THE NEW PARTNERSHIP FOR AFRICA'S DEVELOPMENT (NEPAD)

HEALTH STRATEGY

Contents

SECTION 1: SECTORAL STRATEGIES IN NEPAD

The New Partnership for Africa's Development (NEPAD) is a pledge by African leaders, based on a common vision and a firm and shared conviction, that they have a pressing duty to eradicate poverty and to place their countries, both individually and collectively, on a path of sustainable growth and development. Its African determined programme is underpinned by action-oriented commitments to peace and democracy and good political, economic and corporate governance as the preconditions for sustainable development. Sectoral priorities for development include bridging the infrastructure gap (energy, transport and water and sanitation) and tackling health, education, agriculture, environment and gender challenges. Capital flows and market access initiatives are part of the strategy for mobilising the resources required for development, while a new global partnership is envisaged with development partners.

Responsibility for preparation of sectoral strategies in line with these priorities lies with the NEPAD secretariat. These are presented to the 20 member NEPAD Heads of State Interim Committee, who in adopting NEPAD policies, commit their countries to the strategies. As evidence of the depth of their commitment they open themselves to peer review of their performance. As an organ mandated by the Organisation of African Unity and now by the African Union (AU), the strategies are subsequently taken to the AU for adoption and also become the basis of negotiations with development partners. Development partners include United Nations agencies and other international organisations, developed countries, the private sector and civil society.

NEPAD, through the actions of Heads of State and Government and managed by its Secretariat, facilitates, enables, focuses, leverages and co-ordinates efforts to achieve its strategies, but is not itself an implementation agency. Core responsibility for implementation rests with individual countries, while the African Union, African Development Bank and Regional Economic Communities[1] (RECs) have been identified as key vehicles for regional action and co-ordination.

Among the features that make NEPAD unique as a development strategy is that it is African owned and driven and that Heads of State personally consider and collectively commit to it strategies and priorities and to striving for the achievement of stipulated targets.

Health has been adopted as a priority area for action by the NEPAD Heads of State. This strategy serves to build on and update previous considerations by the Heads of State after input from, amongst others, African Health Ministers at the World Health Organisation (WHO) Regional Committee for Africa, the Southern African Development Community, the West African Health Organisation and an African Expert Consultative meeting. The latter provided a forum for detailed peer review by identified African experts, Regional Economic Communities, United

Nations Agencies and some civil society organizations. This strategy has been adopted at the First Conference of Health Ministers of the African Union and at the AU Summit in Maputo.

In recognition of the close interrelatedness between human and health development efforts, the NEPAD health strategy is incorporated within a broad framework for human resource development in the region. Indeed, the strategy recognises the multi-sectoral nature of the measures needed to reduce disease burden. It therefore aligns with and recognises the contribution to health of the overall programme of NEPAD, including its strategies for economic growth, infrastructure improvements (including water), sustainable human development (including education and gender), agriculture and the environment. Success in and integration with efforts in these areas will support the attainment of health goals. This strategy looks more deeply into the health sector contribution.

This health strategy follows the openness of NEPAD in looking into the root causes of Africa's ills and Africa's potential as the basis for lessons for the way forward. NEPAD proposes primary strategic directions for addressing the health problems and their underlying determinants. It is a comprehensive strategy that takes into account existing initiatives and previously adopted decisions and resolutions by African Heads of State and Government and Ministers of Health, such as at the United Nations General Assemblies on AIDS[2] and Children[3] and in various regional fora, such as the annual OAU/AU, WHO Regional Committees for Africa and the Eastern Mediteranean and at the African Heads of State Summits on AIDS, TB and other Infections and on Malaria.

The Strategy recognises the centrality of health to development, seeking to deepen ownership and responsibility by Africa for the measures required to enhance health and the commitment to these by development partners. Poverty cannot be eradicated, or indeed even substantially alleviated, as long as the high burden of disease, disability and death continues to plague the continent. Rather than setting goals and then presenting a strategy that cannot achieve them, because what is really required seems too much, this strategy attempts to reflect the breadth and scale of what is required. Continuing with "business as usual, or a little more" will not impact seriously on disease burden, nor provide the improvements in health necessary for economic development.

SECTION 2: AFRICA FACES A HUGE BURDEN OF PREVENTABLE DISEASE, DISABILITY AND DEATH

Health is one of the most serious casualties consequent on the poverty, social exclusion, marginalisation and lack of sustainable development in Africa. The numbers of premature deaths (mortality) illustrate this starkly, but there are also high levels of suffering (morbidity) and disability. Africa's 800 million people face a huge burden of preventable and treatable health problems, which not only cause unnecessary death and suffering, but also undermine economic development and damage the continent's social fabric. The burden is in spite of the availability of suitable tools and technology for prevention and treatment and is largely rooted in poverty and in weak health systems. Indeed, although similar to China, India and the Eastern Mediterranean in the 1960s, the health status of the people of sub-Saharan Africa is now worse than any other region in the world. The improvement in health status realized in the 1960s and 1970s has not been maintained, and in some areas there are clear signs of reversal of health gains. Yet, where the necessary conditions have been created, there have been important successes, such as reductions in river blindness and polio.

2.1 Communicable and non-communicable diseases

The HIV/AIDS epidemic poses an unprecedented challenge for Africa, reversing the gains made in life expectancy over the past half century. Life expectancy in the most severely affected countries has been reduced by almost a third, from 60 years to 43 years. 2.4 million people died from AIDS in 2002 and around 3.5 million new infections occurred. HIV prevalence in adults ranges from 1 per cent in some countries in North Africa to above 30 per cent in the high prevalence countries in Southern Africa, where it is estimated that economic growth has been slowed by 2.6%. The growing number of AIDS orphans starkly illustrates the social impact of HIV.

In spite of these statistics, other important health problems should not be overlooked. Examples are the 1 million deaths caused by malaria each year and the 600 000 deaths (on average 30-40 years prematurely) caused by tuberculosis. Malaria has slowed economic growth by 1.3% per annum at a $12 billion economic cost. 34 countries have a tuberculosis burden exceeding the 300 per 100 000 population benchmark for severe disease, with 1.6 million new active cases occurring annually. Sleeping sickness is resurging, affecting between 300 000 and 500 000 people annually.

Communicable diseases of childhood exact a heavy toll: 161 out of every thousand children born in Africa do not reach their fifth birthday. AIDS deaths are adding to the 800 000 children in sub-Saharan Africa who die of diarrhoea before their fifth birthday, the 500 000 from measles, the 600 000 from malaria and the 1.2 million

from pneumonia. Vaccine preventable diseases remain a significant problem. Malnutrition is linked to more than 50 % of all childhood deaths. At the core of this is poverty and an inadequate protein, calorie, vitamin (e.g. vitamin A) and mineral (e.g. iron and iodine) intake. Coverage by programmes to supplement Vitamin A is patchy and in some countries less than 10% of the population are using iodised salt.

Women and adolescents face unique health challenges. Amongst these are the frightening figures that 65% of HIV cases now occur in women and 65% of all new HIV infections are in the 19 to 24 year age group. The scourge of gender based violence and abuse, often worsened in conflict situations is also of great concern.

Non-communicable diseases are a growing cause of both death and disability. Injuries from violence and wars and other mostly preventable causes of physical disability affect millions of Africans. Mental ill-health has also been underestimated and care poorly provided. Only 20% of the estimated 10 million epilepsy sufferers on the continent receive treatment. Although the prevalence rates in Africa are not yet at levels reached elsewhere, the emerging diseases of lifestyle, including diabetes and hypertension and the consequences of tobacco and alcohol consumption, contribute substantially to the health burden.

