African Health Policy Alliance

REPORT ON THE AFRICAN SUMMIT ON PREVENTIVE HEALTH

NATIONAL HEALTHCARE SYSTEM SUSTAINABILITY AND THE ROLE OF PREVENTIVE HEALTH

HELD ON 29–30 OCTOBER 2026 AT THE SUN SQUARE CITY BOWL HOTEL, CAPE TOWN, SOUTH AFRICA

CONVENED AND HOSTED BY AFRICAN HEALTH POLICY ALLIANCE

ACKNOWLEDGEMENTS

The Summit would like to express its sincere appreciation to the African Health Policy Alliance (AHPA) for convening the Summit, and to the Parliament of South Africa, through the Portfolio Committee on Health, for supporting it. Appreciation is also extended to the Planning Committee of the Summit (Dr Kenneth Jacobs, Patrick Mugirwa, Mark Nabasa, Evaline Kibuchi, Paidamoyo Magaya, Gotthard Kasuto and Sunge Kalumo); to NEAPACOH and the Global TB Caucus; to the Partners in Population and Development Africa Regional Office (PPD ARO), the African Institute for Development Policy (AFIDEP), WACI Health, Afrocentric and all presenters, moderators, discussants and partners whose contributions enriched the deliberations.

The Summit also expresses special thanks to Hon Mokhothu Makhalanyane (Chair of Chairs in the National Assembly of Lesotho) for performing the task of Programme Director and Chairperson of the two-day Summit so excellently; to Hon Cedric Frolick (House Chairperson, National Assembly, Parliament of South Africa) for an excellent keynote address; to Her Excellency Wang Xiao, Acting Consul General of the People's Republic of China in Cape Town for the message of support and Hon Dr Charles Ayume (Minister of State for Health for Primary Health Care, Government of Uganda) for the very insightful opening address.

THIS SUMMIT WAS DEDICATED TO GREGORY ALTON JACOBS, WHO PASSED ON 14 OCTOBER 2026 AT AGE 57 – AN EARLY DEATH THAT COULD HAVE BEEN PREVENTED BY EARLY DIAGNOSIS, PROPER REFERRAL, APPROPRIATE AND QUALITY HEALTH CARE.

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ABBREVIATIONS

No.	Abbreviation	Full Name
1	AFIDEP	African Institute for Development Policy
2	AHPA	African Health Policy Alliance
3	AIDS	Acquired Immune Deficiency Syndrome
4	AU	African Union
5	CHW	Community Health Worker
6	ComBaCaL	Community-Based Chronic Care Lesotho
7	COPC	Community-Oriented Primary Care
8	COVID-19	Coronavirus Disease 2019
9	CPA	Commonwealth Parliamentary Association
10	CSO	Civil Society Organisation
11	DRC	Democratic Republic of the Congo
12	EAC	East African Community
13	ECOWAS	Economic Community of West African States
14	FOCAC	Forum on China–Africa Cooperation
15	GDP	Gross Domestic Product
16	GTBC	Global TB Caucus
17	HbA1c	Glycated Haemoglobin
18	HIV	Human Immunodeficiency Virus
19	HPV	Human Papillomavirus
20	IPC	Infection Prevention and Control
21	IPU	Inter-Parliamentary Union
22	KES	Kenyan Shilling
23	NCDs	Non-Communicable Diseases
24	NEAPACOH	Network of African Parliamentary Committees on Health
25	NGO	Non-Governmental Organisation
26	PEPFAR	United States President's Emergency Plan for AIDS Relief

No.	Abbreviation	Full Name
27	PPD ARO	Partners in Population and Development Africa Regional Office
28	PPPs	Public-Private Partnerships
29	ROI	Return on Investment
30	SADC	Southern African Development Community
31	TB	Tuberculosis
32	TBI	Tony Blair Institute for Global Change
33	UHC	Universal Health Coverage
34	UNAIDS	Joint United Nations Programme on HIV/AIDS
35	UNFPA	United Nations Population Fund
36	UNICEF	United Nations Children's Fund
37	US	United States
38	WHO	World Health Organization

CHAPTER 1 – SUMMIT INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION AND BACKGROUND

1.1.1 Africa's health systems are approaching a critical tipping point. Healthcare costs in the African and Middle Eastern regions are projected to increase by 11.3% in 2026,[1] significantly outpacing economic growth and placing further pressure on already constrained national budgets. At the same time, the burden of non-communicable diseases (NCDs) has increased substantially, with their contribution to deaths in Africa rising from 24% in 2000 to 37% in 2019.[2] The number of tuberculosis (TB) cases in the African region was estimated at 2.62 million in 2024,[3] disproportionately affecting economically active populations and perpetuating cycles of poverty. Furthermore, reductions in US foreign assistance in 2025 exposed the vulnerability of health systems heavily dependent on external financing, placing access to essential healthcare services at risk.[4]

1.1.2 These pressures are compounded by demographic change, rapid urbanisation and the growing health impacts of climate change. Collectively, they highlight the limitations of reactive, treatment-centred healthcare systems and underscore the need for a fundamental shift towards prevention, health promotion, early detection and intervention.

1.1.3 The economic case for this transition is compelling. The World Health Organization (WHO) has highlighted the substantial returns on investment in preventive health, estimating that every US$1 invested in addressing NCDs in low and lower-middle-income countries by 2030 can generate approximately US$7 in economic benefits through reduced healthcare costs and improved productivity.[5] Despite these benefits, preventive health remains underfunded and insufficiently integrated into health policy, national planning and public budgeting processes across much of Africa.

1.1.4 It was against this background that the AHPA convened the African Summit on Preventive Health to stimulate policy dialogue, strengthen political commitment and promote preventive health as a strategic priority for improving population health, strengthening health systems and ensuring long-term fiscal and economic sustainability.

1.2 RATIONALE AND SIGNIFICANCE OF THE SUMMIT

1.2.1 The African Summit on Preventive Health was convened in response to the growing imperative for African countries to strengthen the sustainability, resilience and responsiveness of their healthcare systems. Across the continent, health systems face mounting pressures arising from the increasing burden of communicable diseases and

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[1] WTW. (2025, November 11). *Double-digit healthcare cost increases projected to persist into 2026 and beyond*. https://www.wtwco.com/en-gb/news/2025/11/double-digit-healthcare-cost-increases-projected-to-persist-into-2026-and-beyond; WTW. (2025). *2026 global medical trends survey*. https://www.wtwco.com/en-gb/insights/2025/10/2026-global-medical-trends-survey

[2] World Health Organization Regional Office for Africa. (2022). *Deaths from noncommunicable diseases on the rise in Africa*. https://www.afro.who.int/news/deaths-noncommunicable-diseases-rise-africa

[3] World Health Organization. (2025). *Global tuberculosis report 2025*, Section 1.1: TB incidence. https://www.who.int/teams/global-programme-on-tuberculosis-and-lung-health/tb-reports/global-tuberculosis-report-2025/tb-disease-burden/1-1-tb-incidence

[4] Chatham House. (2025, October 16). *Africa after USAID: Who will pay the health bill?*. https://www.chathamhouse.org/2025/10/africa-after-usaid-who-will-pay-health-bill

[5] World Health Organization. (2021, December 13). *Investing 1 dollar per person per year could save 7 million lives in low- and lower-middle-income countries*. https://www.who.int/news/item/13-12-2021-investing-1-dollar-per-person-per-year-could-save-7-million-lives-in-low-and-lower-middle-income-countries; World Health Organization. (2018, May 16). *Investing in noncommunicable disease control generates major financial and health gains*. https://www.who.int/news/item/16-05-2018-investing-in-noncommunicable-disease-control-generates-major-financial-and-health-gains

NCDs, rising healthcare costs, demographic transitions and constrained public resources. These challenges highlight the limitations of healthcare approaches that concentrate predominantly on treating illness rather than preventing disease, promoting health and enabling early detection and intervention.

1.2.2 Despite the recognised public health and economic benefits of preventive health, investment in prevention remains insufficiently prioritised in many national health policies, planning and budgeting processes. Preventive interventions are frequently fragmented or inadequately financed, while public health expenditure continues to be driven largely by immediate treatment and service delivery demands. There is therefore a need to strengthen the integration of preventive health into primary healthcare systems, national development priorities and public financing frameworks, supported by sustainable domestic resource mobilisation and more efficient allocation of available resources.

1.2.3 The Summit was premised on the recognition that preventive health should be regarded not merely as a health-sector responsibility, but as a strategic investment in human capital, economic productivity and national development. Investment in prevention can reduce the burden of avoidable diseases, contain long-term healthcare expenditure, improve workforce participation and productivity, and contribute to stronger and more sustainable economies. Realising these benefits requires sustained political leadership, enabling policy and legislative frameworks, sustainable financing and coordinated action across government sectors and other stakeholders.

1.2.4 A central consideration in convening the Summit was the need to strengthen the relationship between health policy priorities and national fiscal decision-making. The participation of Chairpersons and Members of Parliament serving on Health, Finance and Budget Committees provided an important platform for dialogue between those responsible for health policy and those involved in public resource allocation, budgeting and oversight. This engagement was intended to strengthen political commitment, promote the prioritisation of preventive health in national budgets and enhance parliamentary oversight of health financing and implementation.

1.2.5 The Summit also recognised the importance of African-led approaches and regional collaboration in addressing shared health system challenges. By bringing together parliamentarians, policymakers, academics, clinicians, researchers, health economists, development partners, technical experts, civil society and private-sector representatives, the Summit provided an opportunity to share country experiences, examine evidence, identify practical policy and financing solutions, and strengthen partnerships to advance preventive health across the continent.

1.2.6 Against this background, the Summit sought to establish a common understanding of preventive health as a cornerstone of sustainable healthcare systems, generate practical policy recommendations and develop a shared framework for action. It aimed to translate dialogue into actionable policy priorities, strengthen parliamentary engagement and promote the integration of preventive health into national health and development agendas.

1.2.7 The deliberations culminated in the adoption of the **Cape Town Declaration on Preventive Health**, providing a common framework for continued advocacy, collaboration and coordinated action towards positioning preventive health more firmly within Africa's health and development priorities.

1.3 SUMMIT THEME

1.3.1 The Summit was convened under the theme **Preventive Health: National Healthcare System Sustainability and the Role of Preventive Health**.

1.3.2 The theme emphasised the strategic importance of preventive health in strengthening healthcare systems, improving population health and promoting long-term fiscal and socio-economic sustainability.

1.4 SUMMIT OBJECTIVES

1.4.1 Overall Objective

1.4.1.1 To strengthen political commitment and multi-stakeholder collaboration towards positioning preventive health as a central pillar of resilient, responsive and sustainable healthcare systems in Africa, recognising its contribution to improved population health, fiscal sustainability, human capital development and socio-economic transformation.

1.4.2 Specific Objectives

1.4.2.1 The Summit sought to:

1. **Promote preventive health as a strategic policy and development priority** by strengthening understanding of its contribution to universal health coverage, health equity, access to quality healthcare, improved population health and sustainable health systems.
2. **Strengthen political leadership and parliamentary engagement** through dialogue among Chairpersons and Members of Parliament serving on Health, Finance and Budget Committees, with a view to aligning health priorities with national fiscal policies, budgetary allocations, legislation and parliamentary oversight.
3. **Examine innovative and sustainable health financing approaches** that position prevention as a long-term public investment, including domestic resource mobilisation, integrated primary healthcare financing and the incorporation of costed preventive health interventions into national budgets and development plans.
4. **Demonstrate the economic and fiscal value of preventive health** by examining its contribution to workforce productivity, human capital development and economic growth, as well as its potential to reduce the long-term costs associated with preventable diseases, absenteeism, disability and economic inactivity.
5. **Promote integrated and equitable preventive healthcare delivery** through stronger primary healthcare systems, community-based interventions, health promotion, early detection, immunisation and screening, particularly for vulnerable and underserved populations.
6. **Facilitate the exchange of African country experiences and best practices** in preventive health policy, financing, programme implementation and governance, identifying opportunities to adapt successful interventions and strengthen African-led approaches to health system development.
7. **Explore the role of innovation, digital health and health informatics** in strengthening preventive healthcare delivery, improving health information systems, supporting evidence-informed decision-making and enhancing monitoring, evaluation and accountability.

8. **Strengthen partnerships and multisectoral collaboration** among governments, Parliaments, academic and research institutions, clinicians, development partners, private-sector organisations and civil society, including non-governmental and community-based organisations, to mobilise expertise, resources and institutional support for preventive health.
9. **Advance legislative and institutional frameworks** that embed preventive health in national health strategies, regulatory frameworks, public financing arrangements and broader development agendas, supported by effective governance and accountability mechanisms.
10. **Develop a common African framework for advancing preventive health** through shared policy priorities and recommendations, culminating in the adoption of the **Cape Town Declaration on Preventive Health** as a platform for sustained political commitment, parliamentary engagement and coordinated continental action.
11. **Promote sustained engagement and implementation** through stronger parliamentary networks, technical collaboration, the establishment of an Expert Group on Preventive Health, knowledge-sharing platforms and regular monitoring of progress against agreed commitments.

1.5 SCOPE OF THE SUMMIT

The Summit addressed a broad range of policy, financing, institutional and implementation issues concerning the role of preventive health in strengthening national healthcare systems and advancing sustainable socio-economic development across Africa. The deliberations focused on integrating preventive health into national health policies, public financing frameworks, primary healthcare systems and broader national development priorities.

The discussions were organised around five thematic pillars:

1.5.1 Resilient, Responsive and Sustainable Health Systems

Examining the contribution of preventive health to stronger and more sustainable health systems, with particular emphasis on primary healthcare, universal health coverage, health equity and access to essential services. Discussions covered community-based healthcare, health promotion, immunisation, screening, early detection and the integration of preventive, promotive, curative and rehabilitative services.

1.5.2 Sustainable Health Financing and Fiscal Management

Exploring innovative and sustainable approaches to financing preventive health, including domestic resource mobilisation, public-sector budgeting, integrated primary healthcare financing and the efficient allocation of health resources. Particular attention was given to the economic and fiscal benefits of prevention and the need to position preventive health as a long-term investment in national development and fiscal sustainability.

1.5.3 Implementation and African Regional Perspectives

Examining country experiences, policy approaches and practical interventions for advancing preventive health across Africa. Discussions provided opportunities to share lessons, identify implementation challenges and explore approaches to strengthening national capacity, adapting successful interventions and promoting African-led solutions.

1.5.4 *Innovation, Data and Accountability*

Exploring the contribution of research, innovation, digital health and health informatics to improving preventive healthcare delivery and health outcomes. Discussions covered the application of evidence and technology in decision-making, strengthening health information systems, monitoring programme implementation, and promoting transparency, institutional accountability and effective parliamentary oversight.

1.5.5 *Partnerships for Resilient Health Systems*

Examining opportunities to strengthen collaboration among national governments, Parliaments, academic and research institutions, healthcare professionals, development partners, the private sector and civil society. Emphasis was placed on multisectoral partnerships, resource mobilisation, knowledge exchange and coordinated action to support the implementation and sustainability of preventive health interventions.

