African Health Policy Alliance

AFRICAN PERSPECTIVES ON PREVENTIVE HEALTH

Towards Proactive, Fiscally Sustainable and Equitable Health Systems

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Dr Kenneth L Jacobs

Managing Director: African Health Policy Alliance

kljacobs@africanhealthpolicyalliance.com

https://www.africanhealthpolicyalliance.com

1. Executive Summary

The Problem

African health systems are reaching the limits of an inherited model. The reactive, curative approach that most of the continent still relies on is neither epidemiologically adequate nor fiscally sustainable. Demographic pressure is rising, the communicable disease burden remains unfinished, non-communicable diseases (NCDs) are accelerating, and structural underfunding persists. Against this backdrop, the case for a decisive pivot toward prevention is no longer contested in principle. The open question is one of pace, financing and execution.

The Central Argument

Africa carries roughly 24 percent of the global disease burden but commands only about 3 percent of global health expenditure. No amount of curative spending alone can close that gap. Prevention offers a structurally different return: each US$1 invested in preventive primary care avoids an estimated US$6 to US$14 in downstream curative cost, and broader economic modelling places the return on expanded primary health care at close to US$10 per dollar invested. The continent already holds proof of concept. Rwanda and Ethiopia have shown that community-based architectures deliver transformative outcomes at low per-capita cost. Yet most Sub-Saharan systems remain in what Africa CDC terms the curative consumption trap, directing scarce resources to expensive tertiary care while underinvesting in the primary and preventive services that would reduce that demand in the first place.

Core Policy Messages

CORE POLICY MESSAGES
1. Prevention delivers superior fiscal returns. Each US$1 in preventive primary care avoids an estimated US$6 to US$14 in downstream curative spending.
2. Regional heterogeneity demands differentiated strategies. North African systems lead on preventive capacity; Sub-Saharan systems need targeted infrastructure and workforce investment.
3. The triple burden is accelerating. Communicable disease, NCDs and malnutrition co-exist and compound, requiring integrated multi-sector frameworks.
4. Domestic resource mobilisation is essential. Aid volatility and declining ODA make predictable domestic financing the cornerstone of sustainable prevention.
5. Community health workers are the highest-leverage investment. Programmes in Rwanda, Ethiopia and Ghana combine reach, cultural competency and cost-effectiveness at scale.

This paper synthesises continental perspectives, structural challenges and proven implementation experience across five analytical frames: the epidemiological and economic case for prevention; regional heterogeneity; the triple burden of disease; the fiscal and financing environment; and evidence-based models for delivery. It concludes with ten policy recommendations addressed to national governments, Africa CDC, regional economic

communities and development partners, each designed to be actionable within a three-to-five year planning horizon.

2. The Imperative for Preventive Health

The case for prevention in Africa is self-evident and chronically under-acted upon. The continent bears approximately 24 percent of the global disease burden while commanding only around 3 percent of global health expenditure, a structural imbalance that no amount of curative investment alone can correct. It is also the world's fastest-growing region by population, with the working-age cohort projected to exceed one billion by 2035. How African states build and sustain the health of that population will shape not only continental wellbeing but global economic prospects. Prevention operates across three levels: primary prevention addresses the determinants of disease before onset; secondary prevention targets early detection and intervention; and tertiary prevention manages chronic conditions to forestall deterioration and disability. Africa's systems underperform at all three. Coverage gaps in immunisation, antenatal care, screening and community outreach remain wide even where institutional and technological solutions are increasingly within reach.

The African Preventive Health Summit is a pivotal opportunity to place preventive care at the centre of continental health system design. Its preparatory dialogues require a rigorous, regionally differentiated evidence base that maps both the constraints and the practical pathways available to policymakers. This paper draws on peer-reviewed public health literature, WHO and Africa CDC institutional data, World Bank health financing metrics and country-level case evidence. It situates preventive health within its epidemiological and economic context, maps regional heterogeneity, analyses the triple burden, examines social determinants and the financing landscape, reviews delivery models with demonstrated impact, sets out the New Public Health Order framework, and presents a set of prioritised recommendations followed by concluding observations.