2.2 Conditions related to pregnancy and childbirth

Although Africa constitutes only 12 per cent of the world's population and 17 per cent of its births, it accounts for nearly half of the more than 500 000 women who die annually from pregnancy and conditions related to childbirth. Africa has the highest maternal mortality rate in the world, estimated at about 1 000 deaths per 100 000 live births. About 1 in 20 African women die of conditions related to pregnancy and childbirth, compared to 1 in 4 000 in Europe. Many pregnant women are malnourished, increasing the risk to them and to their babies. Childbearing by adolescents poses particular risks, yet 50 per cent of African women have their first pregnancy by the age of 19 years.

Maternal morbidity and mortality are closely linked with the survival of the newborn. At least 40% of all deaths occurring in the first year of life (infant mortality) occur in the first 28 days (neonatal mortality).

If no changes are made to avert maternal deaths the consequence will be 2.5 million maternal deaths, 49 million maternal disabilities and 7.5 million newborn deaths between 2001 and 2010 and a loss in productivity of US$ 45 billion.

SECTION 3: THE REASONS BEHIND THE HUGE BURDEN OF DISEASE

A number of goals and targets have been set for reduction of the disease burden in Africa. Examples are the health-related Millennium Development Goals[4], the Abuja Declarations[5,6] and targets set in Health-for-All Policy in the 21st Century in the African Region: Agenda 2020.[7] Although the balance of reasons vary from country to country, Africa is not on track to achieve these goals and targets, not because they are unattainable, but because:

· Health systems and services are too weak to support targeted reduction in disease burden

· Disease control programmes do not match the scale of the problem

· Safety in pregnancy and childbirth has not been achieved

· People are not sufficiently empowered to improve their health

· Insufficient resources

· Of the widespread poverty, marginalisation and displacement on the continent

· The benefits of health services do not equitably reach those with the greatest disease burden.

3.1 Health systems and services are too weak to support targeted reduction in disease burden

In order to achieve reduction in disease burden functional and effective health systems that provide prompt and appropriate responses to the health needs of the population are required.

Almost all countries in Africa have developed long- or medium-term health policies, strategies and plans. However, the challenge is in prioritising and delivering. Not all have prepared comprehensive policy frameworks or implementation plans, nor costed them, nor designed budgets that reflect the articulated priorities or their sources of funding. The mismatch between policy intention and budgets may give a false sense of ability to deliver services, which in reality cannot be achieved with the budgeted funds, compromising credibility. Although some countries have developed essential health packages, these have not always been costed, nor delivered. In sub-Saharan Africa, it is estimated that only about 53 per cent of the population has access to health services.

The HIV/AIDS epidemic is placing additional stress on an already overburdened health system. Demand for care of other diseases has not reduced commensurate with the increased load of HIV: AIDS patients not infrequently occupy half a hospital's medical and paediatric beds. The pre-existing and new loads both have

to be addressed by health systems whose budgets have not grown with the challenge – in fact many have been static or have reduced.

For disease prevention and control programmes to be effective, appropriate interventions must be made available and accessible to the people in need in a timely manner. This means that a person in need must be able to access a facility capable of providing the necessary services. Such a facility would have the necessary resources (including personnel), essential drugs and supplies and appropriate technology and infrastructure (including water, power and communication). The reality is that many health systems are unable to meet these needs and cannot provide basic health care. They are characterized by a lack of or dilapidated facilities, inadequate supply systems with frequent breakdowns in availability of essential drugs, an inability to effect emergency referrals to hospital and often a lack of quality assurance. Quite simply, securing an effective health system is critical to combating major diseases.

Central to any effective health system is having sufficient numbers of capable and committed health workers, particularly in more remote areas. There have been many efforts over the years to develop human resources for health, some of which have yielded important results, such as an increase in training opportunities in Africa. Despite these efforts, the situation has not substantially improved. Compared to other low- and middle-income countries, those in sub-Saharan Africa have on average 0.1 doctor per 1 000 people, fourteen times less than the 1.4 per 1 000 other countries have. The skills mix, which should incorporate well-trained mid-level workers, requires attention in many countries, as does the distribution of personnel. Issues related to health professions, including relevance of education and training and motivation and retention of staff, have not always been adequately addressed. Morale among health professionals and other workers is very low and negative attitudes displayed by health workers towards their patients have been a common complaint. Inability to retain staff threatens the system. It is estimated that 23,000 qualified health professionals emigrate annually, while AIDS is taking its toll on the health workforce.

Much has been achieved in the area of generic medicines since the introduction of essential drug programmes in countries. Globally access to essential drugs grew from 2.1 billion people in 1977 to 3.8 billion people in 1997. Despite these achievements essential drugs remain widely unavailable, unaffordable, unsafe or improperly used in Africa. The problems are most acute in poorer parts of Africa where 70 per cent or more of the people lack regular access to essential drugs. The challenges include drug distribution, lack of capacity for local production of drugs and vaccines, and the pricing structure of imported products that puts many drugs out of the reach of Africa.

Despite the fact that 80 per cent of the people in Africa use traditional medicine, few countries have developed national policies, legal frameworks or codes of conduct for its practice. Stewardship of traditional medicine remains weak in most countries,

because of insufficient documentation and evidence on efficacy and safety of traditional medicines and a lack of knowledge of its practices and behaviours. The result is poor co-ordination between traditional medicine and the rest of the health system and a lack of protection of intellectual property rights and endangered medicinal plants.

The 10:90 gap in health research and its funding is used to describe the fact that 90 per cent of the world's research goes into less than 10 per cent of its health problems – those faced by the developed world. The situation in Africa is even worse. One consequence is a lack of public health research, including behavioural and health systems operational research to guide interventions. Although there are important new initiatives, the lack of development of vaccines and more effective drugs for the treatment of malaria, tuberculosis, trypanosomiasis (sleeping sickness) and other communicable diseases, simply because the commercial opportunity is not good enough, remains a blight on the record of international community and the pharmaceutical industry.

The limited capacity at national and sub-national levels to harness health data and analyse them to provide evidence for informing policy and decision-making is a challenge that requires urgent attention. Monitoring and evaluation are central to improving health service delivery. It is the basis for evidence-based policies and strategies and for assessing effectiveness of interventions. Unfortunately, systems for surveillance, monitoring and evaluation in Africa are generally too weak to fulfil this role effectively.

Although advances in information and communication technology have made the world a global village and are a major driver of the global revolution, most health systems in Africa remain dependent on rudimentary methods and systems of communication and information management. These hinder patient care and sharing of knowledge and experiences that would otherwise improve technological and human resource capacity for health development.

3.2 Disease control programmes do not match the scale of the problem

Many measures are available to reduce the burden of disease, disability and death from the major health problems in Africa. For example, influencing sexual behaviour to prevent HIV/AIDS, treatment completion for tuberculosis, rapid treatment for malaria, reaching children to immunise them against measles (and other diseases), use of oral rehydration to prevent dehydration from diarrhoea and early identification and treatment of pneumonia are all possible and would, if available, impact substantially on disease burden, especially as part of an integrated programme. Yet, coverage of health services in sub-Saharan Africa and other countries with a GDP below US$1200 is 44% for directly observed treatment short course (DOTS) for TB, 2% for malaria prevention, 27% for malaria care, 35% for acute respiratory infections (ARIs), 60% for measles immunisation, 20% for

smoking control measures and below 10% for most components of HIV prevention and care.

