parallels with India's ABDM experience, she observed that digital ecosystems provide a foundation not only for healthcare delivery but for broader social development.

Dr. Chekrouni also drew on community health system experiences from Rwanda, Ethiopia, and Senegal, emphasising that community health workers are critical for extending services to remote and underserved populations. She proposed the establishment of an Africa-India Centre of Excellence for Community Health Systems to facilitate research, policy dialogue, training, implementation support, and knowledge exchange focused on community health workforce development, digital public infrastructure, and primary healthcare strengthening.



Mr. Mohamed Ali

Researcher, Somali Institute for Development Research & Analysis (SIDRA), Somalia

Mr. Mohamed Ali presented Somalia's experience strengthening healthcare in one of the most challenging operating environments in the world. He described how decades of conflict, institutional fragility, limited infrastructure, and dependence on external assistance have constrained healthcare delivery, and how Somalia has responded by investing in digital health information systems as a foundation for institutional resilience and governance.

A key achievement was the implementation of an electronic health record platform integrated with DHIS2, which has significantly improved data completeness, reporting timeliness, and information accessibility, with over 1,100 healthcare workers trained in using the system. Mr. Ali emphasised that digital transformation in fragile settings represents an investment in accountability and planning

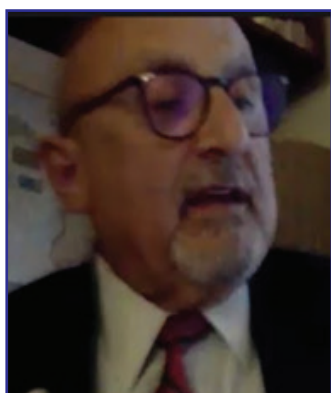
capacity, not simply a technology upgrade. He expressed specific interest in India's experience with interoperable digital health platforms, unique health identities, telemedicine services, and digital public infrastructure, identifying technical assistance in digital health architecture, health informatics capacity building, data governance frameworks, and telemedicine implementation as priority cooperation areas.



Mr. Philemon Okillong

Research Analyst, Economic Policy Research Centre (EPRC), Uganda

Mr. Okillong highlighted the growing challenges facing Uganda's health sector, including declining donor support, limited insurance coverage, workforce shortages, and persistent burdens of malaria, tuberculosis, hypertension, and maternal health challenges. He emphasised pharmaceutical manufacturing and health security as strategic priorities, arguing that reducing dependence on imported medicines and strengthening local production capacity is essential for long-term resilience, a lesson reinforced by global supply chain disruptions during COVID-19. He also discussed opportunities for digital health transformation in improving healthcare access and disease surveillance, and expressed interest in India's experience across digital health, telemedicine, pharmaceutical production, and workforce development.



Dr. Sadek Aly Abdelaal

Member of the of Foreign Affairs (Egyptian Council ECFA), Egypt

Dr. Sadek drew attention to child health as an area that frequently receives insufficient attention within broader healthcare reform discussions. He highlighted challenges related to maternal and child health, emergency preparedness, nutritional deficiencies, and access to specialised paediatric services, arguing that investments in child health generate long-term benefits for human development, educational outcomes, and economic productivity. He advocated stronger India-Africa collaboration in paediatric research, child health surveillance, workforce development, digital

monitoring systems, traditional medicine, and preventive healthcare, and emphasised that health system reforms must explicitly translate into improved outcomes for children and families.

Demand Mapping: African Country Priorities at a Glance

The following tables summarise the key priorities and cooperation requests emerging from African country presentations.