3. The Epidemiological and Economic Context

3.1 A Continent under Compound Pressure

Africa's epidemiological profile is distinctive in its complexity. Where other regions have progressively shifted toward NCDs, much of Sub-Saharan Africa still carries an unfinished communicable disease agenda alongside a fast-growing NCD burden. Malaria remains a leading cause of child mortality across tropical Africa. HIV/AIDS, despite major therapeutic advances, generates a large chronic care load in Southern and Eastern Africa. Tuberculosis incidence remains stubbornly high, and lower respiratory infections account for a disproportionate share of under-five deaths. Superimposed on this is the rise of NCDs. WHO projects that by 2030 NCDs will be the leading cause of death in Sub-Saharan Africa, driven by cardiovascular disease, diabetes, cancer and chronic respiratory disease, and accelerated by urbanisation, dietary transition, tobacco, alcohol and physical inactivity. An estimated 10.9

million people die from NCDs in Africa each year, at an economic cost measured in hundreds of billions of dollars annually.

3.2 The Economic Case for Prevention

The economic logic of prevention is well established and particularly compelling in the African context. Primary and secondary prevention yield benefit-cost ratios far exceeding those of curative intervention. A landmark Lancet Commission analysis estimated that every US$1 invested in expanding primary health care generates a return of approximately US$10 in broader economic value once reduced mortality, improved productivity and long-term fiscal savings are accounted for.

Indicator	Value / Status
Return on US$1 invested in primary health care (Lancet Commission)	**~US$10**
Share of global disease burden carried by Africa	**~24%**
Africa's share of global health expenditure	**~3%**
Annual deaths from NCDs in Africa (WHO estimate)	**~10.9 million**
Projected NCD share of SSA mortality by 2030	**Leading cause**
Government health expenditure as % of GDP (SSA)	**~2–4%**
Rwanda community health insurance coverage	**>96%**
Recent decline in ODA for African health	**~70% reduction**

The costs of under-investment compound over time. Delayed or absent primary care raises the probability of late-stage diagnosis across both communicable and non-communicable categories, turning manageable, low-cost conditions into costly, complex ones. Systems trapped in curative spending face ever-expanding demand for hospital-based care, pushing budgets upward even as outcomes stagnate. For governments operating under tight fiscal envelopes this is a form of developmental self-defeat. The human capital dimension reinforces the point: children who receive adequate nutrition, immunisation and primary care perform better in school and enter the labour force with greater cognitive capacity, and adults who avoid chronic disease remain productive for longer. Health capital is among the most productive investments available to low- and middle-income economies.

3.3 From the Curative Trap to the Proactive Paradigm

Breaking the curative consumption trap requires deliberate institutional and fiscal choices: reallocating budget toward primary and community care; restructuring incentives so that prevention is rewarded rather than penalised; and building the data infrastructure needed to measure and attribute preventive outcomes. The direction of travel is encouraging even where the pace is uneven. Africa CDC's New Public Health Order, launched in 2021, provides continental institutional backing for the shift, embedding prevention within its pillars of health sovereignty, infrastructure resilience and proactive preparedness. That normative leadership

signals to member states, donors and investors that preventive systems are the expected design standard rather than the exception.

4. Regional Perspectives and Heterogeneity

Africa is not a monolith. Its 54 states span a wide range of income levels, governance models, infrastructure endowments and epidemiological profiles. Any serious analysis of prevention must engage this heterogeneity, both to avoid misleading generalisation and to identify the region-specific pathways most likely to succeed.

4.1 North Africa: Highest Capacity, Emerging NCD Challenge

North African states, including Egypt, Morocco, Tunisia, Algeria and Libya, generally report the highest standardised preventive capacity and disease detection scores on the continent. This reflects several structural advantages: higher income levels, more established public health infrastructure, longer-standing primary care networks, and greater integration of health policy with regional blocs such as the Arab League and Mediterranean partnerships. Immunisation coverage is among the highest in Africa, and maternal and child outcomes are significantly better than Sub-Saharan averages, with life expectancy above 73 years in Morocco and Tunisia against a Sub-Saharan average near 60. The central challenge for this sub-region is the management of an accelerating NCD burden, driven by nutritional transition toward processed foods, rising sedentary behaviour and high tobacco use. Egypt faces adult diabetes prevalence above 17 percent, among the highest in the world, and a cardiovascular burden that is rapidly consuming hospital capacity.