There is good evidence from successes across Africa of what is required for effective disease control programmes. These include political will consequent on policy declarations, a focus on the poor, a multi-sectoral approach, sufficient sustainable resources, an emphasis on prevention with a balance between prevention and care, action guided by creation and use of evidence of what works, effective management and monitoring and evaluation and a programme that matches the scale of the health challenge. The converse also applies: without these ingredients, success will be limited. When development partners make short-term commitments and then withdraw before the country is in a position to absorb the financial implications, collapse of good initiatives has followed. Sometimes African countries have even had to undermine other elements of their health system to maintain commitments made when donor support was first provided.

National and international efforts to reduce disease burden have been strengthened over the past few years, and have received political endorsement. Examples include the Global Fund to Fight AIDS, TB and Malaria, UNAIDS programmes, Stop TB, Roll Back Malaria and the Integrated Management of Childhood Illnesses. The Framework Convention on Tobacco Control, Vision 2020 – The Right to Sight and the Global Campaign against Epilepsy are examples of programmes aimed at non-communicable disease burden. The elements of these programmes are based on wide consensus and the strategies they employ are generally regularly updated. The details of these programmes are widely available and do not need to be repeated in this strategy. However, of concern to NEPAD is that many of these efforts are not at the scale required to make the impact necessary to achieve internationally agreed targets for the reduction of disease burden. Also of concern is that some programmes have tended to focus too narrowly and paid little attention to the need to simultaneously support building the core vehicle for their delivery – the health system.

3.3 Safety in pregnancy and childbirth has not been achieved

The reality that in the 21st century one in twenty African women will die of conditions related to pregnancy and childbirth is indicative of the limited chances and choices facing the majority of African women. It is also a reflection of the lack of access to an effective health system. Although poorer women are at greater risk, because of factors such as malnutrition leaving them with smaller pelvises and greater iron deficiency in pregnancy, it has been shown that effective care can dramatically reduce this risk. At the core of significantly reducing morbidity and mortality is a birth assisted by skilled attendants, ante-natal care to address risks during pregnancy and capacity to refer women with complications to a hospital capable of providing basic emergency obstetric care, such as Caesarean sections. Care by traditional and other lesser skilled birth attendants has been shown to be

insufficiently effective. However, skilled care coverage at delivery is only available to 42 per cent of women in Africa. Furthermore, many who need referral will die because of a lack of communication and transport to the hospital, or because the care required there is not available.

The Making Pregnancy Safer and other programmes are working to focus effort on both the unique measures and the health system developments required to do just that – make pregnancy safer. However, these programmes are neither sufficiently developed nor supported to place Africa on track to getting close to achieving the Millennium Development Goal for reduced maternal mortality.

3.4 People are not sufficiently empowered to improve their health

There is much that individuals and families can do to improve their own health, a resource often not recognised by health systems. For example, a drop of chlorine in a litre of water can prevent diarrhoea, while the early use of home made oral rehydration solution can prevent death from dehydration. Use of insecticide-impregnated materials helps prevent malaria, while the use of condoms helps prevent and control the spread of HIV/AIDS and other sexually transmitted infections (STIs). Lifestyle changes in diet and exercise would impact positively on health and life expectancy. Knowing the importance of seeking health care early would also impact on deaths. For example, deaths of children from pneumonia could be reduced if parents were more aware of its easily recognisable symptoms - fast breathing, a cough and a hot body.

The reality is that the potential for reducing disease from such personal actions is not realized in Africa. The contributions of poverty and illiteracy are well recognized, but there is good evidence from Africa that in spite of this much can be achieved. People do not intentionally risk their or their families' health and lives and if empowerment is effective, people are responsive. More can and needs to be done to empower individuals and communities. Providing appropriate information with quality of messages and methods, including use of mass media is a start. The challenge, however, is to create the circumstances in which the poor are the prime actors in their own programmes - in which they are enabled to take action to improve their own health. This is most effectively achieved through community-based interventions.

Health services need to be supplemented by efforts of communities and social structures. These efforts are diverse in nature, ranging from campaigns to care and can be general or may focus on a specific health problem, such as AIDS or disability. They have the ability to achieve results and mobilize energy and voluntarism in a manner that is difficult for formal health services to match. Many extraordinary efforts in Africa provide examples of this potential. They have been successfully spearheaded by non-governmental (NGO), community (CBO) and faith-based organizations, development agencies and individuals. These

organizations have played an invaluable role in the health systems of Africa, and their efforts have been expanding in many countries, especially where government has provided an enabling environment. However, there are massive gaps to be filled, and there is a need for new sustainable indigenous organizations and for the capacity of government to foster and support such developments to be enhanced.

3.5 Insufficient resources

The effective implementation of health policies and plans requires that there be adequate funding. More countries are preferentially allocating funds to health, but funding levels are generally inadequate. Per capita public expenditure on health services is below US$ 50 in 38 of Africa's 53 countries, a figure that is considered the minimum level of funding for an effective health system. Even if private payments are considered, total expenditure remains below US$ 50 in 28 countries. In the least developed countries, total health expenditure is US$ 15 or less per capita.

The main reason for this is simply the poverty of Africa. However, the proportion of public expenditure on health by many African countries is below the 15% benchmark agreed to by African Heads of State and many do not spend the recommended 5% of gross domestic product (GDP) on health. Also, health has not always got its appropriate share of funds mobilised through debt reduction or cancellation.

Development partners have also been found wanting. They are not showing responsiveness to the US$ 22 billion per annum of new development aid the Commission on Macroeconomics and Health determined is needed by 2007 to achieve critical health interventions and the health system needed to support these, nor the US$ 5 billion per annum for research and development and provision of global public goods. Not only this, but many have been lacklustre in their response to the Global Fund to Fight AIDS, Tuberculosis and Malaria. The aim was to reach US$10 billion per annum, yet, even accounting for forward pledges, the first US$ 10 billion has not been reached.

Although the main problem is insufficient resources, there have been allocative and technical inefficiencies in the management of available resources. This will need to be addressed to increase the confidence of governments and development partners that additional resources will be used effectively.

3.6 Widespread poverty, marginalisation and displacement on the continent

Allocative and technical inefficiencies have also compromised poverty alleviation and development, as have inequities in the management of available resources and the factors that have impeded the economic growth and trade opportunities that are

essential to funding increased social spending. But, the link between poverty and health is much wider.

Poverty and ill-health are part of a vicious cycle in which poverty undermines health, and ill-health contributes to poverty and is a reason why individuals and even whole nations are sometimes unable to escape from the poverty trap. Economic evidence confirms this relationship at the individual level and is now supported by a growing body of macroeconomic data that show similar links between better health and higher productivity, and between the national burden of ill-health and the economy. As the Commission on Macroeconomics and Health has shown, substantially improved health outcomes are a prerequisite for developing countries to break out of the cycle of poverty.[8] The HIV/AIDS pandemic has compounded the health effects of poverty and the economic impact of disease burden on countries. Impacting substantially on the burden of AIDS is imperative for Africa's development – it is central to it.

Health is not simply a product of health service efforts. The situation in many sectors has impacted negatively on health.

Shortfalls in agricultural production overall and especially by the poor, due inter alia to natural disasters and lack of land reform, have had a deleterious effect on food security and hence led to increased malnutrition. Lack of household food security is a consequence of poverty and underdevelopment, while its impact on disease burden goes well beyond malnutrition.

Education, and in particular women's education, is advantageous for health. Literate people are better able to take action to improve their own health – the educational level of the mother is one of the main factors determining infant mortality. Lack of education has made it difficult for many to secure their basic needs, including nutrition, or to include health-promoting actions in their lives and that of their children. Poor education has added to the oppressed position of women, and in consequence to poor health, including poor reproductive health.