Table 1: African Country Priorities and Areas for Cooperation with India

Country	Key Challenges	Cooperation Priorities	Relevant Indian Experience
Burundi	Fragmented digital systems, limited health identity infrastructure	Digital public infrastructure, health IDs, EHRs, teleconsultation, AI-enabled diagnostics, digital supply-chain management	ABDM, eSanjeevani, CoWIN/ eVIN, health-tech start-up ecosystem
Zambia	NCDs, workforce shortages, tobacco burden	Telemedicine, health policy analytics, tobacco surveillance, pharmaceutical manufacturing	eSanjeevani, ABDM, digital disease surveillance systems
Cameroon	Health system fragmentation, climate and conflict pressures, workforce shortages	Digital health architecture, telemedicine, workforce training, pharmaceutical production, health financing innovations	ABDM, eSanjeevani

Mauritius	Tobacco-related disease burden, behavioural risk factors	Digital public health tools, behaviour change interventions, preventive health technologies	Digital health communication platforms, telemedicine, AI-enabled public health tools
Morocco	Social protection-health integration	DPI, community health systems, beneficiary registries	ABDM digital identity architecture, Ayushman Arogya Mandirs
Kenya	UHC implementation, rising NCD burden, health system accountability and service delivery challenges	Interoperability frameworks, digital health architecture, telemedicine, workforce development, primary healthcare strengthening	ABDM, eSanjeevani, Ayushman Arogya Mandirs
Somalia	Fragile health systems, data gaps	EHRs, DHIS2 integration, Telemedicine, health informatics capacity	ABDM, digital reporting systems, eSanjeevani
Uganda	Financing gaps, workforce shortages, pharma dependency	Local manufacturing, Telemedicine, workforce training	ABDM, eSanjeevani
Egypt	Child health, limited paediatric surveillance	Preventive child health systems, Traditional medicine research	AYUSH, TKDL

Source: Author compilation.

Table 2: Demand Mapping from African Delegates

Theme	Countries Raising the Issue	Key Requests
Digital Public Infrastructure	Burundi, Kenya, Somalia, Cameroon, Morocco, Uganda	Health IDs, EHRs, interoperability, facility and professional registries
Telemedicine	Burundi, Zambia, Kenya, Uganda, Cameroon, Somalia	Remote consultations, specialist access, primary care integration
Human Resources for Health	Burundi, Zambia, Uganda, Cameroon, Morocco, Kenya	Workforce development, digital health skills, community health worker training
Preventive Healthcare	Zambia, Mauritius, Egypt	NCD prevention, tobacco control, child health surveillance
Traditional Medicine	Egypt, Kenya	Documentation, scientific validation, medicinal plant research
Pharmaceutical Manufacturing	Uganda, Zambia, Cameroon	Technology transfer, local production, regulatory capacity building
Health Financing and UHC	Morocco, Kenya, Uganda	Insurance, social protection, UHC implementation

Source: Author compilation.

Emerging Priorities for India-Africa Health Cooperation

Digital Public Infrastructure for Health: The Strongest and Broadest Demand Signal

Of all the cooperation themes discussed at the conference, demand for India's digital public infrastructure (DPI) model in health was the most broadly distributed and most

specifically articulated. Across nine country presentations, fragmented health information systems, the absence of interoperable data exchange, and weak or non-existent digital health identities were the most consistently identified structural constraints. ABDM was cited, directly and repeatedly, as the reference architecture most relevant to addressing these gaps.

The demand is not uniform in character, and that distinction matters for how cooperation is structured. Countries such as Kenya and Morocco are engaging with ABDM at the level of architectural adaptation, seeking to contextualise its foundational components, including unique health identities, health facility and healthcare professional registries, and consent-based interoperability frameworks, within their own national digital governance structures. Kenya's Digital Health Act and Morocco's integration of digital identity systems into social protection delivery both reflect national reform trajectories already aligned with ABDM's logic. For these countries, the cooperation ask is peer-level: access to design principles, technical standards, and implementation learning rather than direct replication.

Somalia and Cameroon represent a different cooperation register. Somalia's implementation of electronic health records integrated with DHIS2, supported by training for over 1,100 healthcare workers, demonstrates both the appetite for digital transformation and the scale of institutional support required to achieve it in fragile settings. Cameroon's National Digital Health Strategy (2026-2030) signals a country at the beginning of a system-wide digital transition. For both, the demand is for more direct technical assistance in digital architecture design, data governance frameworks, interoperability standards, and implementation capacity.