1.5.6 *Cross-Cutting Issues*

In addition to the five thematic pillars, the Summit addressed several cross-cutting issues that underpin the advancement of preventive health across the continent.

a) Parliamentary leadership and accountability

Parliamentary leadership was recognised as a critical enabler of preventive health, particularly in strengthening legislation, policy development, budget allocation and oversight. Emphasis was placed on aligning national health priorities with fiscal decision-making through closer engagement between parliamentary Health, Finance and Budget Committees.

b) Human capital development and economic productivity

The Summit recognised preventive health as an investment in human capital, workforce productivity and economic growth. Discussions highlighted its potential to reduce healthcare expenditure and the economic consequences of preventable diseases, including absenteeism, disability and reduced workforce participation.

c) African ownership and regional collaboration

The Summit provided a continental platform for sharing experiences, strengthening regional partnerships and promoting African-led solutions to common health system challenges. It also sought to advance a common African agenda for integrating preventive health into national and regional development priorities.

1.6 PARTICIPATING COUNTRIES AND CATEGORIES OF DELEGATES

1.6.1 The Summit brought together **64 participants from 13 African countries**, comprising Members of Parliament serving on Health, Finance and Budget Committees, parliamentary staff, academics, researchers, health experts, development partners, private-sector representatives and civil society organisations (CSOs).

1.6.2 The Summit also benefited from the participation of representatives from China, the United Kingdom and Switzerland, contributing international perspectives and experience to the deliberations.

1.6.3 The diversity of participants facilitated dialogue across political, technical, academic and institutional perspectives, providing an opportunity to examine preventive health from both health-system and broader economic and development perspectives.

1.7 THE CONVENING AND SUPPORTING ORGANISATIONS

1.7.1 Convening Organisation

1.7.1.1 **AHPA** is a South African-based health policy platform committed to strengthening evidence-informed policymaking and promoting dialogue and collaboration among decision-makers across Africa. Operating at the intersection of public health, health financing and governance, AHPA seeks to advance policies that strengthen the resilience and sustainability of health systems while contributing to broader economic and development objectives.

1.7.1.2 Through the convening of the African Summit on Preventive Health, AHPA sought to provide a platform for parliamentary leaders, policymakers, technical experts and other stakeholders to examine the role of preventive health in building financially sustainable, socially responsive and resilient healthcare systems. The initiative also aimed to strengthen political commitment and promote coordinated action in response to Africa's evolving demographic, epidemiological and fiscal challenges.

1.7.2 Supporting Organisations

1.7.2.1 Technical support for the Summit was provided by the Network of African Parliamentary Committees on Health (NEAPACOH), the Partners in Population and Development Africa Regional Office (PPD ARO) and members of the Global TB Caucus, which constituted the Summit Planning Committee.

1.7.2.2 Additional support was provided by AFIDEP, WACI Health and Afrocentric.

1.7.2.3 These organisations contributed to the planning and technical preparation of the Summit, supporting its objective of advancing preventive health through parliamentary engagement, policy dialogue and multi-stakeholder collaboration.

1.7.3 Summit Leadership and Key Contributors

1.7.3.1 The Summit brought together speakers and contributors from AHPA, the University of Cape Town, the Tony Blair Institute for Global Change, the University of Basel, AFIDEP and Afrocentric. Their expertise and perspectives enriched the discussions and contributed to the examination of preventive health from public health, economic, policy and institutional perspectives.

1.7.3.2 The keynote address was delivered by **Hon Cedric Frolick**, House Chairperson of the National Assembly of the Parliament of South Africa. The Summit was chaired by **Hon Mokhothu Makhalanyane**, Chair of Chairs of the National Assembly of Lesotho.

1.7.3.3 The opening address was delivered by **Hon Dr Charles Ayume**, Minister of State for Health for Primary Health Care, Government of Uganda. A message of support was delivered by **Her Excellency Wang Xiao**, Acting Consul General of the People's Republic of China in Cape Town.

1.8 STRUCTURE AND ORGANISATION OF THE REPORT

1.8.1 This report is organised into four chapters, providing an account of the African Summit on Preventive Health, its deliberations, key outcomes and recommendations.

Chapter 1: Introduction and Background

1.8.2 Introduces the Summit and outlines its background, rationale, significance, objectives and scope. It also provides an overview of the participating countries, delegates, convening organisation and supporting partners, and explains the structure of the report.

Chapter 2: Summit Proceedings and Deliberations

1.8.3 Presents an account of the proceedings over the two days of the Summit, capturing the presentations, discussions and key observations under the five thematic pillars: resilient, responsive and sustainable health systems; sustainable health financing and fiscal management; implementation and African regional perspectives; innovation, data and accountability; and partnerships for resilient health systems.

Chapter 3: Cape Town Declaration on Preventive Health and Closing Ceremony

1.8.4 Documents the process leading to the presentation, consideration, amendment and adoption of the **Cape Town Declaration on Preventive Health**. It also outlines the proposed way forward, post-Summit actions and proceedings of the closing ceremony.

Chapter 4: Conclusion and Way Forward

1.8.5 Consolidates the key messages emerging from the Summit and highlights the importance of translating its deliberations and commitments into practical action. It identifies the broader implications for strengthening preventive health across Africa and sustaining the momentum generated by the Summit.

1.8.6 The report is accompanied by annexes containing the Summit programme, the **Cape Town Declaration on Preventive Health** and the list of participants.

CHAPTER 2 – SUMMIT PROCEEDINGS AND DELIBERATIONS

DAY ONE: THURSDAY, 29 OCTOBER 2026

2.1 SESSION 1: OPENING AND WELCOME

2.1.1 Opening and Welcome by Hon Mokhothu Makhalanyane, Chair of Chairs, National Assembly of Lesotho

2.1.1.1 The opening session was moderated by Hon Mokhothu Makhalanyane, Chair of Chairs of the National Assembly of Lesotho and Programme Director of the Summit. Proceedings began with the national anthems of South Africa and the African Union (AU).

2.1.1.2 Welcoming Members of Parliament, health leaders, experts and other delegates, Hon Makhalanyane emphasised that preventive health required coordinated government action, supported by political leadership, sound policies, sustainable financing, credible evidence and community participation. He described the Summit as an opportunity to exchange national experiences and identify practical approaches to placing prevention at the centre of healthcare systems.

2.1.1.3 He called for a shift from predominantly treating illness towards preventing disease, identifying health risks early and promoting longer, healthier lives. Priority interventions included immunisation, screening, health education, healthier environments, addressing the wider determinants of health, and strengthening primary healthcare and community-based services. Given the differing challenges and resource constraints across African countries, he encouraged delegates to share experiences and identify approaches adaptable to their national contexts.

2.1.1.4 Highlighting the growing burden of NCDs, which are projected to become the leading cause of death in sub-Saharan Africa by 2030, he stressed that prevention was equally important in addressing communicable diseases. Beyond improving health outcomes, effective prevention could reduce the human and financial costs of serious illness, ease pressure on healthcare resources and protect human capital by enabling people to participate in education, employment and community life.

2.1.1.5 Hon Makhalanyane outlined the Summit's five thematic areas:

- Resilient, responsive and sustainable health systems;
- Sustainable health financing and fiscal management;
- Implementation and African regional perspectives on preventive health;
- Innovation, data and accountability; and
- Partnerships for resilient health systems.

2.1.1.6 He emphasised that the themes were interconnected and required coordinated action, with financing supporting implementation, innovation strengthened by accountability, and partnerships aligned with national priorities and community needs. He urged delegates to prioritise practical interventions, measurable progress and sustained commitments. He further indicated that the deliberations would inform a declaration establishing shared commitments and a framework for continued engagement and follow-up.

2.1.2 *Welcome Remarks by Hon Masello Senne, Member of the Portfolio Committee on Health, National Assembly of the Republic of South Africa*

2.1.2.1 Hon Masello Senne delivered the welcome remarks on behalf of Hon Faith Muthambi, Chairperson of the Portfolio Committee on Health of the National Assembly of South Africa. She welcomed delegates to Cape Town and thanked them for attending, acknowledging Dr Kenneth Jacobs, former Chairperson of the Portfolio Committee on Health of the National Parliament of South Africa and Managing Director of AHPA, for convening the Summit.

2.1.2.2 Hon Senne observed that African health systems faced competing demands, including HIV, maternal and child health needs and disease outbreaks, placing considerable pressure on public institutions and undermining public confidence. Delayed responses to health threats could also result in household income losses and increased pressure on health facilities. She therefore advocated integrating preventive interventions into primary healthcare, particularly immunisation, antenatal care and screening for conditions such as hypertension and diabetes. This required functional referral systems, adequately equipped laboratories and a supported healthcare workforce.

2.1.2.3 She emphasised that effective healthcare extended beyond clinical services to include treating patients with dignity, addressing their concerns and responding respectfully to misinformation. Given the cross-border nature of many public health challenges, she called for stronger regional cooperation in data sharing, research and knowledge exchange. She also encouraged parliamentarians to examine sustainable financing options for preventive health, particularly screening and early detection.

2.1.2.4 Concluding, Hon Senne stressed that collaboration should translate into tangible outcomes through the exchange of experiences, coordinated parliamentary engagement, evidence-informed policymaking and effective follow-up on agreed recommendations.

2.1.3 *Introduction and Overview of the Summit Objectives by Dr Kenneth Jacobs, Managing Director, AHPA*

2.1.3.1 Dr Jacobs introduced the Summit by outlining its objectives and the importance of bringing together parliamentarians, health experts and other stakeholders to examine how preventive health could strengthen healthcare systems and improve their long-term sustainability across Africa. He highlighted the role of Members of Parliament, particularly Portfolio Committees, in advancing prevention through appropriate legislation, parliamentary oversight and the allocation of adequate resources for prevention, early diagnosis and treatment.

2.1.3.2 To illustrate the consequences of weaknesses in healthcare delivery, Dr Jacobs shared the personal experience of his brother, Gregory Alton Jacobs, who passed away on 14 October 2026 at the age of 57 and to whom he dedicated the Summit. His brother had suffered from extensive tophaceous gout and had repeatedly been diagnosed with gout affecting the knee during visits to health facilities. It was only at a later stage that tibial cancer, which had metastasised to his lungs, was diagnosed. Dr Jacobs reflected that earlier and more accurate diagnosis, followed by appropriate intervention, might have prevented the disease from progressing to such an advanced stage. He used this experience to illustrate the devastating consequences that delayed diagnosis and gaps in healthcare delivery could have for individuals and their families.

2.1.3.3 He emphasised that preventive health was not simply a policy consideration but an issue with direct consequences for individuals, families and communities. He underscored the importance of parliamentary oversight and resource allocation in ensuring that health

systems could identify conditions early, provide timely interventions and prevent avoidable illness and complications.

2.1.3.4 Dr Jacobs encouraged delegates to engage openly, share both successes and challenges, and remain receptive to ideas from other countries and institutions. He stressed that the value of the Summit would depend not only on the quality of its discussions but also on the practical actions taken afterwards.

2.1.3.5 He concluded by urging participants to maintain the networks established during the Summit, use them to sustain collaboration and translate the knowledge and recommendations generated into measurable improvements in preventive healthcare across Africa.

2.1.4 Opening Remarks by Hon Dr Charles Ayume, Minister of State for Health (Primary Health Care), Government of Uganda

2.1.4.1 Hon Dr Charles Ayume thanked Dr Kenneth Jacobs and AHPA for convening the Summit and welcomed the Members of Parliament and other delegates from across Africa. He particularly acknowledged the participation of Budget Committee members and tax specialists, highlighting their importance in discussions on sustainable health financing.

2.1.4.2 The Minister identified three interconnected priorities for advancing preventive health: the changing disease burden and growing pressures on health systems; regional cooperation; and sustainable financing of preventive interventions.

2.1.4.3 He observed that although the Abuja Declaration established a target of allocating 15% of national budgets to health, increased expenditure alone would not guarantee improved outcomes without efficiency, accountability and effective resource utilisation. He challenged political leaders, technocrats and the public to reflect on how existing resources could be better deployed, even in countries falling short of the 15% target. His central message was that the quality and impact of health expenditure mattered as much as the amount allocated.

2.1.4.4 On regional cooperation, the Minister noted that health threats transcended national borders and required collective responses. He highlighted peer-to-peer learning, coordinated disease surveillance, rapid response mechanisms and cross-border resource mobilisation as essential components of regional preparedness. Referring to the Ebola outbreak in the Democratic Republic of the Congo (DRC), he indicated his intention to engage the World Health Organization on convening discussions to strengthen regional outbreak management. He cited Uganda's deployment of health workers to the DRC as an example of African countries providing technical support to one another. He also drew lessons from COVID-19, emphasising the need to strengthen Africa's own pharmaceutical production and vaccine manufacturing capacity.

2.1.4.5 The Minister highlighted the influence of political decisions and wider social determinants on health outcomes. He called for stronger action against corruption and other forms of resource leakage, emphasising that better management of available resources was essential to strengthening health systems. Advocating a health-in-all-policies approach, he stressed that responsibility for health extended beyond Ministries of Health to sectors such as housing, education, employment, food systems and transport, as well as those responsible for clean air and safe water. He urged parliamentarians to advance this approach through legislation, budget allocations and oversight.

2.1.4.6 Drawing on Uganda's experience in addressing sickle cell disease, the Minister highlighted the importance of early diagnosis, screening and public awareness. He cited an estimated annual treatment expenditure of US$678 per affected individual and

approximately 20,000 babies born with the disease. He advocated behavioural change and public education, suggesting that lessons from HIV prevention programmes could inform efforts to reduce the burden of sickle cell disease.

2.1.4.7 He further emphasised the importance of strengthening community health and primary healthcare, particularly through improved sanitation and personal hygiene at household level. He also cited Uganda's Narcotics and Alcohol Bill, which addresses the regulation of narcotic drugs and psychotropic substances, as an example of legislative action to address public health concerns.

2.1.4.8 Addressing the efficient use of healthcare resources, the Minister raised concerns about prolonged hospital admissions and their associated costs. He emphasised the need to strengthen laboratory capacity, particularly blood culture testing, to support accurate diagnosis and appropriate treatment. He also cautioned against inappropriate antibiotic use, highlighting the importance of responsible prescribing and consumption in combating antimicrobial resistance.

2.1.4.9 In conclusion, the Minister called for the Summit to produce practical commitments supported by clearly assigned responsibilities, measurable indicators and monitoring mechanisms. He urged delegates to exchange experiences, strengthen cross-country and cross-sector partnerships, and ensure that preventive health was reflected in national planning and budgetary priorities.

2.1.5 Prevention Through Primary Healthcare and Legislation by Hon Dr James Nyikal, Chair of the Committee on Health, Kenya

2.1.5.1 Hon Dr Nyikal highlighted the importance of primary healthcare in delivering preventive services, particularly in addressing immunisation gaps across the WHO African Region. He reported that the number of zero-dose children increased from 6.1 million in 2019 to 7.3 million in 2022, before declining to 6.7 million in 2023. Although immunisation had averted an estimated 1.8 million deaths in the Region in 2023, approximately 6.7 million children had not received any routine vaccines. These figures underscored the need to strengthen primary healthcare systems and extend essential preventive services, particularly to underserved communities.

2.1.5.2 Drawing on Kenya's experience, Hon Dr Nyikal outlined the 2023 health sector reform package, which sought to strengthen primary healthcare through legislative and institutional changes. He highlighted the Primary Health Care Act, 2023, which formalised the roles of community health promoters and primary care networks within the health system. Approximately 107,000 community health promoters formed part of Kenya's primary healthcare workforce, supporting the delivery of services closer to communities.

2.1.5.3 He explained that the reforms were supported by complementary legislation addressing social health insurance, the financing of health facilities and digital health. Collectively, these measures sought to strengthen the organisation, financing and delivery of healthcare while improving access to primary healthcare and preventive interventions.