4.2 East Africa: CHW Innovation and System Resilience

East Africa hosts some of the continent's most cited preventive innovations, led by Rwanda's community-based health insurance and Ethiopia's Health Extension Programme. Rwanda's Mutuelle de Santé, established in 2004, has achieved coverage above 96 percent, sharply reducing out-of-pocket spending and enabling early preventive intervention at scale through integration with community health worker networks, premium subsidies for the poorest quintiles and strong government coordination. Ethiopia's Health Extension Programme, launched in 2003, deployed over 40,000 female Health Extension Workers across rural communities and contributed to a halving of under-five mortality within a decade. Both models show that community-level infrastructure can deliver transformative outcomes in resource-constrained settings where institutional commitment, financing and community trust are secured.

4.3 West Africa: Expanding Capability amid Constraints

West Africa presents a more complex and varied picture. Ghana and Senegal have made significant strides in primary care infrastructure and shown strong political commitment to universal health coverage. Ghana's National Health Insurance Scheme, while facing fiscal sustainability challenges, has substantially expanded access to preventive services, and

Senegal has been notably effective in integrating community health workers into its national strategy and demonstrating good practice in community-based NCD screening. Large parts of West Africa, however, particularly the Sahel sub-region encompassing Mali, Niger, Burkina Faso and Chad, face extreme preventive capacity constraints. Per-capita government health expenditure in these countries is among the lowest globally, health workforce density is severely inadequate, and conflict and climate shocks have repeatedly disrupted health system functioning. The Sahel's combination of communicable disease, malnutrition and emergent NCDs is among the most acute anywhere on the continent.

4.4 Southern Africa: Advanced Infrastructure, Structural Inequity

Southern Africa contains the continent's highest-income economies, including South Africa and Botswana, and some of its most developed biomedical research infrastructure. It also carries the world's highest HIV/AIDS burden, which has absorbed a disproportionate share of resources for decades. South Africa's public system, despite its technical sophistication, remains deeply bifurcated: a well-resourced private sector serves a minority while an under-resourced public system carries the majority, distorting preventive investment. Botswana, Namibia and Zimbabwe have made notable progress in HIV prevention through combination programmes integrating treatment as prevention, voluntary medical male circumcision and PrEP, offering a model for multi-modal intervention adaptable to other disease areas.

5. The Triple Burden Framework

A central challenge in designing preventive systems for Africa is the simultaneous co-existence of three distinct disease burdens. Unlike high-income countries that have completed epidemiological transition, or earlier-stage low-income settings where communicable disease dominates, much of Africa faces all three at once, with each burden interacting with and exacerbating the others. This has direct implications for how preventive strategies must be designed, financed and delivered.

5.1 Communicable Diseases: The Unfinished Agenda

Despite generations of investment and major initiatives such as the Global Fund and PEPFAR, communicable diseases remain responsible for a substantial share of mortality across Sub-Saharan Africa. Malaria accounts for roughly 600,000 deaths a year globally, over 90 percent of them in Africa and predominantly among children under five. HIV/AIDS, tuberculosis and vaccine-preventable diseases including measles, meningitis and yellow fever continue to generate large, preventable burdens. COVID-19 revealed both resilience and vulnerability: many states demonstrated strong capacity for contact tracing and community mobilisation, but the pandemic exposed weaknesses in diagnostics, supply chains and the integration of surveillance with primary care. A system that cannot reliably detect and respond to outbreaks also lacks the infrastructure for effective primary prevention.

5.2 Non-Communicable Diseases: The Accelerating Transition

The rise of NCDs is among the most consequential and underappreciated public health trends of the present. Cardiovascular disease, type 2 diabetes, chronic obstructive pulmonary disease and cancer are all increasing at rates that far exceed health system adaptation capacity, and WHO estimates that by 2030 NCDs will overtake communicable diseases as the leading cause of death in Sub-Saharan Africa. The drivers are well documented: urbanisation is altering dietary patterns, physical activity and social determinants of health; tobacco use is subject to minimal taxation and regulation in many countries; alcohol consumption is rising; and processed food marketing, enabled by liberalised trade and expanding retail infrastructure, is transforming diets in ways that elevate cardiovascular and metabolic risk. The prevention implications are significant, because most major NCD risk factors are modifiable through a combination of fiscal policy, regulatory intervention and behavioural programming. WHO's best buys for NCD prevention, including tobacco taxation, alcohol policy, salt reduction and hypertension screening, are within reach of most governments but require political will and institutional capacity that remain unevenly distributed.