Burundi presented the most acute digital health gap, with fragmented systems, limited digital identity infrastructure, and a near-total absence of interoperability. Their interest in ABDM's health ID model and AI-enabled diagnostic solutions reflects a foundational need. Uganda's interest in ABDM was similarly framed around foundational infrastructure, linked to its broader concern with pharmaceutical supply chain digitisation and healthcare access in underserved areas.

Morocco's intervention expanded the analytical frame significantly. By illustrating how digital identity systems, beneficiary registries, and digital payment platforms enabled rapid, targeted social protection delivery during the COVID-19 pandemic, Morocco demonstrated that India's DPI architecture has relevance beyond healthcare alone. The convergence between health system digitisation and broader social protection infrastructure is a dimension that IAFS-IV cooperation frameworks should explicitly recognise.

One significant finding from the conference is what was not raised: African country representatives did not substantively discuss health data sovereignty, cybersecurity, or AI governance as demand areas, despite their increasing prominence in global digital health discourse. Whether this reflects implementation-stage prioritisation, lower awareness, or a view that these are downstream concerns, it is a finding that cooperation frameworks should note.

Telemedicine: The Most Immediately Deployable Cooperation Area

Telemedicine emerged as the second strongest and most operationally urgent demand signal. Where DPI demand is primarily about foundational architecture, telemedicine demand is about service delivery: getting specialist consultations to populations that are currently cut off from them by geography, workforce maldistribution, and the cost of travel. These are distinct cooperation asks, and eSanjeevani addresses the second directly.

Burundi, Zambia, Uganda, Cameroon, Kenya, and Somalia identified remote consultation services as a priority area. The specific features of eSanjeevani that attracted interest were its dual-track architecture supporting both doctor-to-doctor and patient-to-doctor consultations, and its demonstrated ability to extend specialist reach to primary healthcare facilities without requiring significant expansion of physical infrastructure. Participants from these countries were not expressing aspirational interest; they were mapping a known and specific constraint onto a model that addresses it at scale.

Somalia's presentation added an important dimension: the relevance of telemedicine in fragile and conflict-affected settings. Where conventional healthcare delivery mechanisms are disrupted by insecurity or institutional breakdown, digital platforms can maintain continuity of care in ways that physical infrastructure cannot. This is a qualitatively different use case from the workforce-distribution challenge raised by Zambia and Uganda, and telemedicine cooperation frameworks should be designed with enough flexibility to address both.

Participants across several presentations noted that telemedicine implementation does not stand alone. It requires complementary investments in connectivity, electricity, device access, regulatory frameworks, and integration with broader health information systems. This points to an important interdependence: DPI and telemedicine are not parallel tracks but complementary layers. Telemedicine functions more effectively within an interoperable digital health ecosystem of the kind ABDM is designed to provide. For IAFS-IV, cooperation in these two areas should be architected together rather than pursued as separate workstreams.

Human Resources for Health: The Cross-Cutting Enabler

Workforce gaps were raised by more country delegations than any other single challenge. Zambia, Uganda, Cameroon, Morocco, Burundi and Kenya all identified shortages of doctors, nurses, specialists, and health informatics professionals as a primary constraint on health system performance. This finding has a direct implication for DPI cooperation: digital health systems can only function as intended if the workforce responsible for implementing and using them has the requisite skills. Human resource development is therefore not a standalone cooperation area but the cross-cutting enabler on which all other digital health investments depend.

Two distinct workforce dimensions emerged from country presentations. The first is clinical and systems-level capacity: the ability of healthcare workers to use electronic health records, telemedicine platforms, digital reporting systems, and clinical decision support tools effectively. The second is health informatics and governance capacity: the ability of institutions to design, manage, and sustain digital health infrastructure, including data governance, interoperability standards, and system administration. Both are currently inadequate across most of the countries represented at the conference.