2.1.5.4 Hon Dr Nyikal emphasised that Parliaments had a critical role in sustaining preventive health interventions through appropriate legislation, adequate budget allocations and effective oversight. He called on legislatures to ensure that primary healthcare received sustained policy and financial support as the foundation for effective prevention and improved health outcomes.

2.2 SESSION 2 – KEYNOTE ADDRESS AND MESSAGE OF SUPPORT

2.2.1 Keynote Address by Hon Cedric Frolick, House Chairperson, National Assembly, Parliament of South Africa

2.2.1.1 In his keynote address, Hon Cedric Frolick cautioned that high-level discussions often generated commitments that failed to translate into practical action. Describing preventive health as a promise made before diagnosis, he emphasised that the Summit's success would ultimately depend on effective follow-up. He called for a broader understanding of prevention that recognised its links to climate change, economic development and the world of work.

2.2.1.2 Referring to Sustainable Development Goal 8 on decent work and economic growth, Hon Frolick acknowledged the importance of economic growth but cautioned against pursuing it at the expense of public health, environmental sustainability and future generations. He advocated a development model that promotes healthy communities, protects natural resources and creates decent, sustainable employment.

2.2.1.3 He identified climate change as a major public health emergency, highlighting its consequences, including heat stress and dehydration among outdoor workers, heightened risks for people with pre-existing health conditions, unsafe water, changing malaria transmission patterns and mental health challenges associated with displacement. These effects, he noted, were particularly severe for vulnerable communities.

2.2.1.4 Agricultural and outdoor workers, emergency responders and people employed in the informal economy were especially exposed to climate-related risks, often without adequate protection. Hon Frolick therefore called for climate adaptation to be recognised as an investment in health, livelihoods and economic resilience. Key priorities included heat-health action plans, reliable weather information, access to safe water, improved workplace conditions and effective emergency preparedness. Achieving these objectives required coordination among employers, workers, health services, municipalities and meteorological agencies.

2.2.1.5 Hon Frolick also stressed the importance of protecting and strengthening the health workforce, which is itself exposed to disease outbreaks and climate-related emergencies. Resilient health systems require adequate staffing, equipment, training, safe working conditions and psychosocial support. He highlighted the contribution of community health workers in connecting communities to immunisation, maternal health services, health promotion, screening and treatment. Their roles should be clearly defined and supported through appropriate training, fair remuneration and adequate resources, complementing rather than substituting for well-funded health facilities.

2.2.1.6 Rejecting the notion that countries must choose between economic growth and environmental protection, he identified cleaner energy, efficient public transport, climate-resilient housing, sustainable agriculture and improved urban planning as opportunities to improve health, protect communities and create employment. Such interventions, however, should reflect local circumstances and support a just transition through community participation, retraining, social protection and alternative livelihood opportunities.

2.2.1.7 The address underscored the importance of partnerships and regional cooperation in responding to interconnected health and climate challenges. Governments, municipalities, employers, trade unions, researchers, civil society, communities and responsible private-sector partners all have a role to play. Digital investments, he added,

should address clearly identified needs and be supported by reliable infrastructure, frontline capacity and public confidence in information management.

2.2.1.8 Hon Frolick outlined five parliamentary priorities for advancing preventive health and climate resilience:

- **Protect workers through legislation and enforcement:** Strengthen occupational health and safety standards, including protection against excessive heat, and ensure access to drinking water, rest, shade, protective equipment and appropriate emergency procedures.
- **Fund effective interventions:** Scrutinise budgets for preventive health and climate adaptation, taking account of expected outcomes, maintenance costs, geographical equity and long-term sustainability.
- **Align policies and strengthen oversight:** Promote coordination across health, labour, energy, agriculture, local government and finance through joint hearings and oversight activities.
- **Strengthen regional and continental cooperation:** Support collaboration on early-warning systems, technical guidance, data-sharing, training, emergency preparedness and health workforce development, while recognising national circumstances.
- **Promote evaluation and accountability:** Assess whether programmes reach their intended beneficiaries, resources are used effectively and equitably, and measurable improvements are achieved. Require transparency and corrective action where implementation falls short.

2.2.1.9 He further emphasised Parliament's responsibility to lead by example through scrutiny of public expenditure, procurement, implementation delays and the equitable distribution of benefits. Effective oversight should draw on evidence from government institutions, workers and affected communities, covering the entire policy and implementation cycle—from development and budgeting to procurement, service delivery and measurable outcomes.

2.2.1.10 In conclusion, Hon Frolick urged delegates to measure the Summit's success by the actions taken after returning to their respective countries. He called for its deliberations to inform legislation, budgets, committee hearings, oversight activities and stakeholder partnerships. Preventive health, he stressed, required sustained investment in health workers, institutions, services and communities, and should be integrated across government sectors, including labour, climate, infrastructure, education, finance and local development. Delegates were encouraged to leave with practical commitments and clear mechanisms for follow-up.

2.2.2 *Message of Support from the Acting Consul General of the People's Republic of China*

2.2.2.1 The Acting Consul General of the People's Republic of China, Her Excellency Wang Xiao, conveyed her support for the Summit and thanked Dr Kenneth Jacobs and the organisers for the invitation. She highlighted China's longstanding health cooperation with African countries, including the deployment of approximately 2,000 medical personnel and support for malaria elimination, maternal and child health, traditional medicine, and emergency responses to diseases and outbreaks.

2.2.2.2 A significant part of her message focused on the outcomes of the Forum on China–Africa Cooperation (FOCAC) Beijing Summit, held from 4 to 6 September 2024. The Summit

brought together China and 53 African countries and resulted in the adoption of the Beijing Action Plan (2025–2027). Key outcomes included financing pledges, ten partnership initiatives, strategic priorities and proposals for strengthened leadership and cooperation.

2.2.2.3 Her Excellency Wang Xiao noted that the African Summit on Preventive Health provided an opportunity for China to better understand participating countries' priorities and expectations. The discussions and outcomes would help identify areas in which China could deepen its cooperation and provide further support for preventive health and health-system development across the continent.

2.3 SESSION 3 – PILLAR 1: ADVANCING RESILIENT, RESPONSIVE AND SUSTAINABLE HEALTH SYSTEMS FOR SOCIO-ECONOMIC TRANSFORMATION: THE CRITICALITY OF PREVENTIVE HEALTH

Moderator: Hon Gerhardine Katjingisiua, Chairperson of the Gender Equality, Health and Social Welfare Committee, National Assembly of Namibia

2.3.1 Session Objectives and Opening Remarks

2.3.1.1 The session examined the importance of preventive health in strengthening health-system resilience, improving population health outcomes, promoting long-term fiscal sustainability and supporting human capital development.

2.3.1.2 In her opening remarks, Hon Katjingisiua welcomed delegates and highlighted the dual challenge facing African health systems: continuing to address infectious diseases while responding to the growing burden of NCDs. She cited the World Health Organization's projection that NCDs would become the leading cause of death in sub-Saharan Africa by 2030.

2.3.1.3 She identified vaccination, health education, screening and antenatal care as essential preventive interventions that improve health outcomes, facilitate early detection and reduce pressure on hospital-based services. She also highlighted the importance of primary healthcare, noting that it could deliver approximately 90% of the essential services required to achieve universal health coverage.

2.3.1.4 Turning to Parliament's role, Hon Katjingisiua identified three core responsibilities:

- **Legislation:** Establishing an enabling legal framework for preventive health and primary healthcare.
- **Budget allocation:** Ensuring adequate and sustained funding for preventive interventions.
- **Oversight:** Monitoring implementation and holding relevant institutions accountable for results.

2.3.1.5 She emphasised that these functions were essential to securing long-term political and financial support for preventive health.

2.3.1.6 Hon Katjingisiua encouraged delegates to share experiences and learn from one another, observing that no single country had all the answers to the challenges confronting health systems. She introduced the two presentations: *Integrated Primary Care: Prevention, Diagnosis and Treatment*, by Prof Tasleem Ras of the University of Cape Town, and *Prevention through Primary Healthcare and Legislation*, by Hon Dr James Nyikal of Kenya. She urged participants to engage actively, emphasising that preventive health was an investment in healthier populations, stronger health systems and more resilient economies.

2.3.2 *Integrated Primary Care: Prevention, Diagnosis and Treatment*

Presenter: Prof Tasleem Ras, Head of the Department of Family, Community and Emergency Care, GSK Chair of Primary Healthcare, University of Cape Town, South Africa

2.3.2.1 In his presentation, *Integrated Primary Care: Prevention, Diagnosis and Treatment*, Prof Ras used cervical cancer to illustrate the importance of investing in people, service pathways and local health services. He explained that cervical cancer was largely preventable through human papillomavirus (HPV) vaccination and screening, which can prevent infection or detect precancerous changes before they progress to invasive cancer. Nevertheless, patients in resource-constrained settings frequently presented at advanced stages, when treatment outcomes were poorer.

2.3.2.2 He argued that delayed diagnosis often reflected weaknesses in health-system organisation rather than the absence of effective interventions. These included transport costs, limited public awareness, overcrowded clinics, inadequate diagnostic equipment and ineffective referral systems. He outlined an integrated pathway encompassing community awareness, primary healthcare screening and assessment, triage and referral, diagnostic confirmation, treatment and continuing care. Patients should be able to move through this pathway without being lost to follow-up or experiencing unnecessary delays and repeated costs.

2.3.2.3 The presentation emphasised that prevention, early detection, diagnosis, treatment and continuity of care should operate as interconnected components of a single service pathway. Hospital-centred systems that respond mainly after illness develops were insufficient to achieve sustainable health outcomes. Prof Ras also advocated a broader understanding of health that recognised the influence of social and economic determinants. He noted that the same integrated approach could address other NCDs, including renal disease associated with diabetes and hypertension.

2.3.2.4 Key interventions across the care pathway included HPV vaccination, screening, community education, health literacy, proactive risk identification and the integration of screening into routine health visits. These interventions needed to be supported by follow-up of abnormal results, competent clinical assessment, basic diagnostic services, clear referral criteria, timely treatment and effective patient-tracking systems. He also highlighted the importance of survivorship, rehabilitation and palliative care. Preventive and curative services, he stressed, should function as complementary elements of primary healthcare rather than fragmented programmes competing for resources.

2.3.2.5 Prof Ras presented three models of community-oriented and integrated primary healthcare:

- **Community-Oriented Primary Care (COPC):** This model defines a population, assesses its health needs and combines clinical services with community-level diagnosis and outreach. Local data are used to guide interventions and monitor outcomes, ensuring that services respond to the needs of a clearly identified community.
- **Brazil's Family Health Strategy:** This model uses multidisciplinary teams supported by community health agents linked to households. It promotes outreach, territorial responsibility and the delivery of preventive, curative and continuing care closer to people's homes. An important lesson is that health teams and their community outreach functions should be financed together.
- **Community-oriented integrated care:** This approach connects prevention, diagnosis and chronic disease management across clinics, community services and

hospitals. It relies on shared protocols, effective referral and feedback systems, patient tracking, local data and community partnerships.

2.3.2.6 Across these models, common requirements included defined populations, multidisciplinary teams, community participation, functional referral networks and performance monitoring. Prof Ras emphasised that integration must be reflected in actual service arrangements rather than remain a policy aspiration.

2.3.2.7 The presentation identified four principal benefits of integrated, community-oriented primary healthcare:

- **Improved access and universal health coverage:** Expanding access, improving responsiveness to underserved populations and reducing geographical and service-related barriers.
- **Better clinical outcomes:** Strengthening the management of chronic conditions, including diabetes, chronic kidney disease and mental health conditions, and improving quality of life.
- **Greater service efficiency:** Improving coordination between health and social services, communication among health professionals and the management of patients with complex needs.
- **Stronger prevention and early diagnosis:** Expanding screening, identifying health needs through community outreach and improving case identification and referral.

2.3.2.8 On workforce requirements, Prof Ras advocated a shift from dependence on overstretched individual clinicians towards supported multidisciplinary teams with complementary responsibilities. Community health workers could contribute through household outreach, health education, mobilisation for screening, patient navigation and tracing. Nurses played a central role in prevention, screening, assessment, treatment of common conditions, follow-up and care coordination. Clinical associates could provide protocol-guided assessments, procedures and diagnostic support within their scope of practice, while nurse practitioners and doctors undertook more advanced assessment, clinical decision-making, treatment and supervision. Rehabilitation professionals supported recovery and disability-related needs, while pharmacists and pharmacy assistants contributed to medicine access, safety, adherence and patient counselling.

2.3.2.9 Effective multidisciplinary teams required clearly defined responsibilities, appropriate training, supervision, reliable supplies, protected working time and safe referral arrangements. Roles should comply with national regulations, professional competencies and established scopes of practice. Prof Ras also identified infrastructure maintenance and sustainability as important challenges, emphasising that workforce planning must align professional skills and responsibilities with the resources needed to deliver services effectively.

2.3.2.10 He observed that functional service pathways remained underdeveloped in many African settings and that workforce effectiveness depended on the wider health-system environment. Four requirements were identified:

- **Adequate infrastructure:** Private examination spaces, screening supplies, basic diagnostic equipment, reliable transport and access to referral services.
- **Standardised service pathways:** Risk-based protocols, referral criteria, appointment escalation and feedback from hospitals to primary healthcare facilities.
- **Accessible health information systems:** Screening registers, patient-tracking arrangements, interoperable records where feasible and performance dashboards.

- **Effective leadership and financing:** Resources for staffing, supervision, procurement, maintenance and community participation.

2.3.2.11 He stressed that a referral was only complete when the patient reached the next level of care and the outcome was communicated to the referring facility.

2.3.2.12 To support the transition from fragmented programmes to integrated primary healthcare platforms, Prof Ras proposed a phased investment agenda:

- **First six months:** Identify priority districts and populations, map existing service pathways, engage communities and frontline health workers, and establish baseline performance measures.
- **Six to eighteen months:** Equip facilities, train and supervise health teams, introduce referral and patient-tracking protocols, and pilot service delivery arrangements in urban and rural settings.
- **Eighteen to thirty-six months:** Expand successful interventions, publish district-level performance dashboards, incorporate patient and health worker feedback, and align budgets and procurement with service demand.

2.3.2.13 Proposed performance indicators included screening coverage, time from first presentation to diagnosis, referral completion rates, loss to follow-up, patient experience and health worker workload. Targets and implementation milestones would need to reflect national circumstances, service capacity and available resources.

2.3.2.14 Prof Ras concluded that integrated primary healthcare required sustained investment in infrastructure, multidisciplinary teams and connected services spanning prevention, diagnosis, treatment and continuity of care. Such investment could improve health outcomes, enable earlier treatment, reduce unnecessary travel and duplication, and strengthen the capacity of health systems to address multiple conditions. He challenged policymakers to consider not only the cost of integrated primary care, but also the consequences of continuing with fragmented services.

2.3.3 Prevention through Primary Healthcare and Legislation

Presenter: Hon Dr James Nyikal, Chairperson of the Committee on Health, National Assembly of Kenya

2.3.3.1 In his presentation, *Prevention through Primary Healthcare and Legislation*, Hon Dr Nyikal observed that the impact of preventive health could be difficult to measure because its success was often reflected in diseases and deaths that did not occur. He distinguished between primary prevention, such as immunisation, and secondary prevention, which focuses on early disease detection. He emphasised the cost-effectiveness of immunisation, citing an estimate that approximately 1.2 million lives had been saved through immunisation as at April 2025.