In spite of the commendable efforts of many governments and their partners in the past decades, in the year 2000, some 276 million people in Africa still lacked access to safe water supplies, while 284 million people were without adequate sanitation. This results in a loss of 24 billion work hours per annum through illness and 40 billion work hours per annum are spent collecting water. The pollution of scarce water sources, contamination of soils by industrial, municipal and agricultural wastes containing toxic and hazardous chemicals, and the rampant spread of disease vectors have compromised health for hundreds of millions of people. But, environmental impacts on health go beyond water and sanitation. For example, household fuel combustion, particularly using firewood and crop residues indoors for cooking, contributes to acute and chronic respiratory infections, including pneumonia.

People living in informal settlements with poor infrastructure face a concentration of environmental hazards. They are exposed to fire, communicable diseases spread by overcrowding, inadequate water and sanitation supplies, air pollution and the health problems of social instability.

Lack of general infrastructure, such as good roads, transport and communications, has impeded health services, especially in the provision of emergency care, while clinics often do not have power, nor a safe water supply.

Socio-political instability and protracted wars have been major problems on the continent. The results are massive displacement of people whose health status is severely compromised.

3.7 The benefits of health services do not equitably reach those with the greatest disease burden

The burden of disease is not evenly spread between and within the countries of Africa, with the poorest quintiles in countries facing the heaviest disease burden. This inequity is a consequence of uneven development benefits and health services. The poorest and most remote people and those displaced by war and other emergencies are especially vulnerable and contribute disproportionately to the disease burden. Consequently, if the aim is to reduce disease burden, then development, public services and health care should benefit the poorest and most marginalized people.

Broad involvement and empowerment of poor people in health development, which is not happening widely, is a crucial requirement for success in the fight against poverty. The underlying principle of the participatory approach is to promote growth and equity and to strengthen the democratic process at the local level through a bottom-up process that enables the poor to become full participants in development and decision-making. Although participation alone cannot overcome all the health barriers arising from economic and social deprivation, communities can become empowered to improve the health of their households if an equitable social policy exists.

The poor and marginalized have limited access to health facilities, health workers and financing mechanisms. Out-of-pocket payments take a large proportion of their incomes: serious illness can impoverish families for many years as they not only lose income and production but also must pay back money borrowed. Displaced communities and those affected by war are even more vulnerable, yet they receive even less health care. Even when peace prevails, capacity and resource limitations do not allow health services to be rapidly scaled up.

SECTION 4: THE NEPAD HEALTH VISION, OBJECTIVES AND TARGETS

Recognising that Africa is not on target to reach the reductions in disease burden agreed to at the United Nations and in other international and continental fora, a choice has to be made. The NEPAD approach could simply be one of seeking to do a bit better than in the past, or it could be one that could, if seriously addressed by both Africa and its development partners, truly impact on the burden of disease, disability and death. In line with the development goals underpinning NEPAD and its overall strategy, the NEPAD health vision, objectives, targets and strategy are based on the latter.

4.1 NEPAD health vision:

An Africa rid of the heavy burden of avoidable ill-health, disability and premature death.

4.2 Goal

The goal of the NEPAD health strategy is to dramatically reduce the burden of disease, especially for the poorest people in Africa.

4.3 Objectives

The heavy preventable burden of disease in Africa is underpinned by poverty and underdevelopment. At its core NEPAD seeks to address the socio-economic, political and environmental factors undermining health. The NEPAD health sector strategy specifically seeks to:

1. Strengthen commitment by and the stewardship role of Governments and mobilize and harness a health and multi-sectoral effort that should include the resources of government, civil society, the private sector and regional and international partners.
2. Strengthen health systems and services so that they can provide effective and equitable health care, built on evidence based public health practice, including incorporating the potential of traditional medicine
3. Scale up communicable and non-communicable disease control programmes, especially recognising the unprecedented challenge posed by HIV/AIDS, tuberculosis and malaria.
4. Strengthen and scale up programmes to reduce the burden due to conditions related to pregnancy and childbirth.

5. Empower individuals, families and communities to act to improve their health, achieve health literacy and integrate effective health interventions into existing community structures.

6. Mobilise and effectively use sufficient sustainable resources to enable health systems and disease control programmes to operate at the level required to reach health targets.

7. Share available health services equitably within countries.

4.4 Principles and values

There are a host of principles and values that could justifiably underpin a health sector strategy for Africa. Without reflecting negatively on those not specified, the following are the key principles and values that the health strategy aims to foster and expects all actions consequent on it to embrace.

NEPAD as a development strategy encompasses the following **principles**, which are critical success factors for the health sector:

- African leadership and ownership of development strategies and accountability for implementation are the foundation of success

- The state has a central role to play in and responsibility for development, which requires political will and commitment by African governments

- Effective development partnerships are essential, as is co-ordination and collaboration between communities, governments and development partners

- Health is both a social and an economic asset that should be invested in and prioritised by governments.

The core health sector **values** underpinning this strategy are that:

- Health and access to quality affordable health care is a human right

- Health is a developmental issue requiring a multi-sectoral response

- Equity in health and health care is beneficial to countries as well as individuals

- Evidence should be the basis of public health practice; effectiveness, efficiency and quality its product.

4.5 Targets

Targets have been set for reduction of the disease burden in Africa in the Abuja Declarations on Malaria and on HIV/AIDS, TB and Other Related Conditions, in the Health-for-All Policy in the 21st Century, at the UN Special General Assemblies on HIV/AIDS and Children, and at the G8 Okinawa Summit[9], all of which are recognised. However, although there are various critiques of them, primacy is given by NEPAD to the internationally agreed benchmarks of the Millennium Declaration.

The health targets are therefore:

1. To halt and begin to reverse the spread of HIV/AIDS by 2015

2. To halt and begin to reverse the increase in the incidence of malaria and other major diseases by 2015

3. To reduce mortality rates for infants and children under-5 by two-thirds by 2015

4. To reduce maternal mortality by 75 per cent by 2015

SECTION 5: THE NEPAD HEALTH SECTOR STRATEGIC DIRECTIONS

The NEPAD health sector strategy is a medium term strategy that follows a comprehensive, integrated approach to addressing the disease burden of Africa. The strategy comprises seven strategic directions. These are to:

- Strengthen commitment by and the stewardship role of government

- Build secure health systems and services

- Strengthen programmes to reduce the burden of disease

- Provide skilled care for pregnancy and childbirth

- Enable individual action to improve health

- Mobilise and effectively use sufficient sustainable resources

- Strive for equity for the poor, displaced and marginalized

These strategic directions would be complementary to interventions in other priority areas identified in NEPAD, recognizing the close linkages between health and overall human development. Thus, the strategy recognizes and supports commitments within NEPAD to addressing broader issues that are undermining health, including poor governance, socio-political instability, economic underdevelopment, poverty, marginalisation and displacement, lack of infrastructure (energy, transport and water and sanitation), low educational levels, agricultural vulnerability, environmental degradation and gender inequality. This strategy focuses on the health sector.