Morocco's proposal for enhanced cooperation on community health systems offered a third dimension. The proposal for an Africa-India Centre of Excellence on Community Health Systems provides a potential institutional mechanism through which such cooperation could be operationalised. By combining India's experience with ASHAs and African experiences with community health worker programmes, the Centre could support training, implementation research, digital tool adoption, and policy exchange across countries. Community health workers serve as the interface between formal health systems and underserved populations, and their role in health promotion, disease prevention, and continuity of care becomes especially critical where digital tools are being introduced into settings with low baseline health system contact. Training community health workers to use digital tools, including mobile health applications and digital reporting systems, is a practical entry point for DPI adoption at the last mile.

India's depth of experience in medical education, public health training, large-scale frontline workforce programmes, and digital health capacity building was widely acknowledged as a substantive resource. Cooperation frameworks should treat workforce development not as a background condition but as a core deliverable of IAFS-IV health partnerships, integrated into both the DPI architecture and telemedicine cooperation tracks from the outset.

Preventive Healthcare and Non-Communicable Disease Control: Digital Tools as Delivery Mechanisms

The growing burden of non-communicable diseases was a recurring theme across African country presentations, and its relevance to the DPI agenda is direct: many of the digital tools best suited to NCD prevention, including disease surveillance platforms, digital risk communication systems, and behaviour change intervention tools, are applications that sit within or depend upon the foundational DPI infrastructure that African countries are seeking to build. The demand for preventive healthcare cooperation and the demand for digital public infrastructure are therefore connected, not parallel.

Zambia's Tobacco Control Data Initiative was the clearest illustration of this connection: digital platforms supporting data collection, surveillance, monitoring, and public accountability for tobacco control policy, functioning most effectively when integrated into a broader interoperable health information ecosystem. The Mauritius intervention reinforced the importance of digital health communication as a preventive healthcare instrument, pointing to AI-enabled tools and social media platforms for risk communication and behaviour change, areas where India's experience in large-scale digital health campaigns is directly applicable.

Egypt's emphasis on child health broadened the preventive healthcare discussion. Maternal and child health, including nutritional monitoring, vaccination tracking, antenatal care follow-up, and early childhood development surveillance, are areas where mobile health applications and electronic health records integrated with community health worker platforms can generate significant impact. Egypt's intervention is a reminder that universal health coverage discussions must explicitly include vulnerable populations.

Across these presentations, preventive healthcare cooperation with India is not primarily about deploying a single platform or programme. It is about building the digital

infrastructure through which preventive interventions, data systems, and risk communication tools can operate at scale, reinforcing the case for treating ABDM-linked DPI architecture as the foundational investment from which downstream preventive healthcare cooperation follows.

Pharmaceutical Manufacturing and Health Security: An Adjacent but Distinct Cooperation Track

Pharmaceutical manufacturing was identified as a strategic priority by Uganda, Zambia, and Cameroon, making it the third most commonly raised cooperation area after DPI architecture and telemedicine. The demand is qualitatively different in character from the DPI and telemedicine asks: where ABDM and eSanjeevani address health system infrastructure and service delivery, pharmaceutical manufacturing cooperation addresses supply chain sovereignty and industrial policy. These are distinct cooperation tracks requiring distinct partnership instruments.

The COVID-19 pandemic provided the immediate backdrop for this demand. Global supply chain disruptions exposed the vulnerability of countries dependent on imported medicines, vaccines, diagnostics, and medical consumables. For Uganda, Zambia, and Cameroon, the lesson was that health security cannot be achieved through procurement alone; it requires domestic or regional production capacity. India's position as a leading global producer of pharmaceuticals and vaccines was acknowledged as both a resource and a potential partnership anchor.

Several interventions reflected a broader African interest in reducing dependence on imported medical products and strengthening regional manufacturing capabilities, creating opportunities for partnership with India's pharmaceutical and vaccine sectors.

Participants were explicit that the cooperation model they are seeking is not aid-based. The language across these interventions was consistently about technology transfer,

regulatory capacity building, quality assurance, and the development of domestic industrial capability, reflecting a broader shift in South-South cooperation discourse from project-based assistance toward institutional and industrial partnerships that build lasting self-reliance.