2.3.3.2 Drawing on his medical experience dating back to 1979, Hon Dr Nyikal recalled the high levels of childhood mortality associated with measles and highlighted the impact of Kenya's vaccination programme between 1979 and 1984. He reported that no measles cases were recorded in Kenya between 1984 and 2005 following the programme. Immunisation had also reduced the incidence of several other diseases that previously caused significant childhood mortality.

2.3.3.3 Despite these gains, he cautioned that routine immunisation gaps remained a concern. The number of zero-dose children in the WHO African Region increased from 6.1 million in 2019 to 7.3 million in 2022, before declining to 6.7 million in 2023. Although immunisation was estimated to have averted 1.8 million deaths in the region in 2023, millions of children remained unreached by routine vaccination programmes.

2.3.3.4 Hon Dr Nyikal outlined Kenya's 2023 legislative reforms aimed at strengthening primary healthcare from community to national level. The Primary Health Care Act of 2023 formalised the role of community health promoters and provided for primary care networks. These reforms were supported by approximately 107,000 community health promoters. The broader reform package also included legislation on social health insurance, facility financing and digital health, including the Digital Health Act.

2.3.3.5 He emphasised that legislation provided the foundation for institutionalising primary healthcare, establishing governance structures, strengthening accountability and ensuring that resources were used as intended. Parliament had a responsibility to sustain preventive healthcare through appropriate laws, adequate budget allocations and effective oversight. He highlighted the importance of clear governance arrangements for primary care networks and appropriate financing of health facilities through parliamentary budget processes.

2.3.3.6 The presentation also addressed implementation challenges associated with digital health reforms, particularly the transition from legacy information systems to digital platforms, the protection of patient information and the maintenance of accurate records. Hon Dr Nyikal stressed that community health frameworks and digital systems required sound legislative foundations, adequate financing and effective implementation arrangements. He further called for regional policy harmonisation supported by strong national legislative frameworks.

2.3.4 Open Discussion

The discussion explored the practical requirements for strengthening primary healthcare, institutionalising preventive health and translating policy commitments into sustainable action. The main issues raised are summarised below.

2.3.4.1 Strengthening primary healthcare infrastructure and financing

2.3.4.1.1 Participants emphasised that the availability of health facilities alone did not guarantee access to effective services. Facilities required adequate infrastructure, equipment, staffing and support services to meet community needs. Parliamentarians were encouraged to scrutinise the funding and maintenance of primary healthcare infrastructure and ensure that preventive health was explicitly reflected in national health policies, strategic plans and budget statements.

2.3.4.1.2 Participants cautioned against treating prevention as a secondary component of healthcare. It should instead be recognised as a strategic investment in the long-term sustainability of health systems, with appropriate and balanced funding for both preventive and curative services. The discussion also highlighted the importance of considering how governments could ensure access to essential primary healthcare services, including the provision of services free at the point of use where supported by public financing arrangements.

2.3.4.2 Institutionalising and supporting community health workers

2.3.4.2.1 A recurring concern was the sustainability and institutional recognition of community health workers. Although several countries had established community-based programmes, these workers were not always formally incorporated into government health structures. In some instances, their continued employment depended heavily on NGO support, resulting in service disruption or deterioration when external organisations withdrew.

2.3.4.2.2 Participants called for community health workers to be integrated into national primary healthcare systems through appropriate employment frameworks, training, supervision,

remuneration and sustainable financing. The discussion highlighted different country experiences: community health promoters in Kenya were reported to receive a monthly stipend of KES 5,000, equivalent to approximately US$100 at the time of the presentation, while community health workers in Uganda were reported to hold a C4 certificate and receive approximately US$40 per month. These examples prompted consideration of appropriate remuneration and support for community-based workers.

2.3.4.3 Strengthening early detection, diagnosis and continuity of care

2.3.4.3.1 Participants stressed that screening and early detection could only improve health outcomes if supported by adequate diagnostic, treatment and follow-up capacity. Concerns were raised about the ability of primary healthcare systems to prevent, detect and respond effectively to infectious disease outbreaks, including Ebola in Central Africa.

2.3.4.3.2 Cancer care in South Africa was cited as an example of the consequences of gaps between early detection and timely treatment. Participants noted that patients could experience disease progression while waiting for appropriate care, underscoring the need to ensure that early diagnosis was matched by effective referral and treatment services.

2.3.4.3.3 The discussion also identified weaknesses in integrated referral pathways, including in South Africa. Participants emphasised that accessible referral arrangements, effective communication between levels of care and feedback to referring facilities were essential to continuity of care. A screening programme should not be considered successful if patients identified with a health condition could not access the necessary diagnostic and treatment services.

2.3.4.4 Promoting sustainable, community-based and integrated service delivery

2.3.4.4.1 Participants called for a reassessment of existing health service delivery models, with greater emphasis on integrated, community-based care. Community-level interventions were recognised as potentially reducing demand for expensive hospital-based services and generating long-term savings for governments. Mental health was cited as an area in which trained community health workers could help identify and support individuals experiencing mental health challenges and facilitate appropriate referrals, potentially reducing avoidable hospital admissions.

2.3.4.4.2 The discussion also highlighted the need to strengthen Africa's participation in vaccine manufacturing and reduce vulnerabilities associated with dependence on external supply chains. Participants expressed concern about the heavy reliance of some community-based services on NGOs and called for governments to establish sustainable financing, management and maintenance arrangements to protect essential services.

2.3.4.5 Measuring the impact and demonstrating the value of prevention

2.3.4.5.1 Participants acknowledged that demonstrating the impact of preventive health remained challenging because its success was often reflected in the absence or reduction of disease rather than visible treatment outcomes. Unlike curative care, where recovery can be readily observed, the benefits of prevention may be less immediately apparent to policymakers and budget decision-makers.

2.3.4.5.2 The importance of using appropriate indicators, national health accounts and preventive health accounts was therefore emphasised. Participants called for stronger evidence on the economic and public health benefits of interventions such as vaccination to help parliamentary health, finance and budget committees assess expenditure proposals, scrutinise programme performance and advocate for adequate funding.

2.3.4.5.3 They also highlighted the need to communicate evidence more effectively to executive decision-makers, demonstrating how investment in prevention could reduce future treatment costs and improve population health.

2.3.4.6 Strengthening parliamentary accountability and implementation

2.3.4.6.1 Participants highlighted persistent gaps between policy commitments and implementation. They called on Members of Parliament to translate existing preventive health declarations and commitments, including those arising from engagements with NEAPACOH, into concrete national parliamentary action. This would require sustained attention through legislation, budget processes, committee hearings and oversight, as well as engagement at continental level through the AU.

2.3.4.6.2 The discussion proposed that Summit recommendations be formally communicated to Ministers of Health and the AU. A formal Summit statement could help ensure that the outcomes of the engagement informed national policy development, parliamentary oversight and implementation. Participants also proposed an implementation mechanism through which countries could exchange experiences, share best practices and monitor progress in translating commitments into practical interventions.

2.3.4.7 Improving regional cooperation and outbreak preparedness

2.3.4.7.1 Participants emphasised that infectious disease outbreaks in one country could pose significant risks to neighbouring states and the wider continent. They expressed concern about delays in mobilising continental support during outbreaks and called for stronger regional solidarity, information-sharing and coordinated responses.

2.3.4.7.2 Referring to the Ebola situation in the Democratic Republic of the Congo (DRC), participants stressed that no country could consider itself safe while another remained affected by a serious infectious disease outbreak. Priorities included stronger cross-border collaboration in contact tracing, disease surveillance and information exchange, as well as timely mobilisation of resources and technical support.

2.3.4.7.3 The discussion also highlighted the importance of developing and strengthening context-specific African health protocols rather than relying exclusively on externally developed approaches. Regional cooperation should support national preparedness and response capacity while recognising the different circumstances and needs of individual countries.

2.3.4.8 Strengthening health information systems and disease surveillance

2.3.4.8.1 Participants raised concerns about weaknesses in health information systems, data management and disease traceability, referring to challenges experienced in the DRC in comparison with South Africa. Reliable information systems were considered essential for linking community-level interventions with primary healthcare facilities, identifying emerging health threats and supporting timely public health responses.

2.3.4.8.2 The discussion called for stronger data collection, management and information-sharing arrangements across institutions and national borders. Effective digital systems should support disease surveillance, patient tracking, referral pathways and evidence-based planning, while ensuring the protection and confidentiality of patient information.

2.3.4.9 Adopting a coordinated, intersectoral approach to prevention

2.3.4.9.1 Participants reaffirmed that preventive health required coordinated action across government sectors and institutions. They observed that collaboration often weakened during implementation, despite strong policy commitments. Effective communication, coordination and referral arrangements were therefore essential to ensuring continuity of care.

2.3.4.9.2 The discussion also raised concerns about health workforce training and retention. Some health professionals trained to international standards subsequently migrated, while others found that their training did not adequately prepare them for local service delivery requirements. Participants called for stronger workforce planning, recruitment, training and retention strategies, taking account of the substantial gap between Africa's health workforce requirements and countries' capacity to recruit and absorb additional personnel.

2.3.4.10 Strengthening health education and disease-specific prevention

2.3.4.10.1 In relation to sickle cell disease, participants underscored the importance of educating young people about the condition, its implications and available preventive and management measures. The discussion reinforced the broader need for targeted health education and community awareness as integral components of preventive health programmes.

2.3.4.11 Building a stronger implementation and accountability framework

2.3.4.11.1 The discussion concluded with a renewed emphasis on the need to move beyond policy declarations towards measurable implementation. Participants called for stronger mechanisms to monitor progress, assess the use of public resources and demonstrate improvements in service delivery. They stressed that parliamentary committees, particularly those responsible for health, finance and budgets, should use available evidence to hold governments accountable for commitments and expenditure.

2.3.4.11.2 The proposed regional exchange and follow-up mechanisms were viewed as important means of sustaining cooperation, sharing practical lessons and supporting national implementation. Participants emphasised that the effectiveness of preventive health would ultimately depend on whether commitments translated into adequately financed, accessible and functioning services at community level.

2.4 SESSION 4 – PILLAR 2: SUSTAINABLE HEALTH FINANCING AND FISCAL MANAGEMENT: POSITIONING PREVENTION AS A LONG-TERM INVESTMENT

Moderator: Hon Bandile Masuku, Chairperson of the Portfolio Committee on Community Safety and TB Caucus Convenor, Gauteng Provincial Legislature

2.4.1 Session Objectives and Opening Remarks

2.4.1.1 The session examined the importance of preventive health as a long-term investment in sustainable health financing and fiscal management. It focused on the macroeconomic conditions shaping health financing in Africa; domestic resource mobilisation; investment in human capital and institutional capacity; and the translation of health benefits at individual and community levels into broader economic and fiscal gains.

2.4.1.2 In his opening remarks, Hon Masuku emphasised that preventive health should be recognised as an investment capable of improving population health while strengthening national economies and protecting public finances. He noted that health systems required adequate, predictable and efficiently utilised funding to meet current needs without compromising their long-term sustainability.

2.4.1.3 Referring to the 2001 Abuja Declaration, under which AU Member States committed to allocating at least 15% of their national budgets to health, he observed that progress towards this target had been uneven. Many countries continued to face difficulties meeting the commitment. He highlighted primary healthcare as a cost-effective

foundation for sustainable health financing and universal health coverage, noting that keeping people healthy was a more sustainable use of limited public resources than relying predominantly on treatment after illness developed.

2.4.1.4 Hon Masuku identified a key financing challenge: the benefits of preventive interventions often accumulated over several years, whereas national budgets were generally prepared annually. He stressed that the returns on prevention extended beyond the health sector, contributing to productivity, education and employment while reducing future expenditure on preventable illnesses. This required a longer-term approach to financing and stronger collaboration among Ministries of Health, Ministries of Finance, governments and parliaments.

2.4.1.5 He encouraged delegates to consider how preventive health could be financed sustainably and how its returns could be demonstrated through credible evidence to inform policy and budget decisions. He introduced the session's speakers: Prof John Deanfield, an expert affiliated with the Tony Blair Institute for Global Change, who would present the economic case for prevention; Dr Sansia Blackmore, an independent tax policy specialist and AHPA Policy Advisor, who would address taxation and domestic resource mobilisation; and discussant Hon Fortune Molokele-Tsiye. He concluded that preventive health was an investment in healthier populations, sustainable public finances and stronger economies.

2.4.2 Sustainable Health Financing: The Economic Case for Prevention

Presenter: Prof John Deanfield, Professorial Research Fellow, University College London, and contributor and expert affiliated with the Tony Blair Institute for Global Change

2.4.2.1 In his presentation, *Health and Wealth Are One Letter Different: Building Prosperity Through Prevention*, Prof Deanfield highlighted the contribution of preventive health to improvements in global life expectancy and healthy life expectancy. However, healthcare expenditure continued to rise as countries faced the costs of communicable diseases and NCDs.

2.4.2.2 He identified the dual economic burden of ill health: rising healthcare expenditure and lost productivity. Africa faced a growing double burden of disease, with infectious diseases remaining prevalent alongside an increasing burden of NCDs. The NCD share of the disease burden had risen from approximately 24% in 2000 to 37% in 2019. Prevention was therefore essential to reducing future treatment costs, protecting productivity and supporting economic growth.

2.4.2.3 Africa's youthful population represented both an opportunity and a responsibility. While the average age in Europe was approximately 42.5 years, Africa's was 19.2 years. By 2050, an estimated 26% of the global working-age population would be African. This demographic advantage presented an opportunity to address health risks early, prevent the development of chronic conditions and protect the continent's future workforce.

2.4.2.4 Prof Deanfield explained that NCD risk factors accumulated long before symptoms appeared. Smoking, hypertension, obesity and unhealthy diets contributed to multiple diseases, making it more effective to address common risk factors collectively than to focus on individual diseases in isolation. Cardiovascular disease illustrated how health risks could develop over many years before becoming clinically apparent.

2.4.2.5 He highlighted the significant challenges in hypertension control across Africa, noting that only approximately one in eight affected individuals achieved adequate blood pressure control. He also emphasised the benefits of early smoking cessation, observing that stopping before the age of 40 could reverse much of the associated loss in life

expectancy. These examples reinforced the importance of early intervention and sustained risk reduction.

2.4.2.6 The presentation identified five ways in which prevention could protect health and prosperity:

- **Addressing risks early:** Identifying and managing health risks before symptoms emerge can prevent or delay disease.
- **Generating long-term benefits:** Early investment can produce lasting gains through healthier lives, lower treatment costs and improved productivity.
- **Maximising health gains:** Addressing common risk factors can prevent multiple conditions and increase the returns from health investments.
- **Demonstrating economic value:** The benefits of prevention can be assessed through avoided healthcare costs, improved productivity and reduced economic losses.
- **Strengthening the investment case:** Evidence of health and economic returns can support sustainable financing and increased investment in preventive interventions.

2.4.2.7 Prof Deanfield argued that health systems designed primarily to treat illness needed to shift towards preventing, detecting and managing chronic conditions. Performance should therefore be measured not only through treatment outputs, but also through health preservation, risk reduction and long-term wellbeing. Preventive health should be recognised as an investment in human capital, economic productivity and sustainable health systems rather than merely an item of healthcare expenditure.

2.4.2.8 The central message was that ill health imposed a double cost through increased healthcare expenditure and lost economic potential. Investment in prevention offered an opportunity to reduce both costs while improving population health and supporting Africa's long-term prosperity.