5.1 Strengthen commitment by and the stewardship role of government

The NEPAD vision for health development can only be achieved when governments seize their stewardship role. This involves providing effective vision and influence, appropriately leading and steering the health sector and enabling coherent and consistent intersectoral action, in the interests of the nations health and health care. Ministries of Health need to enhance the effectiveness of interventions in the public, private and not-for-profit sectors, appropriately using all the tools potentially at their disposable. Stewardship must be applied not only to responsibilities that mainly fall directly under the jurisdiction of the Ministry of Health (stewardship in health); but also to setting the direction of health development leading to the strategic management of the health system (stewardship of health); as well as stewardship of factors in the broader social, political and economic environment that will enhance health required by government, civil society and

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regional and international development partners (stewardship for health). Credibility will come not just from pronouncements, but from matching statements with action. Ministries need to build their capacity to effectively fulfil their stewardship role in an environment that is becoming increasingly complex and that is changing rapidly. A first step is to achieve a high level of visibility for health and to advocate effectively for government commitment to the health sector and for the nation to place a high value on health and with attaining and retaining the resources needed – human, financial and material. These resources must then be equitably allocated and efficiently managed. Successful stewardship will include effective policy and plan formulation, including clarity on the role and nature of the private sector and civil society, health legislation and regulation, co-ordination of effort and development of norms and standards. Ongoing monitoring and evaluation must be tied to interventions to address problems identified.

Continental bodies, in particular the AU and ADB and Regional Economic Communities (RECs), together with UN institutions have a key stewardship responsibility. RECs in particular will need to strengthen their health capacity to fulfil their responsibilities. These should include moves towards common legal frameworks and governance and in combined programmes and purchases in those areas where there is synchrony in policies, as great benefit can be derived from the potential economies of scale. RECs also have a critical responsibility to forge joint and merged efforts against burdens of disease that cross national boundaries.

5.2 Build secure health systems and services

The process of building health systems to effectively meet even the basic health needs of Africa's people and support disease control will take time and will require sustained commitment over many years. There can be no single health system recipe, given the diversity of national health systems and service situations in Africa. Furthermore, each country will have different priority areas for attention: in one country this may be access to drugs, in another human resources and in another communication. Thus, each country will need to prepare its own country-specific health policy and strategic plan for securing its health system.

In developing country-specific policies and strategic plans, the role of the various stakeholders must be recognized. The roles of each of the public service, private sector, NGOs, CBOs and others who make up the diverse group of health care providers must be clearly recognized and be well-defined, so that all can work in a co-ordinated fashion towards achieving the country's health development goals. The relative strengths of each stakeholder should be taken advantage of in order to maximize the additive contributions of all organizations.

Although there may be no generic prescriptions, it is possible to identify common requirements of an effective health system. These are service provision and care at all levels, human resource development, essential medicines and supplies, health

technologies, health information and research, and institutional public health, capacity.

In order to ensure access to health services, countries should increase the number of primary care facilities to the point whereby at least 80 per cent of the population is within one hours travelling time to the nearest health facility. Secondary level health facilities, such as district hospitals required for supporting primary care and for referral of cases have to be situated equipped and staffed to enable them to carry out their roles. Many will need to be revitalised. The entire district health system should be operationalised so that different units work in unison. Higher-level facilities, including teaching hospitals, should be adequately supported so that they can carry out their functions of providing care, training health workers and undertaking research, without using an excessive proportion of available funds.

Special attention needs to be paid to peripheral health systems and to strengthening management at the district level, tied to decentralisation. There is a real need for trained managers who can effectively mobilise, motivate and innovate as well as plan, organise and budget, and who stay in a district for a meaningful period of time. There should be regular supervision that encourages and enables performance and empowers staff and greater local involvement, including community oversight.

As health is a labour intensive sector, whose success is integrally tied to human resource capability, countries should prioritise human resources for health, seeking to staff services with sufficient numbers of capable workers. In addition to mobilizing more finances for human resources, countries must have developed policies and plans and training and development approaches which meet country needs. There should be a balance of professional and auxiliary staff to ensure suitable skills, cost-effectiveness and availability. Countries should ensure effective management of human resources for health by updating their employment and deployment policies, developing flexible career paths, providing supportive supervision and continuing education and fostering motivation and retention strategies. They should demonstrably value their health workers and recognize their professional worth and the adverse circumstances under which many work. Training should be increased and salaries and work conditions improved. These are the actions needed to help ensure availability and retention of appropriately qualified staff at all levels of the health system and to counter the push factors in international migration.

Countries also have to ensure availability of essential medicines and supplies by ensuring that all steps in the chain are functioning effectively. This requires their improved selection, purchase, storage, distribution and rational use, secured at a cost affordable to the health system and the consumer. The quality, safety and efficacy of medicines should be ensured, by strengthening regulatory and quality assurance programmes.

Appropriate use of technology has a vital role to play in improving quality of care. The choice and application of technologies should be guided by public health priorities, keeping a balance between affordability and proven effectiveness. National standards and norms, coupled with appropriate selection, effective procurement, provision and maintenance and rational utilisation reflecting efficient technology management is the combination needed to support quality health care.

Institutional public health capacity and centres of excellence on the continent, within a sub-regional framework, must be developed, as must south-south cooperation and more effective and relevant links with the north, which will continue to play an important role. These include reference laboratories, schools of public health, specialized clinical centres and research institutes. African experts should collaborate and network more with each other, to learn from one another and to enhance their contribution to disease control and health service development. Systems and organizations need to be put in place to enable such collaboration.

Governments need to recognize the wide use and hence importance of integrating traditional medicine into national health systems and creating an enabling environment for optimising its contribution. The latter includes mobilizing and connecting all stakeholders. It is essential to strengthen structures of traditional medicine through analysis of the prevailing systems and with the involvement of traditional health practitioners and communities, while at the same time being aware of the limitations in traditional medicine and the risk of opportunism by individuals. Some of the organizational requirements include the establishment of a national multidisciplinary body responsible for the coordination of traditional medicine; formulation of a policy and legal framework; allocation of adequate resources; development of regulations for the local production and rational use of traditional medicines; and protection of intellectual property rights.

Progress towards achievement of the objectives of the strategy should be regularly monitored. Health information systems should be strengthened to support the decision-making process, particularly in order to provide information to guide local managers. Efforts should be concentrated on the improvement of the vital statistics registration systems, epidemiological surveillance, morbidity and mortality registration and resource management information systems. Research in general and operational research specifically must be recognized as necessities for improving health system performance and not as luxuries. In consequence, health systems need to budget for and support research that provides evidence for use by policy- and decision-makers at all levels. Appropriate arrangements have to be made to ensure that the results of research can indeed influence health policy and practice.

5.3 Strengthen programmes to reduce the burden of disease

Although there is a need to address the full range of health problems affecting Africa, there is little doubt that the immediate priority must be to reduce the burden of disease caused by AIDS and also by TB, malaria and childhood communicable diseases. The NEPAD disease control proposals are broadly aligned to existing international or continental initiatives and the commitments of the action plans of the Abuja Declarations on Malaria and on HIV/AIDS, TB and Other Related Infections and to securing the funding needed for their implementation. While considering this strategy's focus on the health system elements of prevention and control of the health burden, the collaborative multi-sectoral effort required to address them fully must always be seen to be at the forefront of efforts.

NEPAD envisages a massively scaled up AIDS prevention effort incorporating education, access to condoms, voluntary counselling and testing, treatment for sexually transmitted infections (STIs) and prevention of mother-to-child transmission. Targeting of those at high risk, such as sex workers, migrant workers and youth must be stepped up and prioritised. Care includes home-based care and care of orphans, improvements in quality of life, treatment and prophylaxis of opportunistic infections and use of anti-retrovirals. As with other diseases, effective care will require affordable drugs and strengthened health systems, including effective drug distribution, strengthened laboratory services and caring health staff. It also requires community action and empowered individuals and families.

A key element in AIDS prevention is reaching the youth. Investing simultaneously more broadly in health promotion amongst youth will yield many benefits now and in the future. They will be empowered with accurate information to reduce their risk of sexually transmitted infections and HIV/AIDS, early and unwanted pregnancies, alcohol and substance use/abuse and chronic diseases of lifestyle. Young people should be involved in the design, implementation and evaluation of the policies and programmes that affect them.