5.3 Malnutrition: A Multi-Directional Burden

The malnutrition dimension is distinctive in its directionality. Africa faces simultaneous problems of undernutrition, including stunting, wasting and micronutrient deficiency that disproportionately affect children and pregnant women, and overnutrition, including overweight and obesity rising rapidly among urban populations. These are not contradictory trends but different manifestations of a food system in rapid transformation. Stunting remains highly prevalent across much of Sub-Saharan Africa, affecting nearly one in three children under five. Stunted children face elevated infectious disease risk, reduced cognitive development and poorer economic outcomes across the life course, and micronutrient deficiencies in iron, zinc, iodine and vitamin A are widespread and interact with communicable disease susceptibility. At the same time the rapid rise of overweight and obesity in urban populations is generating a new wave of NCD risk that coexists with, and in many households literally co-resides with, undernutrition. Preventive strategy must therefore address both ends of the spectrum at once, combining community nutrition education, fortification, school feeding, regulation of unhealthy food marketing to children, and social protection that addresses food insecurity.

6. Social Determinants and Structural Barriers

Health outcomes in Africa are shaped not only by the availability and quality of services but by the broader structural conditions in which people live: income, education, employment, housing, sanitation and safety. Strategies that address only the proximate determinants of disease, such as pathogens, risk behaviours and individual choices, while ignoring the structural conditions that generate and sustain those risk factors are unlikely to achieve

durable population-level change. A defining feature of the literature on African health systems is precisely this central role of social determinants.

6.1 Poverty and Health Access

Poverty is the most pervasive social determinant of health in Africa. Low income constrains access to preventive services through several channels: inability to pay for consultations, medicines and transport; the opportunity cost of seeking care, including lost wages and childcare; and the cognitive and motivational burden of managing economic precarity. Catastrophic health expenditure, defined as out-of-pocket spending above 10 percent of household consumption, affects a significant share of African households, particularly in the lowest income quintiles. This is not only a humanitarian concern but an economic one. Health-poverty traps, in which illness generates income loss that in turn constrains health investment, are a well-documented feature of low-income health dynamics.

6.2 Education, Gender and Behaviour

Educational attainment is among the strongest predictors of health-seeking behaviour, preventive care uptake and health literacy across African contexts. Women's education in particular has a multiplier effect: educated women tend to have fewer children, space births more appropriately, access antenatal care more consistently, and make better-informed decisions about nutrition and child health. Gender inequalities in health access remain significant, with social norms in many communities continuing to restrict women's mobility, decision-making autonomy and access to information. Preventive programmes that do not actively address gender dynamics risk reproducing existing inequities rather than reducing them.

6.3 Sanitation, Housing and the Urban Challenge

Access to safe water, adequate sanitation and decent housing is foundational to communicable disease prevention. Diarrhoeal diseases, almost entirely preventable through clean water and sanitation, remain among the leading causes of child death in Africa, and respiratory infections spread more easily in overcrowded, poorly ventilated housing. As Africa's urban population expands toward a projected 1.5 billion by 2050, the health profile of informal settlements and peri-urban communities becomes increasingly central to continental disease burden. Urban preventive strategies must contend with informal economies, irregular service delivery and the particular vulnerability of migrant populations.

6.4 Climate Change as a Health Determinant

Climate change is increasingly recognised as a direct and escalating determinant of African health outcomes. Rising temperatures expand the geographic range of malaria-transmitting mosquitoes, threaten food production and nutritional status, and increase the frequency and intensity of extreme weather events that displace populations and disrupt health infrastructure. Drought in the Horn of Africa has been linked directly to increases in acute malnutrition and to cholera and yellow fever outbreaks, as water scarcity compromises sanitation and hygiene.

Preventive planning must therefore incorporate climate risk into its analytical frameworks, an integration that remains nascent in most national health strategies.

7. Financing Preventive Health

Sustainable preventive systems require sustainable financing, and Africa's financing landscape has been significantly disrupted in recent years. Understanding its structure, current pressures and available policy tools is essential to any realistic assessment of how prevention can be scaled.