2.4.3 The Road to Socially Beneficial Taxation: Linking Domestic Resource Mobilisation with Responsive Governance

Presenter: Dr Sansia Blackmore, Independent Tax Policy Specialist and AHPA Policy Advisor

2.4.3.1 In her presentation, *The Road to Socially Beneficial Taxation: Linking Domestic Resource Mobilisation with Responsive Governance and Quality Healthcare*, Dr Blackmore observed that significant human suffering persisted despite global reductions in poverty, particularly in developing countries. Much of this suffering was attributable to preventable and treatable health conditions. Addressing these challenges required adequately funded programmes, institutional capacity, effective governance and sustainable resource mobilisation.

2.4.3.2 She argued that taxation should be understood not merely as an instrument for raising government revenue, but also as a social tool that shapes the relationship between governments and citizens through the social contract. Unlike development aid and resource rents, taxation could generate important governance and development benefits by strengthening the relationship between taxpayers and the state.

2.4.3.3 Dr Blackmore cautioned that domestic resource mobilisation did not automatically translate into improved development outcomes. Taxation was not inherently socially beneficial and could become harmful where revenue was extracted coercively without corresponding improvements in public services. Socially beneficial taxation required

reciprocity: citizens needed to see tangible improvements in services and social welfare arising from the taxes they paid.

2.4.3.4 She highlighted tax bargaining as an important element of participatory governance. Taxpayers were stakeholders in public finances and had a legitimate interest in how public resources were raised and spent. Responsive governance, transparency, accountability and citizen engagement could strengthen tax morale and public trust in state institutions. The success of a tax system, she argued, should therefore be assessed not only by the revenue it generated, but also by its contribution to service delivery and societal wellbeing.

2.4.3.5 The presentation warned that high levels of tax collection could coexist with corruption, weak public services and governance failures. Where citizens' demands for accountability and reciprocal benefits were met with increasingly coercive tax collection, the relationship between the state and society could deteriorate. Dr Blackmore therefore advocated transparency, accountable public expenditure and visible improvements in service delivery as foundations for sustainable domestic resource mobilisation. A fiscal social contract based on trust and fairness was essential to lasting social progress.

2.4.4 Sustainable Health Financing and Fiscal Management: Positioning Prevention as a Long-Term Investment

Discussant: Hon Fortune Daniel Molokele-Tsiye, Member of the Parliament of Zimbabwe, Co-Chair of the Pan-African Parliamentary Taskforce on Domestic Financing for Health, and Member of the Caucus on Tuberculosis

2.4.4.1 Hon Molokele-Tsiye emphasised the importance of positioning preventive healthcare as a long-term investment in human capital, health-system sustainability and economic development. He highlighted the fiscal pressures confronting African governments, including constrained public budgets, debt-servicing obligations, competing expenditure priorities and declining development assistance for health.

2.4.4.2 Referring to the 2001 Abuja Declaration, he noted that progress towards the commitment to allocate at least 15% of national budgets to health remained limited. In 2021, governments allocated an average of 7.4% of national budgets to health, with only two of the AU 55 Member States meeting the 15% target. He also referred to earlier preliminary estimates indicating a decline in development assistance for health between 2024 and 2025.

2.4.4.3 He cautioned that preventive programmes were particularly vulnerable to budget cuts because their benefits often materialised over the longer term. Governments therefore needed to protect evidence-based and cost-effective interventions, even where immediate results were less visible than those associated with curative services.

2.4.4.4 The presentation stressed that mobilising domestic resources had to be matched by adequate health-system capacity. The health workforce in the WHO African Region had increased from approximately 1.6 million in 2013 to 5.1 million in 2022; nevertheless, a shortage of 6.1 million health workers was projected by 2030. Challenges remained in aligning professional training, recruitment, employment and deployment with service needs and available resources.

2.4.4.5 Access to essential medicines was another concern. Only 28% of low-income countries reportedly had general availability of all WHO-recommended hypertension medicines in pharmacies or primary healthcare facilities. Hon Molokele-Tsiye emphasised that sustainable health financing needed to support not only programmes, but also the workforce, infrastructure, medicines and systems required to deliver effective services.

2.4.4.6 Preventive healthcare was presented as an investment with benefits extending beyond the health sector, including reduced treatment costs, improved wellbeing and greater participation in education and employment. Hypertension illustrated the potential returns of early detection and sustained management. Approximately 1.4 billion people worldwide were living with hypertension in 2024, yet only slightly more than one in five had the condition under control.

2.4.4.7 Citing WHO estimates, he noted that controlling hypertension in half of those affected could prevent 76 million deaths by 2050 and generate annual health-cost savings of approximately US$100 billion. Bangladesh was cited as an example of progress, with some regions increasing hypertension control rates from 15% to 56% between 2019 and 2025 through the integration of hypertension services into essential healthcare, supported by improved screening and follow-up.

2.4.4.8 The presentation also highlighted evidence of the economic returns from preventive interventions. A systematic review of public health interventions had found positive returns on investment in many settings, although these varied according to the intervention and methodology. The WHO investment case for NCDs indicated that every US$1 invested in selected interventions in low- and lower-middle-income countries could generate at least US$7 in returns by 2030, at an additional cost of approximately US$1.27 per person annually.

2.4.4.9 Further evidence from immunisation programmes indicated that investments across 94 low- and middle-income countries were estimated to generate returns of US$26.10 for every dollar invested against ten pathogens during 2011–2020, and US$19.80 during 2021–2030. These findings reinforced the importance of sustained investment in proven preventive interventions.

2.4.4.10 The presentation also drew attention to the wider social and economic costs of mental, neurological and substance-use conditions, with reference to evidence from South Africa. Health investments should therefore be assessed not only in terms of their immediate costs and direct health outcomes, but also their longer-term effects on productivity, education, employment and economic development. Preventive interventions often required upfront expenditure, while many of their benefits accrued over time.

2.4.4.11 In conclusion, Hon Molokele-Tsiye urged parliamentarians, particularly members of health, finance and budget committees, to make balanced, evidence-informed decisions on preventive healthcare. While immediate affordability and service-delivery needs remained important, budget decisions also needed to recognise the long-term returns of prevention. Protecting investment in preventive healthcare was essential to the future health workforce, the economy and community wellbeing, and required a perspective extending beyond annual budget cycles.

2.4.5 Open Discussion

The discussion examined the challenges and opportunities associated with financing preventive health sustainably. Key themes included domestic resource mobilisation, taxation, the economic case for prevention, community-level investment and the role of Parliament in ensuring accountability.

2.4.5.1 Domestic resource mobilisation and budget prioritisation

2.4.5.1.1 Participants considered how governments, particularly Ministries of Finance, could be encouraged to allocate greater resources to preventive healthcare. Questions were raised about which community-level interventions delivered tangible and measurable

improvements in health outcomes, and whether tax exemptions in African countries generated sufficient public benefit to justify the associated loss of government revenue.

2.4.5.1.2 The possibility of earmarking revenue from selected taxes for preventive health programmes was also discussed. Participants noted that human resources for health constituted one of the largest components of health expenditure, highlighting the need for effective workforce planning and sustainable financing arrangements.

2.4.5.2 Balancing the economic and social value of healthcare

2.4.5.2.1 Participants cautioned against viewing healthcare exclusively through an economic lens. They argued that excessive commodification of health services could deepen inequality and undermine equitable access to essential care. Nevertheless, delegates acknowledged that demonstrating the economic and fiscal benefits of prevention was important to strengthening its case for funding, particularly within increasingly constrained public budgets.

2.4.5.2.2 The discussion reaffirmed that health was influenced by factors extending well beyond the health sector. Access to safe drinking water, adequate sanitation, safe roads, nutritious food, decent housing, education and environmental protection were identified as important contributors to population health. This reinforced the need for integrated, multisectoral approaches in which health was recognised as a shared government responsibility.

2.4.5.3 Behavioural change and community-based prevention

2.4.5.3.1 Behavioural change was identified as one of the most challenging, yet essential, components of effective prevention. Participants considered how investment in community-based interventions could encourage healthier lifestyles and support sustained behavioural change. Community ownership, family involvement and engagement with trusted local structures were highlighted as important conditions for the acceptance, effectiveness and sustainability of preventive health programmes.

2.4.5.4 Earmarked taxation and health financing

2.4.5.4.1 The use of earmarked taxation to finance preventive health generated considerable debate. Some participants supported ring-fencing revenue as a means of securing predictable funding for prevention programmes. Others cautioned that large dedicated funds could create governance and accountability risks without appropriate oversight arrangements.

2.4.5.4.2 Experiences from South Africa involving tobacco taxation, illicit markets and sugar taxes were discussed, illustrating both the potential benefits and practical limitations of health-related taxation as a financing instrument. Participants recognised the need to balance revenue generation, public health objectives, enforcement capacity and accountability in the design of such measures.

2.4.5.5 Making the investment case for prevention

2.4.5.5.1 Participants observed that governments often prioritised visible infrastructure projects over community-based preventive interventions, despite the potential long-term social and economic returns of prevention. They called for preventive health programmes to be presented to policymakers in terms that clearly demonstrated their broader benefits, including reduced future treatment costs, improved productivity and stronger human capital.

2.4.5.5.2 Strengthening the evidence base was considered essential to influencing budgetary decisions, securing political commitment and demonstrating the value of sustained investment in prevention.

2.4.5.6 Strengthening parliamentary oversight and intersectoral collaboration

2.4.5.6.1 The discussion reaffirmed that sustainable preventive healthcare required a whole-of-government approach, supported by collaboration across health, finance, water and sanitation, transport, education and local government. Participants emphasised Parliament's responsibility to scrutinise public expenditure, strengthen accountability and advocate for adequate, predictable and sustainable financing of preventive health interventions.

2.4.5.6.2 They stressed that health and finance committees should work together to ensure that prevention was reflected in national budget priorities and that public resources were directed towards interventions with demonstrable health and social benefits.

2.5 SESSION 5 – PILLAR 3: IMPLEMENTATION – AFRICAN REGIONAL PERSPECTIVES ON PREVENTIVE HEALTH

Moderator: Hon Discent Bajila, Chairperson of the Committee on Health, Parliament of Zimbabwe

2.5.1 Session Objectives

2.5.1.1 The session explored African experiences in implementing preventive healthcare, with a focus on successful and innovative practices, financing models, persistent challenges and opportunities for strengthening prevention at local, national, regional and continental levels. It aimed to:

- Promote an Africa-focused approach to preventive healthcare, driven by action at local, national, regional and continental levels.
- Examine the clinical and fiscal dimensions of preventive health across African countries, including progress, successful initiatives and persistent challenges.
- Identify opportunities to build on existing progress and strengthen collaboration among countries and regional partners.
- Consider implementation strategies that are responsive to national and regional contexts and feasible within available resources and institutional capacities.

2.5.2 African Regional Perspectives: Evidence from Zimbabwe – Regional Experiences in Implementing Preventive Health Interventions

Presenter: Hon Discent Bajila, Chairperson of the Committee on Health, Parliament of Zimbabwe

2.5.2.1 The presentation examined Zimbabwe's experience in implementing preventive health interventions, highlighting successful practices, financing models and the challenges and opportunities associated with strengthening prevention across the health system.

2.5.2.2 Hon Bajila emphasised that sustainable preventive health interventions required consistent government investment. Drawing on Zimbabwe's HIV response, he reported that adult HIV prevalence had declined from 26.5% in 1997 to 10.5% in 2023, while new infections had fallen by approximately 78% since 2010. An estimated 1.3 million people were living with HIV in the country.

2.5.2.3 Voluntary medical male circumcision, introduced in 2009, was identified as an important prevention intervention, with more than 2.5 million men circumcised by the end of 2023. The intervention was associated with an estimated 60% reduction in the risk of female-to-male HIV transmission. Zimbabwe had also demonstrated how medical circumcision could be integrated with traditional practices through engagement with community and traditional leaders. Among the VaRemba community, 98% of 672 boys and men attending one circumcision camp opted for medical circumcision while maintaining respect for cultural traditions.

2.5.2.4 Progress in preventing mother-to-child transmission of HIV was another example, with transmission rates declining from 22% in 2010 to 6.4% in 2015 following the accelerated adoption of updated WHO guidelines. Hon Bajila also referred to the introduction of lenacapavir, a twice-yearly long-acting injectable HIV prevention technology, in January 2026, initially targeting pregnant and breastfeeding women. Zimbabwe had also achieved the 95-95-95 HIV treatment targets among adults.

2.5.2.5 On sustainable financing, Hon Bajila presented Zimbabwe's AIDS Levy, introduced in 1999, as an example of domestic resource mobilisation. The levy imposes a 3% tax on individual income and the profits of employers and trusts. The Zimbabwe Revenue Authority collects the revenue and transfers it to the National AIDS Trust Fund, administered by the National AIDS Council and subject to annual audits by the Comptroller and Auditor-General.

2.5.2.6 The AIDS Levy has predetermined allocations, including 50% for treatment and 10% for prevention. The prevention allocation also enables Zimbabwe to provide co-financing when accessing Global Fund support. A 2023 case study estimated that the fund had generated approximately US$30 million. Beyond HIV services, the levy had supported interventions addressing gender-based violence, sexual and reproductive health services for girls and young women, comprehensive sexuality education and legal-sector sensitisation. These initiatives had also contributed to reforms relating to the criminalisation of HIV exposure, non-disclosure and transmission.

2.5.2.7 Despite these achievements, Hon Bajila acknowledged challenges relating to transparency, administrative costs and the levy's revenue-generating capacity. Zimbabwe remained heavily reliant on external funding. Between 2018 and 2020, PEPFAR reportedly contributed approximately 32–42% and the Global Fund 26–41% of HIV expenditure, compared with government contributions of only 2–12%. He also noted the continuing vulnerability of girls and young women, who accounted for approximately 60% of new HIV infections.

2.5.2.8 Drawing on Zimbabwe's experience, Hon Bajila identified six lessons for other African countries:

- Establish legislated, earmarked health levies, administered through national revenue authorities and independently audited funds.
- Allocate a defined proportion of domestic health revenue to prevention and use domestic contributions to leverage external financing.
- Integrate preventive interventions into existing service-delivery platforms, including antenatal clinics and schools, rather than creating parallel structures.
- Involve traditional and community leaders in designing and implementing interventions to strengthen local ownership and acceptance.
- Accelerate the adoption and implementation of updated WHO guidelines and other evidence-based interventions.

- Develop costed donor-transition plans and protect domestic budget allocations for preventive health programmes.

2.5.2.9 In conclusion, Hon Bajila noted that Zimbabwe's experience demonstrated the importance of sustained domestic financing, integrated service delivery and community engagement in achieving preventive health outcomes. He stressed that domestic resources should form the foundation of preventive health financing rather than serve merely as a supplementary contribution. He then invited Dr Kenneth Jacobs, Managing Director of AHPA, to present the report on the preparatory online dialogues.

2.5.3 Report on Preparatory Online Dialogues

Presenter: Dr Kenneth Jacobs, Managing Director, AHPA

2.5.3.1 Dr Jacobs presented findings from three preparatory online dialogues held between July and August 2026. The participating countries were Eswatini, Kenya, Lesotho, Malawi, Namibia, South Africa, Tanzania, The Gambia, Uganda, Zambia and Zimbabwe. The dialogues provided a platform for exchanging country experiences and approaches to preventive healthcare. Each session included country case studies followed by discussions on progress, challenges and lessons that could be adapted to different national contexts.