Tuberculosis control is to be based on early presentation for care by chronic coughers, a high index of suspicion in HIV-positive people, case detection using microscopy and multiple-drug treatment using the directly observed treatment short course (DOTS) strategy and enlisting the private sector and communities in overall TB control. Efforts should be made to scale up initiatives for dealing with the linkages between TB and HIV/AIDS.

Malaria efforts should include increased use of insecticide-treated materials and other vector control measures, prompt diagnosis and treatment, including home initiated care, chemoprophylaxis for pregnant women, and early detection and response to outbreaks.

The prevention and control of childhood infectious diseases includes consolidation of the "Integrated Management of Childhood Illnesses" (IMCI) programme. In

addition to HIV/AIDS, TB and malaria, early identification and treatment of pneumonia and prevention and rehydration for diarrhoea are critical. Immunisation coverage must be ensured. Breastfeeding for at least six months, adding oil to staple diets, vitamin A capsules, iodised salt and iron rich foods all supplement the core requirement of food security. Indeed, good nutrition and household food security have a critical role to play in reducing the burden of disease, both directly and indirectly. Concerted efforts must be made to reach children and young people living in especially difficult situations, i.e. those affected by HIV/AIDS, orphans, refugees and the internally displaced, street children, the physically and mentally challenged, and others. The principles of the Convention on the Rights of the Child[10] should guide all interventions.

Strategies to address other important causes of disease burden are recognized by the NEPAD programme. Efforts for targeting diseases for elimination, such as leprosy, polio and measles, need continued support. NEPAD supports measures to control other communicable diseases of importance in Africa, such as sleeping sickness, river blindness and schistosomiasis, and for the reduction of deaths and disability from non-communicable diseases, including those related to tobacco, mental ill-health, substance abuse, violence and injuries, work-related injury and disease and importantly from the emerging chronic diseases related to lifestyle.

5.4 Provide skilled care for pregnancy and childbirth

The reduction of maternal and newborn morbidity and mortality requires a package of specified promotive and preventive measures and screening for and early care of problems identified during pregnancy. It also requires effective and immediate access to skilled assistance in childbirth and easy access to referral facilities for complications, such as those requiring Caesarian sections. In consequence, the process of making pregnancy safer requires suitable staff and interventions throughout the district health care system from effective client education and participation to functional supply, communication and transport systems. Thus, while this programme will focus on pregnancy and childbirth, it is also a strategic entry point to strengthen the health system, as many of the measures required have to address weaknesses in the system as a whole.

The inclusion of gender mainstreaming in health policy, improving women's rights and the elimination of all forms of violence against women (including female genital mutilation which should be prohibited by law) and access to family planning are important features of the wider women's health programme that is required. The central role played by women in providing health care and in socio-economic development should be recognized and supported.

5.5 Enabling individual and community action to improve health

Health literacy means attaining the basic knowledge and skills to enhance a person and their family's health in a manner that favourably influences attitudes and behaviour. In much the same way as literacy enables people to read and experience all the benefits associated with it, achieving health literacy allows people to experience the benefits of better health. The approach should be comprehensive and developmental. Too often, single disease programmes have provided information in a manner that tells people what to do, rather than contextualising their learning. The methods pursued should enable appropriate skills and action (behaviour) and not simply knowledge. It should enhance dignity and provide information to support decision-making, avoiding approaches that are patronizing, condescending or humiliating as these tend to alienate people from health-enhancing actions. Political support for the messages is essential and appropriate legislation, such as control of exploitative advertising, should be used in support of preventive messages.

The resources of the state, including public broadcasters, should be optimally used to spread health messages. Packaging learning in interesting formats, such as radio drama and linking it to real life situations offer greater impact. Community structures and community-based organizations are potentially very valuable routes for health promotion, while use of national figures, such as musicians, and peer education, are also influential means of learning. If there is leadership from Heads of State and a high profile, concerted effort, there is no reason why health literacy cannot be rapidly improved.

The NEPAD health programme seeks to achieve a real scaling up of community involvement in a range of health issues, starting with the major causes of disease burden. At the core is a commitment to mobilize energy and voluntarism in a manner that is difficult for formal health services to match, and to achieve results in groups that formal services struggle to reach.

On the one hand, it is important that people do not simply wait for government to do things for them, yet on the other, organizations do not arise spontaneously in sufficient numbers. Health ministries will therefore need to create an enabling environment for community involvement, facilitate the emergence of local NGOs and CBOs and provide funding to initiate efforts in underserved areas. As situations vary from country to country, there is no single way of doing this. Each country should consider the local situation and incorporate a deliverable approach to community involvement in its country plan. The details may be different, but the aim is common to all countries: to reach all sectors of society, especially the poorest and most marginalized, in a sustained programme of social mobilization in support of health. The aim is to combine community energy with equitable, honest and effective government effort – without the latter this can become a way of government excusing itself from its responsibilities and creating a system of second class care for the poor and less powerful.

5.6 Mobilise and effectively use sufficient sustainable resources

The individual and collective efforts of African countries to battle the heavy burden of disease and unnecessary death on the continent must entail the mobilization of substantial additional resources, both domestic and foreign. African governments and development partners alike must translate the international strategies adopted in the area of health development into concrete financial commitments. Much less will, when distributed, be spread too thin to make the impact required. At the same time recipient and donor countries as well as international institutions and NEPAD must work together to make ODA more effective.

It is envisaged that the additional funds will come from 3 main sources:

- NEPAD countries committing more of their own resources to health in line with commitments made in the Abuja declarations

- Countries preferentially directing funds mobilised from debt cancellation to health

- Increased support from development partners

As evidence of their own commitment to this programme, Heads of State will lay the ground for sustainable interventions and each country will show its commitment to this programme by setting explicit goals for domestic spending in the health sector and by allotting a higher priority to health in their national budgets. For each country, the amount committed will be different, but will be such that no observer would question the country's resolve to tackling its burden of disease and to moving towards the target of 15% of public expenditure committed to in Abuja. This must be factored into Medium Term Expenditure Frameworks.

As economies grow with implementation of the overall NEPAD programme, so will dependence on development partners reduce for sustaining the health systems of Africa. However, for now there is no question that development partners should achieve the target of 0.7 per cent of gross national product (GNP) as ODA to developing countries and 0.15 to 0.2 per cent to least developed countries. This would provide the basis for funding to achieve the target of US$ 22 billion identified by the Commission on Macroeconomics and Health – the minimum if development partners are serious about making real progress towards achieving the Millennium Development Goals It would also bring in new money and not just result in a shuffling of the pack or a drawing out of funds from other sectors needing support – and whose development is critical for health. They should further provide support in setting up effective health infrastructures and impact on the pharmaceutical industry to make drugs and vaccines more widely available and affordable, particularly those needed for HIV/AIDS, malaria and tuberculosis.

Emphasis must be placed on untied aid, aid effectiveness and the implementation of monitoring and peer review mechanisms for mutual accountability. The international donor community must strive to streamline its approach to health funding through increased harmonization and coherence of donor policies and aid practices towards the achievement of the Millennium Development Goals.

The resources mobilised, including those of the Global Fund to Fight AIDS, Tuberculosis and Malaria, must not just go into disease specific programmes but also into securing the vehicle that needs to provide much of the specific prevention and care that has to be implemented - the health system. At the same time, the disease programmes must receive enough funds to match the scaling up that are required of them.

NEPAD is committed to strengthening mechanisms in its member countries for accessing, allocating, distributing and managing additional sources of funding. NEPAD countries recognise well that funding flows are in no small part going to be linked to their ability to effectively use and account for funds. Ministries of Finance will need to pay particular attention to this in the health sector and to the capacity building required for effective and accountable use of funds.