The regional dimension of this demand is also significant. Several participants suggested that collaborative manufacturing models involving multiple African governments, regional bodies, research institutions, and private sector actors could create economies of scale that individual country-level initiatives cannot achieve. IAFS-IV should consider whether pharmaceutical manufacturing cooperation is best structured bilaterally, regionally, or in combination with multilateral frameworks such as the Africa CDC's Partnerships for African Vaccine Manufacturing (PAVM).

Traditional Knowledge and Integrative Health: Bounded but Genuine Demand

Traditional medicine and indigenous knowledge systems attracted interest at the conference, but the demand signal was narrower and more specifically defined than in other thematic areas. Egypt and Kenya were the primary voices for cooperation in this space, and their asks were focused: documentation and scientific validation of traditional practices, medicinal plant research, and policy development for integrating traditional medicine within national health systems. This is a qualitatively different kind of cooperation ask from the DPI architecture and telemedicine demands. India's AYUSH framework and the TKDL attracted genuine interest as institutional models for how traditional knowledge can be systematically documented, protected from misappropriation, and made available for research and policy engagement. Dr. Charulata's presentation highlighted the potential for integration between traditional medicine and preventive healthcare strategies, noting that many traditional systems emphasise holistic well-being, nutrition, lifestyle modification, and community engagement, areas directly relevant to NCD prevention. This framing offers a

bridge between the traditional medicine cooperation track and the preventive healthcare agenda.

The realistic scope for cooperation in this area, based on the evidence from country presentations, is research partnerships, documentation initiatives, and policy dialogue rather than large-scale programme deployment. IAFS-IV should reflect this calibration: a dedicated but appropriately sized workstream on traditional knowledge cooperation, anchored in joint research and evidence generation, would serve the genuine demand that exists without overstating it.

Health Financing, Social Protection and Universal Health Coverage

Although digital public infrastructure and telemedicine dominated the conference discussions, several interventions highlighted the importance of health financing and social protection as foundational determinants of healthcare access and system resilience. Morocco, Kenya, and Uganda each raised concerns related to financial protection, insurance coverage, sustainability, and the ability of health systems to maintain services in the face of fiscal and external financing constraints.

Morocco provided the most developed articulation of this agenda. Dr. Nouzha Chekrouni described the country's transition from fragmented assistance programmes toward a more integrated model of universal social protection, emphasising the role of digital identity systems, beneficiary registries, and payment platforms in enabling efficient targeting and delivery of health and social benefits. Her intervention demonstrated that digital public infrastructure can serve not only healthcare delivery objectives but also broader social protection goals by improving transparency, reducing exclusion, and strengthening administrative efficiency.

Kenya's ongoing implementation of the Taifa Care Programme similarly highlighted the importance of sustainable financing arrangements for achieving universal health coverage. While digital technologies can improve

service delivery and accountability, their effectiveness ultimately depends on systems that reduce financial barriers to care and protect households from catastrophic health expenditure. Kenya's experience suggests that digital health reforms and financing reforms must advance together rather than as separate policy agendas.

Uganda raised concerns regarding declining donor support, limited insurance coverage, and long-term sustainability. These challenges underscore a broader transition confronting many African health systems as they seek to reduce dependence on external financing while expanding access to essential services. In this context, India's experience with large-scale publicly financed health protection schemes, digital beneficiary management systems, and integrated service delivery platforms offers potentially valuable lessons.

A key insight emerging from the conference is that health financing and digital transformation is increasingly interconnected. Digital public infrastructure can strengthen enrolment systems, beneficiary identification, provider empanelment, claims management, and programme monitoring, thereby improving both efficiency and accountability. Future India-Africa cooperation should therefore view health financing, social protection, and digital health not as separate domains but as mutually reinforcing pillars of universal health coverage.