2.5.3.2 Four key themes emerged: sustainable financing of preventive healthcare amid fiscal constraints; the growing double and triple burden of disease; emerging health risks associated with obesity, malnutrition and changing lifestyles; and demographic pressures, including population growth and family planning.

2.5.3.3 The report highlighted WHO projections that NCDs would become the leading cause of death in sub-Saharan Africa by 2030, surpassing communicable, maternal, neonatal and nutritional conditions combined. Participants also noted the persistence of malnutrition, with approximately one in three children under five affected by stunting in 2024, alongside rising childhood overweight.

2.5.3.4 Demographic pressures were another concern. Sub-Saharan Africa's population was projected to increase by approximately two-thirds by 2050, while the region's average fertility rate stood at 4.3 children per woman in 2024. These trends reinforced the importance of integrating family planning and population projections into long-term health and economic planning.

2.5.3.5 Dr Jacobs emphasised that preventive healthcare required coordinated government action, particularly across health, finance and planning portfolios, supported by sustainable domestic financing. Moving from a predominantly curative approach towards prevention required deliberate budgetary commitments and parliamentary appropriation decisions.

2.5.3.6 Dr Jacobs quoted Hon Dr Anthony Masamba who observed during the online dialogues: "Preventive health's biggest battles are not fought in hospitals, but in appropriations committees and budget reviews." The observation highlighted Parliament's responsibility to protect preventive health allocations and ensure that interventions were practical, implementable and financially sustainable.

2.5.3.7 Dr Jacobs concluded that preventive healthcare needed to become a budgetary priority across African countries, requiring a deliberate shift from financing illness towards investing in prevention. He then invited Hon Dr Anthony Masamba to present Malawi's experience in responding to polio outbreaks, which had been highlighted during the preparatory dialogues.

2.5.4 *African Regional Perspectives: Evidence from Malawi – Response to the 2026 Polio Outbreak and Lessons for Africa*

Presenter: Hon Dr Anthony Masamba, Chairperson of the Committee on Health, Parliament of Malawi

2.5.4.1 Hon Dr Masamba presented Malawi's experience in responding to successive polio outbreaks, highlighting the importance of early detection, rapid response, routine immunisation, community engagement and sustainable financing.

2.5.4.2 Malawi experienced two polio outbreaks within four years. In February 2022, the country reported a case of wild poliovirus type 1. The President declared a national emergency within 24 hours, followed by six rounds of door-to-door vaccination. An independent assessment in May 2024 found no evidence of continued transmission.

2.5.4.3 A subsequent outbreak involving circulating vaccine-derived poliovirus type 2 (cVDPV2) was detected in late 2025 and early 2026. This included a case involving an unvaccinated seven-year-old child who developed paralysis. The Ministry of Health declared a public health emergency on 27 January 2026. Inadequate immunisation coverage, poor sanitation and vaccine hesitancy were identified as contributing challenges, demonstrating the need for integrated prevention strategies.

2.5.4.4 Despite resource constraints, Malawi implemented an extensive vaccination response. An initial campaign reached approximately 1.3 million children in eight districts, representing 97% of the target population. Three nationwide rounds between April and June 2026 vaccinated more than seven million children across all 29 districts. A further campaign in August reached approximately 7.37 million children under ten years of age.

2.5.4.5 Community engagement was central to the response. Health workers conducted door-to-door vaccinations and outreach through schools and health facilities, while traditional and religious leaders helped address vaccine hesitancy and reach remote communities. The presentation also highlighted the timely remuneration of frontline workers through mobile money and the coordination of vaccination campaigns with neighbouring countries, including Zambia, Mozambique and Zimbabwe.

2.5.4.6 Hon Dr Masamba cautioned that high vaccination coverage alone did not establish that transmission had been interrupted. Continued surveillance was therefore essential to confirm that the outbreak had been contained.

2.5.4.7 On financing, Malawi's health allocation for 2026/2027 was approximately 9.2% of the proposed national budget, below the 15% commitment under the Abuja Declaration. The outbreak response relied substantially on global vaccine stockpiles and support from WHO and other partners. With the global polio programme facing a funding shortfall of nearly 30%, Hon Dr Masamba called for increased domestic investment in immunisation, disease surveillance and frontline health workers. He also emphasised Parliament's responsibility to protect preventive health allocations through effective budget oversight.

2.5.4.8 The presentation identified the following lessons for other African countries:

- Declare outbreaks promptly and activate emergency response structures.
- Strengthen disease surveillance, including environmental and sewage testing.
- Ensure rapid access to vaccines and efficient distribution to communities.
- Maintain vaccination quality and coordinate responses across national borders.
- Engage traditional and religious leaders to address misinformation and vaccine hesitancy.

- Increase domestic financing for routine immunisation, sanitation, hygiene and frontline health workers.

2.5.4.9 In conclusion, Hon Dr Masamba stressed that mass vaccination campaigns were essential during outbreaks but could not replace sustained investment in routine immunisation and public health systems. He urged parliamentarians to prioritise preventive health financing and address gaps in immunity, sanitation and health-system capacity before future outbreaks occurred.

2.5.5 *African Regional Perspectives: South African Return on Investment Study*

Presenter: Dr Kenneth Jacobs, Managing Director, AHPA

2.5.5.1 The Economic and Fiscal Case for Investing in Preventive Health

2.5.5.1.1 Dr Jacobs presented AHPA's South African Return on Investment (ROI) Study, published in September 2026, which examined the economic and fiscal benefits of preventive health and the importance of translating investment evidence into government policy and budgetary decisions.

2.5.5.1.2 He argued that the principal constraint was not a lack of evidence demonstrating the value of prevention, but the failure to translate that evidence into appropriate financing mechanisms and sustained budget allocations. Preventive health, he maintained, should be recognised as a long-term economic and fiscal investment rather than simply an expenditure item within health budgets.

2.5.5.2 The Economic and Fiscal Burden of Preventable Diseases

2.5.5.2.1 The presentation highlighted the substantial health and economic burden associated with preventable diseases in South Africa. Global Burden of Disease 2023 estimates attributed approximately 116,000 deaths to HIV, making it one of the country's leading causes of mortality. However, South Africa's Thembisa model provided a lower estimate of approximately 53,000 HIV-related deaths in 2023/24, illustrating differences between estimation methodologies.

2.5.5.2.2 The relationship between HIV and tuberculosis was also emphasised, with evidence indicating that a substantial proportion of TB-related deaths occurred among people living with HIV. The two epidemics therefore needed to be considered together in health planning and resource allocation.

2.5.5.2.3 NCDs accounted for approximately 60% of the 477,000 deaths recorded in South Africa in 2023. Their estimated economic cost was approximately 4.4% of GDP, equivalent to more than R300 billion annually. Cardiovascular diseases constituted the largest category of NCD-related deaths.

2.5.5.2.4 Mental, neurological and substance-use conditions also carried significant economic consequences, estimated to cost South Africa approximately 4% of GDP annually. Evidence from the Mental Health Investment Case published in 2025 indicated that the long-term cost of inaction substantially exceeded the cost of scaling up appropriate interventions.

2.5.5.2.5 Taken together, these figures illustrated the health and economic consequences of underinvestment in prevention and the potential benefits of addressing preventable disease burdens through effective interventions.

2.5.5.3 The Economic Returns on Investment in Preventive Health

2.5.5.3.1 Dr Jacobs presented international evidence of the economic returns associated with preventive health. A 2017 systematic review of 52 studies reported a median return of

approximately US$14 for every US$1 invested in public health interventions. Returns varied according to the type and level of intervention. Legislative measures, including taxation and regulation, showed particularly high returns, although the evidence base for these interventions was more limited.

2.5.5.3.2 The WHO's 2018 investment case for low- and lower-middle-income countries similarly estimated that every US$1 invested in recommended NCD interventions could generate at least US$7 in economic benefits. The investment was projected to save approximately 8.2 million lives and generate US$350 billion in economic gains by 2030.

2.5.5.3.3 Dr Jacobs cautioned that international estimates could not automatically be applied to South Africa, as realised returns depended on national economic conditions, labour-market circumstances and the design and implementation of interventions. Nevertheless, the evidence demonstrated the potential of preventive health to reduce treatment costs, improve productivity and generate wider economic benefits.

2.5.5.3.4 Despite these potential returns, preventive health remained inadequately reflected in public budgets. Dr Jacobs observed that health systems generally treated prevention as expenditure, whereas economic analysis increasingly recognised it as an investment in future health, human capital and productivity. He called for preventive health investments to be more effectively recognised, costed and incorporated into national budgeting processes.

2.5.5.4 Financing Models and International Experiences

2.5.5.4.1 The presentation examined different approaches to financing preventive health, emphasising the importance of selecting an appropriate financing mechanism before introducing new interventions. International examples illustrated the strengths and limitations of various models.

2.5.5.4.2 The Philippines' Sin Tax Law, introduced in 2012, earmarked approximately 85% of incremental revenue from specified tobacco and alcohol taxes for health, primarily to support universal health coverage. The resulting revenue contributed to increased health-sector funding and expanded health insurance coverage among poorer households. However, the sustainability of the model depended on the continued availability of revenue from the designated tax base and legislative support.

2.5.5.4.3 Thailand's ThaiHealth model was presented as an example of an autonomous health promotion fund financed through a 2% surcharge on tobacco and alcohol excise revenues. It demonstrated how dedicated funding could support health promotion and prevention outside conventional departmental budget allocations.

2.5.5.4.4 Australia's VicHealth was cited as an example of a protected health promotion programme, illustrating the value of sustained institutional and budgetary support for preventive health activities.

2.5.5.4.5 South Africa's HIV and TB Investment Case was also cited as an example of how investment-case methodologies could inform national budgetary decisions. The work had supported Treasury budget submissions and contributed to the introduction of a conditional grant for TB. WHO and United Nations Development Programme investment-case methodologies were identified as additional tools for demonstrating the economic value of preventive interventions and supporting evidence-informed resource allocation.

2.5.5.4.6 The presentation acknowledged that each financing model involved trade-offs. Earmarked taxation could generate dedicated revenue but remained dependent on the sustainability of the tax base; autonomous funds required strong governance and accountability; protected budget allocations depended on continued government

commitment; and investment cases provided evidence for decision-making but did not generate funding directly.

2.5.5.5 Key Recommendations and Proposed Way Forward

2.5.5.5.1 Dr Jacobs recommended that countries prioritise preventive interventions for which economic and fiscal returns were already documented, rather than delaying action pending further research. For South Africa, he identified HIV prevention, salt regulation, the sugar levy, and the early detection of hypertension and diabetes as particularly relevant priorities.

2.5.5.5.2 He further recommended that governments:

- Recognise preventive health as a long-term economic and fiscal investment rather than simply a health expenditure.
- Prioritise interventions supported by demonstrated health and economic returns.
- Develop costed, multi-year preventive health programmes and incorporate them into national budgets and development plans.
- Identify appropriate and sustainable financing mechanisms before introducing new interventions.
- Integrate disease prevention, screening, early detection and treatment into primary healthcare financing arrangements.
- Strengthen coordination across government sectors to account for the wider economic and social benefits of prevention.
- Improve monitoring, evaluation and accountability to assess implementation and the returns on preventive health investments.

2.5.5.5.3 For South Africa, Dr Jacobs recommended commissioning a comprehensive national preventive health investment case to guide policy development, resource allocation and sustainable financing. He noted that the country had already developed investment cases for HIV and mental health, demonstrating the potential to extend this methodology to other preventive health priorities.

2.5.5.6 Conclusion

2.5.5.6.1 The presentation concluded that the principal challenge was not a lack of evidence demonstrating the value of prevention, but the absence of appropriate institutional and financing arrangements to translate that evidence into sustained investment. Dr Jacobs called for a shift from financing illness towards investing in health, supported by costed interventions, appropriate financing mechanisms and protected multi-year budget allocations. Countries should begin with interventions offering demonstrable returns and establish sustainable financing arrangements before introducing additional measures.

2.5.5.6.2 The central message was that the evidence supporting preventive health was already strong; the priority was to establish financing frameworks that enabled governments to act on that evidence and translate potential returns into improved health outcomes and long-term economic benefits.

2.5.6 African Regional Perspectives: Evidence from Zambia – Investing in Preventive Health: A Parliamentary Perspective

Presenter: Hon Dr Joseph Musanje, Member of Parliament, Parliament of Zambia

2.5.6.1 Hon Dr Musanje emphasised the importance of investing early in prevention, bringing services closer to communities and sustaining interventions through legislation, budget

allocations and parliamentary oversight. Prevention, he noted, protected health, household incomes and economic productivity while reducing the costs of illness and caregiving.

2.5.6.2 The presentation highlighted evidence of the economic benefits of prevention, including a median return on investment of approximately 14:1 across 52 public health interventions and an estimated US$7 in benefits for every US$1 invested in selected NCD interventions. Hypertension was cited as a major global challenge. Bangladesh provided an example of improved hypertension control, with rates increasing from 15% to 56% between 2019 and 2025 following the integration of treatment into essential health services.

2.5.6.3 Zambia's cervical cancer prevention programme illustrated the value of strengthening community-based preventive services. Since screening was introduced in 2006, more than 1.5 million women had been screened. In 2019, Zambia introduced HPV testing, using existing HIV clinics as service-delivery points. By 2021, the programme had expanded to all ten provinces, and more than 40,000 women had been screened using HPV-based methods in 2023.

2.5.6.4 Hon Dr Musanje stressed that cervical cancer elimination required an integrated approach encompassing HPV vaccination, screening, follow-up and timely treatment. Zambia had introduced a single-visit screen-and-treat model in 345 facilities, alongside self-sampling to improve access. Achieving WHO's 2030 elimination targets would require investment in trained health workers, laboratory capacity, screening supplies and effective referral and follow-up systems.

2.5.6.5 Zambia's 2023 cholera outbreak further demonstrated the importance of integrating healthcare with water, sanitation and hygiene interventions. By 18 January 2024, approximately 10,887 cases and 432 deaths had been reported across nine provinces. The response combined oral cholera vaccination, water provision, sanitation improvements and hygiene promotion, with more than 1.4 million vaccine doses delivered by January 2024.

2.5.6.6 The outbreak exposed weaknesses in coordination and fragmented budgeting across government departments. The presentation highlighted the need for integrated planning between health, water and sanitation authorities to ensure that vaccination, disease surveillance, safe water, sanitation and community education were implemented as complementary interventions.

2.5.6.7 On sustainable financing, Hon Dr Musanje highlighted Zambia's National Health Insurance Act of 2018, which established a national health insurance scheme that became operational in September 2019. The scheme sought to improve equitable access to essential health services through a dedicated insurance fund, provider accreditation and quality assurance. He stressed that financing reforms needed to translate into accessible and effective healthcare services.

2.5.6.8 Key lessons for other African countries included strengthening primary healthcare and community-based services; integrating screening and treatment; investing in health personnel and laboratory capacity; coordinating health interventions with other sectors; and using parliamentary legislation, budgeting and oversight to secure sustainable preventive health financing.

2.5.6.9 In conclusion, Hon Dr Musanje encouraged African countries to share experiences and adapt successful interventions to their national contexts. Drawing on Malawi's polio response and Zimbabwe's HIV financing model, he emphasised that effective prevention

depended on practical delivery through accessible screening, vaccination, safe water, sanitation and sustained access to essential healthcare services.