7.1 The External Aid Shock

African health systems have historically depended heavily on external development assistance for health, which financed a significant share of HIV/AIDS treatment, immunisation and primary care infrastructure across many Sub-Saharan countries. Evidence suggests that external health assistance to Africa has declined by as much as 70 percent in recent years, driven by donor fiscal pressures, shifting geopolitical priorities and, in the case of certain funding streams, policy changes that have disrupted established financing flows. The shock is not uniformly distributed: higher-dependency states, typically lower-income, fragile or conflict-affected, have absorbed the largest absolute impacts, while even countries with more diversified financing have experienced disruption to specific programme areas, particularly HIV/AIDS and TB, with downstream effects on the wider health system. The contraction has made the case for domestic resource mobilisation not merely a matter of principle but of immediate operational necessity.

7.2 The Abuja Target and Fiscal Reality

The 2001 Abuja Declaration set a target of 15 percent of national budgets allocated to health. More than two decades on, most African countries remain well below it, with government health spending in Sub-Saharan Africa averaging roughly two to four percent of GDP. The shortfall reflects competing priorities such as debt service and security, limited fiscal space from low tax mobilisation, and in some cases governance constraints on budget execution. Closing the gap requires expanding the tax base, improving budget execution efficiency, and building the political constituency for preventive investment among decision-makers who typically face incentives oriented toward visible, curative and electorally salient spending.

7.3 Innovative Financing Mechanisms

Several instruments are directly relevant. Health taxes on tobacco, alcohol and increasingly sugar-sweetened beverages serve a dual function, generating dedicated revenue while reducing consumption of leading NCD risk factors. WHO evidence on tobacco taxation is compelling: a 10 percent price increase produces roughly a four to five percent reduction in consumption while raising revenue that can be earmarked for health promotion. Kenya, South Africa and Tanzania have implemented earmarked tobacco levies with demonstrable impact. Risk-pooling mechanisms, including community-based and national social health insurance,

are critical to extending preventive access to low-income populations. Evidence from Rwanda, Ethiopia and Ghana shows that community insurance, when subsidised for the poorest households and well administered, can approach universal coverage at affordable cost, provided actuarial design, premium review and integration with social protection are handled carefully.

FINANCING PRINCIPLES FOR SUSTAINABLE PREVENTIVE SYSTEMS
Predictability. Multi-year commitments reduce the volatility that disrupts preventive programme continuity.
Risk pooling. Community and national insurance spread risk across income groups, enabling access for the poorest.
Earmarking. Health taxes and dedicated levies create durable funding streams insulated from annual budget competition.
Efficiency. Unit cost analysis and results-based financing improve returns on preventive expenditure.
Integration. Financing reform must be embedded within broader public financial management modernisation.

8. Implementation Models: Evidence from Practice

The strongest argument for preventive investment is empirical, not theoretical. A growing body of evidence shows that well-designed, adequately funded preventive programmes deliver transformative outcomes at scale. This section reviews the clearest examples and the design features most consistently associated with success.

8.1 Community Health Worker Programmes

Community health workers have emerged as one of the most cost-effective instruments available to African systems for the delivery of preventive services. By deploying trained lay community members as advocates, educators and basic care providers within their own communities, CHW programmes combine geographic reach with cultural competency and social trust in ways that facility-based services cannot replicate. Ethiopia's Health Extension Programme, which by 2015 had deployed over 40,000 workers to rural communities, contributed to an estimated 75 percent reduction in maternal mortality and a 68 percent increase in antenatal care coverage between 2000 and 2015. Rwanda's Community Health Worker Programme, which supports over 45,000 CHWs organised into Village Health Teams, has been instrumental in achieving over 95 percent immunisation coverage and near-universal use of insecticide-treated bed nets for malaria prevention. Ghana's Community-based Health Planning and Services initiative, which places health compound officers in sub-district communities, has improved coverage of antenatal care, child nutrition screening and immunisation, particularly in rural and northern regions.

The design features common to successful programmes are consistent across settings: community selection and accountability mechanisms that build trust and sustainability;

adequate compensation, whether monetary or non-monetary, that sustains motivation; strong supervisory links to the formal health system; regular training and skills refreshment; and integration with referral pathways that ensure workers can connect clients to higher-level care when needed.