Table 3: Cooperation Priority Levels Based on Conference Evidence

Priority Level	Cooperation Area	Countries Raising the Issue
High	Digital Public Infrastructure	Burundi, Kenya, Somalia, Cameroon, Morocco, Uganda
High	Telemedicine	Zambia, Kenya, Uganda, Cameroon, Somalia, Burundi
High	Workforce Development	Zambia, Uganda, Cameroon, Morocco, Kenya, Burundi

Medium	Pharmaceutical Manufacturing	Uganda, Zambia, Cameroon
Medium	Preventive Healthcare and NCD Control	Zambia, Mauritius, Egypt
Medium	Health Financing and Social Protection	Morocco, Kenya, Uganda
Emerging	Traditional Medicine and AYUSH	Egypt, Kenya

Source: Author compilation.¹

Conclusion and Way Forward

The consultation demonstrated that health cooperation is no longer a stand-alone development sector but an integral component of economic resilience, human capital development, digital transformation, and South-South cooperation. The discussions highlighted growing convergence between African priorities and India's experience across digital health, pharmaceutical manufacturing, community health systems, and preventive healthcare. As preparations advance for the Fourth India-Africa Forum Summit (IAFS-IV), health should be positioned as a strategic pillar of the India-Africa partnership, alongside trade, technology, education, and capacity building. The conference findings provide a practical foundation for translating this shared vision into concrete areas of cooperation.

What the Evidence Shows

Demand for ABDM's foundational architecture was the strongest and most broadly distributed signal across country presentations. The core elements attracting interest were unique digital health identities, interoperable health information exchange, health facility and healthcare professional registries, and consent-based data governance

frameworks. Countries at varying stages of digital health development, from Somalia's early-stage DHIS2 integration to Kenya's Digital Health Act implementation, identified these components as relevant to their national reform agendas.

Demand for eSanjeevani's telemedicine model was the second most prominent signal, with six countries explicitly identifying remote consultation services as a high-priority cooperation area. The platform's dual-track architecture was recognised as particularly relevant for health systems where specialist services are concentrated in urban centres and rural populations face significant access barriers.

Demand for AYUSH and TKDL cooperation was present but narrower, confined primarily to research collaboration, documentation of indigenous knowledge, and scientific validation of traditional practices, a qualitatively different kind of cooperation ask that does not centre on DPI deployment and should be tracked and resourced accordingly.

Differentiated Cooperation Modalities

A credible way forward requires distinguishing between two cooperation registers that emerged from country presentations. The first is peer-level adaptation, where countries such as Morocco and Kenya are seeking to learn from and contextualise India's DPI architecture within their own national frameworks and governance structures. The second is technical assistance and capacity building, where countries such as Somalia and Uganda require more direct support in implementation, workforce training, and institutional development. IAFS-IV cooperation instruments should be structured to accommodate both modalities rather than applying a single partnership model across all country contexts.

Priorities for IAFS-IV

Based on the breadth and specificity of demand documented across country presentations, the following areas merit prioritisation in the IAFS-IV health cooperation agenda.

First, ABDM-linked digital health architecture cooperation, including support for health ID systems, interoperability frameworks, and health registries, represents the area of highest and most broadly distributed African demand and should anchor the digital health pillar of IAFS-IV.

Second, eSanjeevani-modelled telemedicine partnerships, structured to address both specialist access gaps and primary healthcare strengthening, represent the most immediately deployable cooperation area and should be operationalised with country-specific adaptation rather than uniform rollout.

Third, human resource development for digital health, encompassing training in health informatics, digital system implementation, and data governance, was identified as a cross-cutting enabler by multiple country representatives and should be integrated into cooperation frameworks across both of the above areas rather than treated as a standalone workstream.

Fourth, pharmaceutical manufacturing cooperation, raised by Uganda, Zambia, and Cameroon, represents a significant demand area that sits adjacent to the DPI agenda and warrants a dedicated cooperation track under IAFS-IV, given its implications for health security and supply chain resilience.

An additional proposal emerging from the conference was the establishment of an Africa-India Centre of Excellence on Community Health Systems to support training, implementation research, digital health adoption, and knowledge exchange.

Cooperation should also seek alignment with continental institutions, particularly Africa Centres for Disease Control and Prevention, whose growing role in digital health, disease surveillance, health security, workforce development, and pharmaceutical manufacturing provides opportunities for scaling successful India-Africa partnerships beyond bilateral arrangements. Engagement with Africa CDC and

related continental initiatives could enhance coordination, sustainability, and regional impact.