5.7 Strive for equity for the poor, displaced and marginalized

Successfully impacting on the disease burden of the poorest and most marginalized people of Africa requires economic recovery pursued in a manner where real benefits reach those in greatest need. A central feature of NEPAD is the war on poverty and marginalisation, the success of which will contribute to health. A strong focus on the needs of the poor, including food security, will provide significant health returns. Strengthening public services impacts most on the poor, as this is where they access care. Such strengthening is central to this strategy.

Displaced communities and those affected by war need to receive services. This should include services for women and children, including immunization. Special arrangements may need to be made to provide health care, possibly through NGOs. Then, as soon as peace prevails, health services need to be rapidly scaled up because of the burden of treatable disease that has built up. This is also an effective entry point for reconstructing communities and societies and building their confidence in the post-conflict era.

Health services must reach the poor for their health to improve. In many countries, the cost of health care to poor families is catastrophic, and NEPAD envisages changes in health financing systems to achieve fairness. Thus, prepaid financing arrangements such as government budgets or (carefully constructed) health insurance must be considered for implementation. Certainly fee-for-service at the time of service is not a desirable option. Fairness in financing health systems is not only of moral value, but it also offers the best return on investment.

SECTION 6: INSTITUTIONAL ARRANGEMENTS

As the architects of their own sustainable development, African governments must take responsibility for ensuring the political, economic and corporate good governance that is essential to effective health development efforts and increased capital inflows. The imperative of health development poses a challenge to African leaders to provide bold and imaginative leadership that is genuinely committed to restoring and maintaining peace and security, promoting and protecting democracy and human rights, and developing clear standards of accountability, transparency and participatory governance at the national and sub-national levels.

Successful implementation of the NEPAD health strategy is contingent upon the achievement of innovative and effective partnerships between African governments and health development partners, based on the principle of African ownership, and underpinned by active collaboration and coordination at the global, regional and national levels. The task of strengthening institutions and governance is therefore of crucial importance. Building human and institutional capacities for health requires a comprehensive approach that should address such areas as social infrastructure, social service delivery, education and training, nutrition, sanitation and social integration.   The NEPAD strategic vision for health development can only be achieved through increased resource mobilization, strengthened management and more equitable distribution and allocation of financial and human resources.

Core responsibility for implementation of NEPAD strategies lies with countries, and where it requires a regional focus, with regional economic communities. However, multiple parties will act in support of the programme.   These include UN agencies, the African Union, development partners (e.g. developing countries), donor organisations (e.g. foundations), African institutions (e.g. universities) and civil society organisations. African capacity, including the health capacity in the AU and the RECs, need to be strengthened.

NEPAD itself is not an implementation agency.   NEPAD's role is to develop strategies and programmes and to facilitate, create focus and energy and to leverage, arising from the development of an African determined and driven strategy and the personal commitment of Heads of State. This is obtained inter alia through adoption of this strategy and its programme of action by the NEPAD Heads of State Interim Committee and by African Union Heads of State. NEPAD will also support securing financial and other resource commitments from both African countries and development partners and with countries and RECs will take responsibility for performance against the plans. Monitoring and evaluation of progress and adjusting the strategy and actions is also part of the role of the Secretariat, while the peer review mechanism of NEPAD provides for independent evaluation. NEPAD does not envisage duplicating existing capacity, nor building a large organisation. Rather it is committed to strengthening capacity on the

continent, including in the Regional Economic Communities. It will play a facilitator role in proposing health development projects that are crucial for regional integration, a key feature of NEPAD's policy framework. The promotion of priority projects for the regeneration of the African continent is a role of the Secretariat and it will provide the impetus for this in the health sector.

Although countries are responsible for implementation of NEPAD strategies and programmes, NEPAD recognises that programmes do not emerge organically and that facilitation is required. Thus, for each of the programmes there will be a NEPAD partner (or partners) as a lead agency responsible for co-ordinating and supporting the effort towards implementation of the programme of action on the continent. This could be the African branch of a UN agency, an African institution (e.g training, research), a regional non-governmental organisation or other partner that meets the general NEPAD criteria as implementation partners. In determining who should be NEPAD's implementation facilitation partner the comparative advantages of the key stakeholders in health will be considered.

WHO Afro, with its capacity at its head office and its country offices is considered ideally placed to and has already provided essential technical support to the core NEPAD Health function and it is envisaged that this will continue. Given its comparative advantage in international health development, NEPAD also envisages that it will play a central role in the implementation of the NEPAD Health Strategy.

SECTION 7: INITIAL PROGRAMME OF ACTION

The NEPAD health strategy is a medium term one, based on the recognition of what is required to sustainably tackle the huge burden of avoidable disease, death and disability in Africa. This is what NEPAD will advocate for and support. At the same time, NEPAD recognises that an appropriate initial programme, comprising a set of actions and projects is needed to set the path for the medium term and to lay the foundation for success. This initial programme of action is listed below. It is not intended as a list from which to make selective choices, but rather as a composite set that needs to be actioned concurrently. As the strategy unfolds, further elements will be added to this initial programme. Critically, the strategy does not specify initial projects on equity for the poor, displaced and marginalized, because it is a golden thread that is considered to be an essential focus and part of each action.

7.1   Strengthening commitment, enabling stewardship and harnessing a multi-sectoral effort

7.1.1   Create a NEPAD Presidential Advocacy for Health Group to mobilise commitment from Africa and from development partners to this Strategy.

7.1.2   Establish a health system observatory programme to provide the capacity to monitor and evaluate progress towards achieving this strategy, including reporting to the NEPAD Heads of State.

7.1.3   Institutionalise the preparation of National Health Accounts as a key tool for appropriate financial decision making in the health sector.

7.1.4   Reach an international agreement on migration, especially with regard to ethical recruitment of health personnel from Africa, while putting in place mechanisms to improve the value placed on health workers, to address the adverse conditions of service and to improve motivation and retention.

7.2   Securing health systems and building evidence-based practice

7.2.1   Strengthen the technical capacity for policy making and budget linked planning in Ministries of Health.

Launch a sustainable health systems programme including the following elements

7.2.2   Operationalize effective local health systems through establishing demonstration districts in all countries that can test delivery strategies and provide a model for replication.

7.2.3 Create a fund to support innovations in health systems and the sharing of successful new approaches to encourage new developments and evidence based practice.

7.2.4 Provide rural clinics with the infrastructure required for effective operation, starting with tele, radio or satellite communication to reduce isolation and enable calls for emergency assistance.

7.2.5 Test new models for drug supply to rural clinics and hospitals to overcome supply system problems.

7.2.6 Strengthen and increase capacity of training programmes for multipurpose clinic staff.

7.2.7 Increase the capacity for public health training in Africa, so that the required cadre can be cost-effectively achieved.

7.2.8 Increase funding for operations and health systems research, including community based interventions, to strengthen the evidence base on which public health decisions are made and to enable health research to become integral to the health system.

7.2.9 Build capacity in Africa for health research relevant to the challenges and needs of the continent and its health systems.

7.2.10 Support the capacity for local production of essential drugs, including anti-retrovirals so as to make drugs more affordable

7.2.11 Advocate and leverage support for development of the new drugs and vaccines needed by Africa.

7.2.12 Establish reference laboratories in each of the regions in Africa to support disease and drug resistance surveillance and provide training.