2.5.7 *Open Discussion: Making the Investment Case for Prevention in Healthcare Across Africa*

2.5.7.1 Participants examined the challenges affecting the implementation and sustainability of preventive healthcare across African countries. The discussion focused on community engagement, sustainable financing, institutional capacity, programme integration and Parliament's role in strengthening preventive healthcare.

2.5.7.2 Community and traditional leadership

2.5.7.2.1 Participants emphasised the importance of engaging religious and traditional leaders, given their influence on cultural practices, beliefs and community behaviour. These leaders could help build trust, address misconceptions and encourage the uptake of preventive health interventions.

2.5.7.3 Adapting legislative and institutional models

2.5.7.3.1 Participants considered how successful legislative and institutional models could be adapted by lower-income countries. They emphasised the value of learning from other countries while taking account of differences in economic conditions, institutional capacity and governance arrangements.

2.5.7.4 Protecting HIV and TB financing

2.5.7.4.1 The sustainability of HIV and tuberculosis financing was a particular concern. Participants cautioned that consolidating disease-specific funding could result in resources allocated to TB being diverted to HIV programmes, potentially reversing progress in TB prevention and control. They called for adequate funding to be protected for individual disease programmes while promoting integrated service delivery.

2.5.7.5 Zimbabwe's AIDS Levy and dedicated financing

2.5.7.5.1 Participants sought clarification on how revenue from Zimbabwe's AIDS Levy was protected for HIV-related interventions. It was explained that the funds were transferred directly into a dedicated AIDS Trust Fund, rather than the Consolidated Fund, and administered by the National AIDS Council, with oversight by the Auditor-General. Participants noted that the model could offer lessons for strengthening national health financing institutions, including the proposed National Health Council.

2.5.7.6 Addressing social and gender-related vulnerabilities

2.5.7.6.1 Participants stressed that effective HIV prevention required more than funding and medical interventions. Social dialogue, community participation and action to address gender inequalities were considered essential. Particular attention was given to the vulnerability of adolescent girls and young women, alongside the need to include boys and men in prevention programmes.

2.5.7.7 Community-led initiatives

2.5.7.7.1 Community initiatives implemented in collaboration with UNFPA and UNAIDS were highlighted, including the "Not in My Village" campaign, which addresses harmful cultural practices such as child marriage. Traditional leaders were reported to be leading community campaigns, while Members of Parliament were initiating constituency-level activities under the theme "Not in My Constituency". These initiatives illustrated the

potential of political and traditional leadership to address social determinants of health and reduce vulnerability to HIV.

2.5.7.8 Donor dependence and domestic resource mobilisation

2.5.7.8.1 Participants expressed concern about declining donor support for HIV and TB programmes. Malawi was cited as an example of substantial reliance on the Global Fund and other development partners, with government funding for HIV interventions reportedly minimal since 2019. In anticipation of reduced donor financing, the Parliamentary Committee on Health had advocated increased domestic resource mobilisation.

2.5.7.8.2 The importance of community-led interventions, including paediatric HIV programmes, was also highlighted. Participants were informed that approximately K600 million, equivalent to US$200,000, had been allocated to community-led HIV/AIDS interventions in Malawi.

2.5.7.9 Malawi's proposed National Health Fund

2.5.7.9.1 Malawi's proposed National Health Fund was discussed as a potential mechanism for strengthening domestic financing. The Fund was expected to be managed by the Secretary for Health and Sanitation, allowing resources to be transferred directly into it rather than the Consolidated Fund. Priority would be given to interventions expected to have the greatest impact. Participants stressed the importance of early detection and community-based HIV services, particularly in rural areas where HIV prevalence remained a concern.

2.5.7.10 Integrating disease-specific programmes

2.5.7.10.1 Participants observed that fragmented, disease-specific programmes continued to limit the ability of African health systems to address the combined burden of communicable and NCDs. They questioned why patients undergoing TB screening could not also be screened for HIV, diabetes and hypertension using available diagnostic platforms. Integrated screening and prevention were identified as opportunities to improve efficiency, reduce duplication and provide more comprehensive care.

2.5.7.11 Parliamentary oversight and institutional accountability

2.5.7.11.1 The discussion emphasised Parliament's role in addressing institutional weaknesses and improving coordination across government departments. Legislation and parliamentary oversight were identified as important tools for promoting integrated approaches to preventive healthcare.

2.5.7.11.2 Participants also proposed that parliamentary committees consult the Office of the Auditor-General before conducting oversight engagements with government departments. Such consultations could help identify institutional weaknesses and audit concerns, enabling committees to ask more focused questions and strengthen accountability.

2.5.7.12 Prioritising prevention in national budgets

2.5.7.12.1 Participants noted that preventive healthcare was not always recognised as a distinct budgetary priority, despite immunisation, screening and early detection being core preventive interventions. They called for prevention to be adequately reflected in national health budgets and considered alongside curative services.

2.5.7.13 Summary of the discussion

2.5.7.13.1 The discussion concluded that sustainable preventive healthcare depended on stronger institutional coordination, predictable domestic financing, meaningful community participation and effective parliamentary oversight. Participants called for a shift from fragmented, disease-specific programmes towards integrated health systems capable of addressing multiple health challenges.

2.5.8 Breakaway Session

Moderator: Hon Dr Monday Rude, Chairperson of the Committee on Health, Parliament of Uganda

2.5.8.1 The breakaway session provided an opportunity for participants to consider three themes:

- Preventive health approaches at local, national, regional and continental levels.
- Clinical and fiscal perspectives on preventive healthcare across Africa.
- The status of preventive health across countries, including progress, effective interventions and outstanding challenges.

2.5.9 Preventive Health Approaches at Local, National, Regional and Continental Levels

2.5.9.1 Group 1 presented recommendations for strengthening preventive health approaches at local, national, regional and continental levels.

2.5.9.2 At the local level, the group emphasised community mobilisation, age-appropriate and context-sensitive interventions, and adequate funding to compensate community actors involved in preventive health activities.

2.5.9.3 At the national level, the group called for increased investment in preventive healthcare and proposed allocating 30% of national health budgets to prevention, supported by clearly defined parameters. It also recommended prioritising prevention in national health strategic plans to facilitate dedicated funding; advocating for the 2% allocation to research under the Abuja Declaration; and adopting programme-based budgeting with dedicated allocations for preventive interventions.

2.5.9.4 At the regional level, participants recommended developing and strengthening regional preventive health frameworks, supported by joint procurement mechanisms to improve efficiency and access to essential health commodities.

2.5.9.5 At continental and global levels, the group highlighted the need to identify and strengthen existing international prevention frameworks, including those relating to pandemic preparedness, as well as continental human rights frameworks relevant to health.

2.5.10 Current Status of Preventive Health Across Countries: Progress and Challenges

2.5.10.1 Group 2 presented an overview of preventive healthcare across African countries, highlighting approaches that were producing positive results. These included bringing preventive services closer to communities, protecting priority and vulnerable groups, and reducing financial barriers to accessing healthcare.

2.5.11 Clinical and Fiscal Perspectives Across Africa

2.5.11.1 Group 3 presented clinical and fiscal perspectives on preventive healthcare across Africa, noting that prevention priorities differed across disease areas and required context-specific approaches. In cancer prevention and control, particular emphasis was placed on early detection to improve the prospects of timely diagnosis and treatment.

2.6 RECAP OF THE SUMMIT DELIBERATIONS

Presenter: Dr Brenda Mungai, Senior Research and Policy Analyst – Global Health, AFIDEP

2.6.1 Dr Mungai presented a recap of the Summit's deliberations, noting that the two-day policy forum had brought together parliamentarians and partners from 13 African countries to examine the sustainability of national healthcare systems and the role of preventive health in addressing Africa's health challenges.

2.6.2 The Summit was organised around five policy pillars: resilient health systems; sustainable health financing; implementation and African regional perspectives; innovation, data and accountability; and partnerships for resilient health systems. The programme included plenary presentations, discussant contributions, open discussions, question-and-answer sessions and a working group session.

2.6.3 The deliberations positioned preventive health as a foundation for sustainable healthcare systems and an investment in economic development, productivity and long-term fiscal sustainability. They culminated in the presentation and adoption of the Cape Town Declaration on Preventive Health.

2.6.4 Building an Integrated Care Pathway

2.6.4.1 The recap emphasised the need to integrate prevention, early detection, treatment and continuity of care into a single, person-centred pathway. Screening and diagnosis alone have limited value unless patients can access appropriate treatment and follow-up services.

2.6.4.2 Four elements were identified as essential to an integrated care pathway:

- **Defined populations:** Organising health services around identifiable communities and their specific health needs to support targeted interventions.
- **Task-shared teams:** Coordinating nurses, clinicians, rehabilitation professionals, pharmacists, allied health professionals and community health workers, to expand access to preventive, rehabilitative and curative services.
- **Functional referral systems:** Ensuring that referrals are completed, patients reach the appropriate level of care and relevant clinical information is communicated back to the referring service.
- **Measurement and learning:** Monitoring screening coverage, time to diagnosis, referral completion, loss to follow-up and patient experience to assess performance and guide improvements.

2.6.5 Financing Prevention as a Long-Term Investment

2.6.5.1 Preventive health was presented as a long-term investment in population health, productivity and fiscal sustainability, rather than expenditure competing with curative services. Effective prevention can reduce avoidable demand for costly treatment and help preserve public resources.

2.6.5.2 The discussions highlighted the importance of domestic resource mobilisation and appropriately designed tax policies. Participants noted that taxation formed part of the social contract between governments and citizens, and that its legitimacy depended on accountability and visible public benefits.

2.6.5.3 The Summit also emphasised the need for transparent management of ring-fenced and special-purpose funds, supported by regular audits, accountability mechanisms and safeguards against the diversion of resources. Financing arrangements should strengthen the broader preventive health system, including its workforce, infrastructure, referral pathways, information systems and institutional leadership, rather than focus on isolated interventions.

2.6.6 *Parliamentary Leadership in Implementation*

2.6.6.1 Parliamentary leadership was identified as essential to translating preventive health commitments into action. Parliamentarians were encouraged to use their legislative, budgetary and oversight powers to embed prevention in national health policies and secure adequate funding.

2.6.6.2 Four key areas of parliamentary action were highlighted:

- **Legislation:** Establishing sound legal frameworks for primary healthcare, community health systems and digital health, supported by appropriate safeguards.
- **Financing:** Ensuring that preventive health priorities are reflected in national budgets and that high-impact programmes receive sustainable funding.
- **Oversight:** Monitoring implementation, health outcomes, referral performance and public expenditure, rather than focusing solely on activities undertaken.
- **Regional cooperation:** Strengthening links between national parliaments, regional parliamentary networks, the AU and technical partners to promote coordination and shared learning.

2.6.6.3 The recap proposed that health-system performance should ultimately be assessed by whether people could progress from identifying a health concern in their communities to receiving appropriate diagnosis and treatment without being lost in the system, facing repeated charges or being turned away without care.

2.6.7 *Lessons from Country Experiences*

2.6.7.1 Country experiences from Kenya, Zimbabwe, Zambia and Malawi illustrated practical approaches to strengthening preventive healthcare.

2.6.7.2 Kenya's Primary Health Care Act of 2023 was highlighted for providing a legal foundation for community health promoters and primary care networks, alongside complementary reforms in health financing and digital health.

2.6.7.3 Zimbabwe's AIDS Levy demonstrated how earmarked revenue could be channelled into an audited fund, with a defined proportion allocated to prevention and complemented by donor financing.

2.6.7.4 Zambia's cholera response illustrated the importance of coordinating vaccination, water and sanitation interventions across government ministries and sectors.

2.6.7.5 Malawi's experience highlighted the importance of domestic resource mobilisation, community-led interventions and protected financing arrangements in sustaining preventive health programmes.

2.6.7.6 Across these examples, the recap emphasised the value of delivering interventions through existing health systems, involving community leaders in programme design and planning for the transition from donor-supported initiatives to sustainable domestic financing.

2.6.8 *Key Messages from the Summit*

2.6.8.1 The recap highlighted the need for a targeted, evidence-based approach to prevention. It is acknowledged that not every screening intervention is appropriate, and not every preventive intervention is necessarily less costly than treatment. Prevention must therefore move beyond policy aspiration to practical programmes supported by adequate financing and measurable outcomes.

2.6.8.2 The Summit also reinforced the close relationship between population health and economic wellbeing. Investing in the health of citizens was recognised as an investment in national productivity, economic growth and long-term development.

2.7 SESSION 6 – PILLAR 4: INNOVATION, DATA AND ACCOUNTABILITY – IMPROVING HEALTH OUTCOMES THROUGH EVIDENCE, TECHNOLOGY AND ACCOUNTABILITY

Moderator: Hon Chaatila Chibulo, Member of Parliament, Zambia

2.7.1 *Session Objectives*

2.7.1.1 To examine the role of digital technology in extending access to healthcare, the importance of evidence and data in strengthening accountability, and the need for collaboration to scale up effective health interventions.

2.7.1.2 Hon Chibulo introduced the session by highlighting the role of evidence and technology in strengthening preventive health. He noted that health-system data supported early intervention, planning and resource allocation. Citing the WHO report that 129 countries had national digital health strategies, he emphasised the importance of digital innovation, evidence-based approaches and community engagement in improving health outcomes.

2.7.2 *Zambia's Changing Population and the Case for Prevention*

2.7.2.1 Hon Chibulo highlighted Zambia's rapid population growth. The 2022 Census recorded a population of 19.7 million, approximately 50% higher than in 2010. He noted that this growing, youthful population presented significant economic potential, provided that people entered adulthood healthy, educated and productive.

2.7.2.2 He emphasised the importance of early preventive interventions, including immunisation, screening, nutrition, sanitation and health education. Population growth and urbanisation were also placing increasing pressure on health infrastructure, the workforce and supply chains. Demographic and health data were therefore essential for anticipating demand and allocating resources effectively.

2.7.2.3 With 55.3% of the population living in rural areas, he stressed that digital solutions needed to account for differences in connectivity, infrastructure and access to skilled personnel. Such solutions should complement existing community networks, including traditional leaders, schools and civil-society organisations.

2.7.2.4 He further underscored the need for reliable, timely and comparable data, supported by investment in skills, infrastructure, maintenance and effective governance, to ensure that health systems could respond to demographic change.

2.7.3 *Three Priority Areas for the Session*

2.7.3.1 The session addressed three key areas:

- **Digital health innovation and early detection:** Using digital records, mobile technologies and remote consultations to improve access, identify risks early and strengthen follow-up.
- **Evidence-based preventive health and technology assessment:** Assessing the safety, effectiveness and cost-effectiveness of health interventions to inform government adoption and funding decisions.
- **Data-driven surveillance and epidemiological systems:** Strengthening disease monitoring to identify trends and outbreaks, plan services and support timely preventive action.

2.7.3.2 The objective was to draw lessons from successful approaches in Africa and elsewhere and consider how these could be adapted to national contexts.

2.7.4 Accountability and the Role of Parliamentarians

2.7.4.1 Hon Chibulo emphasised that public trust was essential to digital health, particularly in relation to the protection and responsible use of personal information. He highlighted Parliament's role in strengthening this trust through appropriate legislation, budget allocations for digital infrastructure and workforce development, and evidence-based oversight of health services and outcomes.

2.7.5 Digital Clinical Decision Support to Strengthen Community-Based Care for Hypertension and Diabetes

Presenter: Prof Niklaus Labhardt, University Hospital and University of Basel, Switzerland, and SolidarMed

2.7.5.1 Prof Labhardt presented the ComBaCaL model, demonstrating how digital clinical decision-support systems could equip trained community health workers to undertake selected clinical functions, including screening, diagnosis and first-line management of hypertension and diabetes, particularly in remote and underserved communities.