8.2 Universal Health Coverage: Rwanda's Model

Rwanda's Mutuelle de Santé is among the most cited examples of successful universal health coverage in a low-income setting. Established in 1999 and scaled progressively from 2004, it has achieved membership above 96 percent through income-stratified premiums ranging from near-zero for the poorest to modest fees for higher-income groups, strong government support, and active mobilisation through CHW networks. The scheme covers preventive and primary care without co-payment at point of use, creating incentives for early engagement, and evaluations document significant reductions in out-of-pocket spending alongside improvements in child nutrition and immunisation. The experience shows that near-universal preventive coverage is achievable at low per-capita income where institutional commitment, community ownership and adequate public subsidy are sustained.

8.3 Behaviour Change and Health Communication

Preventive outcomes are ultimately shaped by behaviours at individual, household and community levels. Shifting them requires sustained investment in communication that is culturally resonant, locally accessible and evidence-based. Social and behaviour change communication is highly cost-effective, particularly when embedded within CHW programmes and integrated with mass media. Radio remains the most pervasive medium across Sub-Saharan Africa, and radio-based HIV prevention campaigns have produced measurable changes in testing and condom use. Mobile-phone messaging, including SMS reminders for immunisation, antenatal visits and medication adherence, has shown strong efficacy where network coverage is adequate, though design must account for gender and age differentials in phone ownership and digital literacy.

8.4 Lifestyle Modification and NCD Prevention

African practice increasingly addresses lifestyle modification as a primary and secondary NCD prevention strategy. Programmes combining dietary counselling, physical activity promotion, tobacco cessation and hypertension screening have been implemented in Ghana, South Africa, Kenya and Senegal, and group-based models facilitated by trained workers show particular promise in scalability and acceptability. Integrating NCD prevention into primary care, so that blood pressure measurement, glucose screening and brief counselling become routine, is both feasible and cost-effective. South Africa's Integrated Chronic Disease Management model and Kenya's primary care NCD integration show how system redesign can embed prevention within existing infrastructure without standing up parallel vertical programmes.

9. The New Public Health Order Framework

Africa CDC's New Public Health Order is the most significant normative framework for continental health system transformation to emerge in recent decades. Launched by Director-General Dr Jean Kaseya in 2021, it provides an institutional and strategic architecture for the shift from fragmented, reactive responses toward integrated, proactive and sovereignty-oriented systems. It is organised around three interconnected pillars.

- **Health sovereignty.** The framework asserts Africa's right and responsibility to design, finance, manufacture and govern its own health systems and medical countermeasures. This includes the rapid expansion of African pharmaceutical manufacturing capacity, a priority underscored by the pandemic's disruption of global vaccine supply chains, and the development of continental policy frameworks that reflect African epidemiological realities rather than external assumptions.
- **Infrastructure resilience.** The framework emphasises physical and institutional health infrastructure that is robust to shocks, whether epidemiological such as pandemics and outbreaks, climatic such as droughts and floods, or geopolitical such as supply chain disruptions and aid shocks. This includes investment in laboratory networks, disease surveillance, immunisation cold chains and health information systems.
- **Proactive pandemic preparedness.** Drawing on lessons from COVID-19, Ebola and mpox, the framework prioritises standing preparedness capacity over the reactive, ad hoc emergency responses that have historically characterised Africa's outbreak response. This includes the Africa Pathogen Genomics Initiative, the Africa Medical Supplies Platform and the institutionalisation of One Health approaches that integrate human, animal and environmental surveillance.

Within this frame, prevention is not merely a technical intervention but a dimension of health sovereignty: the ability to maintain population health independently of external aid, to anticipate threats before they escalate, and to govern health decisions in line with African priorities. The framework is embedded within the wider African Union agenda, including Agenda 2063 and the Africa Health Strategy 2016 to 2030. The Summit's preparatory dialogues can translate this normative consensus into concrete national commitments, ideally generating country-specific prevention roadmaps that align with the framework while reflecting differentiated regional realities.