7.3 Scaling up disease control

Pro-actively provide support for the following programmes against the major burdens of disease whose practice should coincide with the approach in this strategy and enable them to deliver at scale and to build the capacity required:

7.3.1 Enhance prevention / promotion related HIV programmes in particular peer education programmes for vulnerable groups and those targeting youth.

7.3.2 Advocate for and support the provision of affordable anti-retroviral therapy (ART) and treatment of opportunistic infections in persons living with HIV/AIDS.

7.3.3 Support the expansion of services for voluntary counselling and testing.

7.3.4 Support the scaling-up of interventions for the prevention and treatment of STIs.

7.3.5 Support the implementation of initiatives that increase access to and improve the quality of TB DOTS services such as community based DOTS, collaborative TB/HIV/AIDS activities and public-private partnerships.

7.3.6 Develop regional strategies to mobilise human and financial resources for TB control activities, and to ensure uninterrupted supply of affordable quality anti-TB drugs in all countries.

7.3.7 Facilitate mechanisms for financing, procurement and distribution of effective malaria control interventions, such as use of artemisinin derivatives, insecticide treated nets and insecticides, so that they reach vulnerable populations.

7.3.8 Include Integrated Management of Childhood Illness (IMCI) implementation in all district health plans.

7.3.9 Advocate and support inclusion of IMCI into pre-service training of health workers towards achieving sustainability in capacity.

7.3.10 Advocate and support trypanosomiasis elimination through revival of case detection and treatment, improved surveillance and targeted vector control.

7.3.11 Promote and support control of schistosomiasis and soil-transmitted helminths to improve school performance and adult productivity.

7.3.12 Advocate for and support lymphatic filariasis elimination as a tool for poverty reduction.

7.3.13 Enable countries to develop comprehensive responses to the increasing incidence of lifestyle-related chronic diseases e.g cardio-vascular disease (CVDs), lung cancer and diabetes, through promotion of proper diet, physical activity and the reduction of consumption of tobacco, alcohol and other substances.

7.3.14 Improve the management of epilepsy at primary health care level and contribute to the reduction of the *Treatment Gap* of people living with epilepsy.

7.4   Reducing conditions associated with pregnancy and childbirth

7.4.1   Support the establishment of an effective programme for the reduction of mortality from conditions associated with pregnancy and childbirth, and enable the effective integration of maternity services with the health system.

7.5   Empowerment of people to improve their health

7.5.1   Create a public communications for health literacy programme, using available capacity in Africa to cost-effectively empower people to take action to improve their own health.

7.5.2   Create a programme to enable countries to more effectively support and enable non-governmental and community organisations to make their unique contribution to prevention and care.

7.6   Mobilise sufficient sustainable resources

7.6.1   Seek commitments of countries to develop a timetable to reaching the agreed benchmark of allocating 15% of public spending to health.

7.6.2   Seek commitment to and a timetable for development partner support of US$ 22bn per annum in new health development aid for Africa.

SECTION 8: MONITORING AND EVALUATION

At the country level, African governments should regularly monitor and assess progress towards the goals and targets outlined in this health strategy. Countries will be supported to collect, analyse and disaggregate data, including strengthening and/or building community capacity for monitoring, assessment and planning.

At the regional level, arrangements should be made for periodic reviews in order to more effectively address obstacles and accelerate successful actions. The results from the reviews should be used to share best practices, strengthen partnerships and accelerate progress in the implementation of the health strategy.

In line with the commitment for peer review in NEPAD, it is envisaged that regular reports will be provided to the Heads of State assessing progress towards achieving the objectives, targets and strategic directions and the initial programme of action set out in this report. Independent reviews will also be undertaken through the NEPAD African Peer Review Mechanism.

The envisaged health systems observatory will be one of the routes for gathering information for the purposes of monitoring and evaluation, but all countries and development partners will need to pool and share their expertise, information and resources to enable a continent wide picture to emerge on so broad a strategy. All the detailed plans for the initial programmes identified will include a plan for monitoring and evaluation, and NEPAD implementation partners will need to provide regular progress reports.

SECTION 9: CONCLUSION

There is growing recognition of the importance of health in development strategies, exemplified by the fact that three of the Millennium Development Goals are directly related to health: reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases.

The NEPAD Health Strategy represents a solemn commitment by African governments to set the continent on the path of sustained human development, and to rid Africa's people of the suffering, humiliation and economic burden imposed by unnecessary disease and death. It draws on the unique features of NEPAD – its African ownership, the commitment of Heads of State, and its broad base in merging political, economic and social development and good governance.

The NEPAD Health Strategy embraces the spirit of the Rio Declaration[11] that 'Human beings are at the centre of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature'. This vision was reiterated in the Declaration of the Johannesburg World Summit on Sustainable Development[12]. While recognizing that this vision remains distant for many African people, the NEPAD Health Strategy represents an important step to bestow future African generations with a real prospect of life free from a heavy burden of avoidable disease and disability and premature death.

The Health Strategy proposes an inter-sectoral and integrated approach to health development. It embraces the values and goals underlying the Health-for-All Policy for the 21st Century in the African Region: Agenda 2020. It reflects the understanding that disease-focussed programmes alone are not sufficient to achieve desired results, and that addressing the underlying determinants of health is crucial to ensuring sustainable human and health development. It further recognises that, that effective health systems and community involvement are essential to success and that disease control efforts are not only dependent on this, but themselves need to be brought to scale.

Without a concerted national, regional and international commitment to health development in Africa, the pledges assumed by the international community in the Millennium Development Goals and other international fora will remain yet another failed promise of better lives for millions of African people. This must include countries prioritising investment in their people's health, which will provide a credible basis for a strengthened partnership between NEPAD and the international donor community for substantial supplementary investment in health. This investment will be amply repaid not only in the millions of lives saved each year, but in increased continental and global economic development and security.

References

[1] The recognised Regional Economic Communities are: Arab Maghreb Union (AMU), Community of Sahel and Saharan States (CEN-SAD), Common Market for Eastern and Southern Africa (COMESA), Economic Community of Central African States (ECCAS), Economic Community of West African States (ECOWAS), Intergovernmental Authority for Development (IGAD), Southern African Development Community (SADC).

[2] Declaration of Commitment on HIV/AIDS, "Global crisis – Global action" Adopted at the 26th Special Session of the General Assembly of the United Nations, 25-27 June 2001.

[3] A World Fit for Children. Adopted at the 27th Special Session of the General Assembly of the United Nations, 10 May 2002.

[4] Millennium Development Goals, adopted at the United Nations Millennium Summit, 6-8 September 2000.

[5] The Abuja Declaration on HIV/AIDS, Tuberculosis and other related infectious diseases adopted at The African Summit on HIV/AIDS, Tuberculosis and other related infectious diseases, Abuja, 26-27 April 2001.

[6] The Abuja Declaration and Plan of Action, adopted at The African Summit on Roll Back Malaria, Abuja, 25 April 2000.

[7] Health-for-All Policy in the 21st Century in the African Region: Agenda 2020. Adopted by the World Health Organization, Regional Committee for Africa, 2002.

[8] Macroeconomics and Health: Investing in Health for Economic Development. Report of the Commission on Macroeconomics and Health, World Health Organisation, 2001.

[9] Final Communique' of the G8 Kyushu Okinawa Summit21-23 July 2000.

[10] The UN Convention on the Rights of the Child. Adopted at the 61st plenary meeting of the United Nations General Assembly, 20 November, 1989.

[11] Rio Declaration on Environment and Development. Adopted at the United Nations Conference on Environment and Development. Rio de Janeiro, 14 June, 1992.

[12] Johannesburg Declaration on Sustainable Development adopted at the World Summit on Sustainable Development, Johannesburg, 4 September, 2002.