DAKSHIN and RIS, as platforms for South-South knowledge exchange and policy dialogue, are well positioned to take these priorities forward through focused capacity-building workshops and conferences that bring together, on a shared platform, the Indian institutions with the experience and the African agencies with the need, translating the commitments of this conference into concrete IAFS-IV outcomes.

Endnote

- ¹ The prioritization reflects the frequency, specificity, and operational readiness of cooperation requests articulated during the conference discussions. Themes that were raised by multiple countries and linked to identifiable Indian programmes or platforms were categorized as High Priority.



RIS

Research and Information System
for Developing Countries

विकासशील देशों की अनुसंधान एवं सूचना प्रणाली

RIS specialises in issues related to international economic development, trade, investment and technology. It is envisioned as a forum for fostering effective policy dialogue and capacity-building among developing countries on global and regional economic issues. The focus of the work programme of RIS is to promote South-South Cooperation and collaborate with developing countries in multilateral negotiations in various forums. Through its following centres/forums, RIS promotes policy dialogue and coherence on regional and international economic issues.



The word “DAKSHIN” (दक्षिण) is of Sanskrit origin, meaning “South.” The Hon’ble Prime Minister of India, Shri Narendra Modi, inaugurated DAKSHIN – Global South Centre of Excellence in November 2023. The initiative was inspired by the deliberations of Global South leaders during the Voice of the Global South Summits. DAKSHIN stands for Development and Knowledge Sharing Initiative. Hosted at the RIS, DAKSHIN has established linkages with leading think tanks and universities across the Global South and is building a dynamic network of scholars working on Global South issues.



AIC at RIS has been working to strengthen India’s strategic partnership with ASEAN in its realisation of the ASEAN Community. AIC at RIS undertakes research, policy advocacy and regular networking activities with relevant organisations and think-tanks in India and ASEAN countries, with the aim of providing policy inputs, up-to-date information, data resources and sustained interaction, for strengthening ASEAN-India partnership.



CMEC has been established at RIS under the aegis of the Ministry of Ports, Shipping and Waterways (MoPS&W), Government of India. CMEC is a collaboration between RIS and Indian Ports Association (IPA). It has been mandated to act as an advisory/technological arm of MoPSW to provide the analytical support on policies and their implementation.



FITM is a joint initiative by the Ministry of Ayush and RIS. It has been established with the objective of undertaking policy research on economy, intellectual property rights (IPRs) trade, sustainability and international cooperation in traditional medicines. FITM provides analytical support to the Ministry of Ayush on policy and strategy responses on emerging national and global developments.



BEF aims to serve as a dedicated platform for fostering dialogue on promoting the concept in the Indian Ocean and other regions. The forum focuses on conducting studies on the potential, prospects and challenges of blue economy; providing regular inputs to practitioners in the government and the private sectors; and promoting advocacy for its smooth adoption in national economic policies.



FIDC, has been engaged in exploring nuances of India’s development cooperation programme, keeping in view the wider perspective of South-South Cooperation in the backdrop of international development cooperation scenario. It is a tripartite initiative of the Development Partnership Administration (DPA) of the Ministry of External Affairs, Government of India, academia and civil society organisations.



FISD aims to harness the full potential and synergy between science and technology, diplomacy, foreign policy and development cooperation in order to meet India’s development and security needs. It is also engaged in strengthening India’s engagement with the international system and on key global issues involving science and technology.



As part of its work programme, RIS has been deeply involved in strengthening economic integration in the South Asia region. In this context, the role of the South Asia Centre for Policy Studies (SACEPS) is very important. SACEPS is a network organisation engaged in addressing regional issues of common concerns in South Asia.



Knowledge generated endogenously among the Southern partners can help in consolidation of stronger common issues at different global policy fora. The purpose of NeST is to provide a global platform for Southern Think-Tanks for collaboratively generating, systematising, consolidating and sharing knowledge on South South Cooperation approaches for international development.

— Policy research to shape the international development agenda —

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