10. Policy Recommendations

The following ten recommendations are addressed to national governments, Africa CDC, regional economic communities and development partners. They are grounded in the evidence reviewed here and organised around five action clusters: financing, data, workforce, cross-sector integration and international cooperation. Each is designed to be actionable within a three-to-five year horizon.

#	Recommendation	Rationale	Lead / Timeline
R1	**Establish dedicated preventive health budget lines with multi-year commitments**	Predictable, ring-fenced budgets sustain CHW programmes and primary care; annual budgeting creates unsustainable volatility.	Finance & Health Ministries · 1–2 yrs
R2	**Implement or scale health taxes on tobacco, alcohol and SSBs**	Best-buy evidence shows dual fiscal and epidemiological returns; earmarked revenue funds prevention while cutting NCD risk.	Revenue Authorities · 1–3 yrs
R3	**Scale community health worker programmes with adequate compensation**	Ethiopia, Rwanda and Ghana show transformative impact at low per-capita cost when pay, training and supervision are adequate.	Health Ministries · 2–4 yrs
R4	**Implement community or national insurance with pro-poor subsidies**	Rwanda's Mutuelle shows UHC feasibility at low income; subsidies for the poorest quintiles are essential to access.	Health & Social Protection · 3–5 yrs
R5	**Establish standardised longitudinal preventive health data registries**	Data gaps prevent ROI measurement; registries enable evidence-based allocation and benchmarking.	Statistics Offices · 2–3 yrs
R6	**Integrate NCD prevention into all primary care encounters**	Routine BP, glucose and BMI screening is cost-effective and avoids vertical programme duplication.	Primary Care Platforms · 2–4 yrs
R7	**Develop nationally contextualised SBCC strategies with community co-design**	Behaviour change at scale requires culturally resonant communication; external templates underperform.	Health Communication Units · 1–2 yrs
R8	**Embed climate risk analysis in national health strategic plans**	Climate-driven health impacts require anticipatory planning absent from most current strategies.	Health & Environment · 2–3 yrs
R9	**Align national prevention strategies with the New Public Health Order**	Alignment ensures coordination, technical support and eligibility for continental financing.	Governments / Africa CDC · Immediate
R10	**Establish REC-wide preventive health performance scorecards**	Regional benchmarking creates peer accountability and sustains ministerial commitment.	Regional Economic Communities · 2–3 yrs

Not all recommendations carry equal urgency. For governments at early stages of reform, R1 on budget lines, R3 on CHW scale-up and R9 on framework alignment are the highest-leverage, lowest-barrier starting points. For more advanced systems, R2 on health taxes, R5 on data registries and R6 on NCD integration represent the most impactful next tier. Development partners are encouraged to prioritise R5 and R8, where technical assistance

and co-financing can generate outsized returns and where the global public-goods character of the outputs justifies international support.

11. Conclusion

Africa's transition toward preventive health systems is not merely a technical challenge but a foundational dimension of the continent's development trajectory. Systems that prioritise prevention will produce healthier, more productive populations, reduce the fiscal burden of preventable disease, and build the human capital that Agenda 2063 requires. The evidence reviewed here shows that the path is clear, the tools are available and the models exist. What remains is political commitment, predictable financing and the institutional infrastructure to translate intent into action at scale.

The Summit arrives at a moment of acute urgency, with external financing contracting, the triple burden intensifying and a narrowing window to address NCD trends before they entrench. It also arrives at a moment of genuine momentum, with the New Public Health Order, the expansion of CHW programmes across multiple regions, and the growing political salience of universal coverage providing a foundation for accelerated progress. The preparatory dialogues must move beyond diagnosis to action. This paper offers the evidence architecture for that transition. The goal, preventive systems that are equitable, resilient and fiscally sustainable, is both achievable and essential.

SUMMIT PREPARATORY DIALOGUE FOCUS AREAS
Dialogue 1 — Financing. How can governments create predictable domestic funding streams insulated from ODA volatility?
Dialogue 2 — Workforce. What design features allow CHW programmes to achieve and sustain transformative impact?
Dialogue 3 — Data. What minimum data infrastructure enables evidence-based preventive investment decisions?
Dialogue 4 — Integration. How can systems be redesigned to address poverty, education and sanitation as systemic prevention?
Dialogue 5 — Regional coordination. What role should RECs play in harmonising standards, benchmarking and cross-border knowledge transfer?

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