2.7.5.2 The presentation highlighted the substantial burden of hypertension and diabetes, alongside persistent gaps in diagnosis, treatment and disease control. Among participants diagnosed with hypertension, 88% knew their status, 67% reported receiving treatment and only 47% had controlled blood pressure. For diabetes, the corresponding figures were 80%, 61% and 40%, respectively.

2.7.5.3 These gaps were attributed partly to long distances to health facilities, overstretched clinics and difficulties maintaining continuity of care. The presentation highlighted the need for innovative models that bring essential healthcare services closer to households.

2.7.5.4 The ComBaCaL model was implemented through a consortium involving SolidarMed, Lesotho's Ministry of Health, the University of Lesotho and the University of Basel. It combined task-sharing with community health workers, digital clinical decision support, evidence-based clinical practices and person-centred care.

2.7.5.5 The digital application, based on the open-source Community Health Toolkit, operated offline and followed Lesotho's Standard Treatment Guidelines. It provided step-by-step guidance on screening, diagnosis, prescribing, medication titration and referral. A real-time dashboard also enabled nurses to supervise community health workers remotely.

2.7.5.6 The programme achieved high screening coverage. A total of 7,763 adults were screened for hypertension, representing 98% coverage, with 17% identified as having hypertension. A further 5,478 adults were screened for diabetes, also achieving 98% coverage, with 4.1% identified as having diabetes.

2.7.5.7 The model was well received by communities and community health workers. Among 322 participants surveyed, 97% considered community health worker-led care acceptable, while the same proportion said they would recommend community health worker prescribing. Of 103 community health workers surveyed, 95% were satisfied or very satisfied with the application, and 99% reported that it made service delivery easier and improved care quality.

2.7.5.8 The Summit was also informed of three cluster-randomised trials conducted across 103 villages, comprising 52 intervention villages and 51 control villages. The trials assessed the safety and effectiveness of community health worker-led first-line care for hypertension and diabetes.

2.7.5.9 The first trial compared community health worker-led care with facility referral for patients with uncontrolled hypertension. Blood pressure control was achieved by 58% of participants in the intervention group, compared with 48% in the control group. Among participants included in the complete-case analysis, the respective figures were 69% and 55%.

2.7.5.10 The second trial compared community health worker-led care with facility-based care for patients with hypertension. Blood pressure control was achieved in 78% of the community health worker-led group and 74% of the facility-based group. The findings met the trial's specified non-inferiority criterion, indicating that community health worker-led care was not inferior to facility-based care.

2.7.5.11 The third trial examined community health worker-led care for people with type 2 diabetes. The intervention group achieved an average HbA1c level of 6.5%, compared with 7.1% in the control group. Linkage to care during the initial months was also higher in the intervention group, at 81%, compared with 41% in the control group.

2.7.5.12 Prof Labhardt reported that the trials identified no safety signal indicating a disadvantage associated with community health worker-led care. The serious adverse events recorded did not demonstrate a safety disadvantage for the intervention groups.

2.7.5.13 The policy implications were significant. Appropriately trained and supported community health workers could undertake more than health education and referrals. With digital decision-support tools and professional supervision, they could provide first-line treatment for uncomplicated hypertension and diabetes, while referring patients with complications, adverse effects or poorly controlled conditions to health facilities.

2.7.5.14 Under the proposed model, community health workers screened and diagnosed adults in their villages, provided first-line treatment and conducted monthly household follow-ups, supported by remote nursing supervision. This approach could enable health facilities to focus more resources on patients requiring specialised care.

2.7.5.15 The presenter stressed that community health workers were not intended to replace nurses or doctors, but to complement existing healthcare teams. By managing uncomplicated cases closer to communities, they could improve access, strengthen continuity of care and allow facility-based professionals to concentrate on more complex cases.

2.7.6 *Strengthening Health Outcomes through Accountability, Parliamentary Oversight, Health Governance, Data and Evidence-Informed Decision-Making*

Presenter: Hon Mokhothu Makhalanyane, Chair of Chairs, National Assembly of Lesotho

2.7.6.1 Hon Makhalanyane examined Parliament's role in strengthening health-system accountability and ensuring that policy commitments translated into improved health outcomes.

2.7.6.2 The presentation highlighted the importance of strategic policy frameworks supported by effective oversight, coalition-building, regulation and accountability. Drawing on the WHO Health Systems Governance Framework, the presenter identified three key parliamentary levers: evidence; legislation and public finance; and oversight. He outlined a four-stage process through which Parliament could influence health outcomes, progressing from evidence and data to action, parliamentary oversight and ultimately improved health outcomes.

2.7.6.3 On evidence and data, the presenter emphasised that Parliament required reliable information on disease burdens, access to healthcare, health inequalities and service-delivery performance. Such evidence should inform legislation, budget allocations and national health priorities. Without it, policy and financial decisions risked failing to address actual health needs or achieve maximum impact.

2.7.6.4 Regarding legislation and public finance, Parliament was identified as central to translating policy commitments into action through evidence-based laws, resource allocation and the setting of national priorities. Parliamentarians were encouraged to assess whether legislation and budgets adequately reflected disease burdens and prioritised preventive healthcare, rather than focusing predominantly on responses to health crises.

2.7.6.5 Parliamentary oversight was highlighted as essential for assessing health-system performance, scrutinising budgets, engaging technical experts and monitoring progress against established targets. Through effective oversight, Parliament could ensure that resources reached intended beneficiaries, programmes achieved their objectives and policies responded to emerging evidence. This required reliable and impartial data against which performance could be measured.

2.7.6.6 The presentation further emphasised the need to integrate health information from facilities, communities, laboratories and digital platforms to strengthen evidence-based decision-making. Fragmented information systems, with data dispersed across facilities, ministries and reporting platforms, limited policymakers' ability to assess overall health trends and service-delivery gaps. The presenter stressed that data integration was not merely a technical issue, but also a governance responsibility requiring coordinated systems and consistent reporting.

2.7.6.7 Integrated health information could help policymakers identify vulnerable populations, locate areas of greatest need and target preventive interventions and resources more effectively. The presentation demonstrated how data collection and integration could support risk identification, targeted action and improved health outcomes.

2.7.6.8 Nutrition was presented as an example of the importance of integrated health information. The presenter explained that malnutrition encompassed deficiencies, excesses and imbalances in nutrient intake, including undernutrition, micronutrient deficiencies, overweight, obesity and diet-related NCDs. African countries were increasingly experiencing a nutrition transition in which persistent undernutrition coexisted with rising overweight and obesity.

2.7.6.9 To illustrate the scale of the challenge, the presenter cited WHO estimates indicating that approximately 2.6 billion adults globally were overweight in 2024, including 940 million living with obesity. An estimated 35 million children under five were also overweight. These figures highlighted the need for information systems to capture the multiple dimensions of malnutrition and support coordinated policies across health, education, agriculture, food systems and urban planning.

2.7.6.10 The presenter emphasised that preventive health policies should address both undernutrition and obesity through a life-course and multisectoral approach, supported by effective legislation, regulation, service delivery, research and data systems. He cautioned against stigmatising people living with obesity, noting that the condition was shaped by interacting environmental, social, biological and behavioural factors. Health data should therefore be used to identify barriers, guide appropriate interventions and improve access to support, while protecting personal information and ensuring that communities understood how their data would be used.

2.7.6.11 In conclusion, Hon Makhalanyane called on Parliaments to demand integrated evidence when considering legislation and budgets, strengthen information-sharing across health facilities, laboratories and community services, and regularly assess progress against national health targets with input from technical experts. He reinforced the importance of ensuring that evidence informed decisions, budgets enabled implementation and parliamentary oversight determined whether policies and interventions were delivering measurable improvements in health outcomes.

2.7.7 Innovation, Evidence and Technology: Scaling Health Solutions through Stakeholder Collaboration

Presenter: Hon Stephen Mule, Chair of the Global TB Caucus and Member of Kenya's National Assembly

2.7.7.1 Hon Mule examined how evidence, innovation and technology could improve health outcomes through enabling policies, sustainable financing and stakeholder collaboration.

2.7.7.2 He outlined three interconnected stages for translating innovation into health impact: evidence and innovation; policy and implementation; and improved health outcomes. Promising research and technologies, he noted, often remained at pilot stage without appropriate policies, financing and integration into routine health services.

2.7.7.3 At the evidence and innovation stage, interventions needed to be assessed for effectiveness, safety and suitability for real-world implementation. Digital technologies could strengthen early detection, remote monitoring and service delivery. As an example, he cited WHO's recommendation of computer-aided detection software for interpreting chest X-rays in tuberculosis screening and triage. He emphasised that financing, trained personnel and enabling policies were necessary to make such technologies accessible.

2.7.7.4 At the implementation stage, evidence-informed policies and regulatory frameworks were required to support the adoption of proven interventions. Sustainable financing and integration into routine services were equally important to ensure continuity, wider access and lasting impact.

2.7.7.5 Highlighting the global TB burden, Hon Mule reported that approximately 10.7 million people developed TB in 2024, while 1.23 million died. In Kenya, a 2016 prevalence survey found that only about 40% of people with TB were captured by the national notification system. This demonstrated the need to strengthen case detection and link patients across different healthcare providers to treatment.

2.7.7.6 Kenya's public-private collaboration in TB control illustrated how research could inform practical interventions. Patient pathway analysis showed that approximately 42% of people with presumptive TB initially sought care in private facilities, yet only 13–21% of notified cases came from that sector. This highlighted the importance of including private providers in national disease-control programmes.

2.7.7.7 To address this gap, Amref Health Africa, with support from the Global Fund and in partnership with the Respiratory Society of Kenya, the National Tuberculosis Programme and county health departments, implemented a public-private mix initiative in nine counties. The project mapped 2,027 private facilities, secured memoranda of understanding with 1,405 and established TB service reporting in 1,269. Approximately 880 private healthcare workers were trained, while digital tools and routine reporting systems supported patient tracking and linkage to care.

2.7.7.8 The initiative screened 4.3 million people and identified 260,922 with presumptive TB. Of these, 108,723 (approximately 42%) were investigated, resulting in 14,026 diagnoses. Almost all diagnosed patients (99%) commenced treatment, demonstrating the contribution of public-private collaboration to case detection and treatment.

2.7.7.9 Despite these gains, fewer than half of those identified with presumptive TB received further investigation, while some categories of private providers contributed relatively few diagnoses and required targeted support. Private-sector notifications increased across participating counties, reaching 37% in Kiambu and Mombasa, but declined after the project ended. This highlighted the difficulty of sustaining donor-funded initiatives and the need to embed private-sector engagement in routine health systems through domestic financing.

2.7.7.10 Hon Mule also highlighted substantial financing gaps in the TB response. The 2023 United Nations Political Declaration on Tuberculosis set targets to treat 90% of people developing TB by 2027, provide preventive treatment to 90% of those at high risk, and mobilise US$22 billion annually for TB services by 2027, rising to US$35 billion by 2030. It also targeted US$5 billion annually for TB research by 2027. However, funding for TB services was approximately US$5.7 billion in 2023, while research funding stood at about US$1 billion. He emphasised that domestic resource mobilisation, alongside donor support, was essential to closing these gaps.

2.7.7.11 On Parliament's role, he explained that legislators supported implementation through enabling legislation, budget allocations and oversight rather than direct programme delivery. He cited Kenya's Parliamentary TB Caucus, formally recognised within Parliament and working with the Health Committee, as an example. He also noted that the Global TB Caucus had supported the establishment of national TB caucuses in 57 countries, strengthening political engagement and collaboration.

2.7.7.12 Parliamentarians were encouraged to ensure that laws and national guidelines enabled private providers to participate in public health programmes and national reporting systems. They were also urged to allocate domestic funding to sustain interventions previously dependent on donors. Referring to Kenya's prolonged TB drug stockout in 2013, Hon Mule stressed that budget allocations had to translate into the availability of essential medicines and uninterrupted treatment.

2.7.7.13 He identified key indicators for parliamentary oversight, including the proportion of TB notifications from private providers, the proportion of people with presumptive TB who underwent investigation, and the proportion of diagnosed patients who started treatment. Monitoring the full patient pathway would help Parliament identify service-delivery gaps and assess programme performance.

2.7.7.14 In conclusion, Hon Mule emphasised that research and innovation delivered meaningful impact when translated into accessible and sustainable health services. This required effective PPPs, enabling policies, sustainable financing and reliable information systems. He urged parliamentarians to incorporate proven innovations into national guidelines, provide the necessary budgetary support and monitor implementation through parliamentary oversight. He then handed over to Hon Chaatila Chibulo to facilitate the discussion.

2.7.8 Open Discussion

2.7.8.1 The discussion focused on strengthening continental and regional collaboration, promoting country ownership of health priorities, improving preventive healthcare and addressing persistent health-system challenges across Africa.

2.7.8.2 Regional and continental collaboration

2.7.8.2.1 Stronger collaboration between the AU and WHO was identified as essential to advancing preventive health. The Africa Think Tank Platform was highlighted as a potential avenue for engagement, while AFIDEP, already working with the AU Commission, expressed interest in collaborating with AHPA.

2.7.8.2.2 Participants also called for stronger advocacy with the AU. NEAPACOH expressed its willingness to support AHPA in promoting preventive health as the foundation of African healthcare. Engagement with the AU, Pan-African Parliament and WHO was considered important, particularly given the historical need for deliberate efforts to secure parliamentary participation in continental and global health processes.

2.7.8.2.3 NEAPACOH was recognised as an important platform for connecting parliamentary advocacy with the AU and promoting the integration of preventive health into continental policies, programmes and commitments, in collaboration with AHPA.

2.7.8.3 Infection prevention and control

2.7.8.3.1 Participants emphasised the need to strengthen attitudes and practices relating to infection prevention and control (IPC), particularly by extending preventive measures beyond healthcare facilities into households and communities.

2.7.8.4 External support and access to essential health commodities

2.7.8.4.1 Uganda's proposed Memorandum of Understanding with the United States, involving US$1.8 billion in anticipated support subject to the resolution of outstanding issues, was discussed. However, shortages of essential health commodities, including antiretroviral medicines, mosquito nets and malaria medicines, remained a concern, particularly in rural communities.

2.7.8.5 Strengthening tuberculosis prevention and diagnosis

2.7.8.5.1 Persistent TB transmission highlighted the need to expand access to rapid diagnostics and improve early detection, particularly given the airborne nature of the disease.

2.7.8.6 Parliamentary independence and country ownership

2.7.8.6.1 Participants stressed the importance of parliamentary independence and national ownership of health priorities. External funders should not determine parliamentary priorities; countries needed to retain authority to shape their health agendas according to national needs and circumstances.

2.7.8.7 Using evidence to prioritise interventions

2.7.8.7.1 The WHO-CHOICE framework was highlighted as a useful tool for assessing the cost-effectiveness of interventions, particularly for NCDs, and supporting the prioritisation of interventions with the greatest health benefits relative to available resources.

2.7.8.8 Strengthening prevention across the continuum of care

2.7.8.8.1 Participants emphasised the complementary roles of primary and secondary prevention in reducing disease progression, complications and healthcare costs. Although lifestyle interventions and counselling were recognised as important, sustaining behavioural change remained challenging and required approaches that addressed broader social and behavioural influences.

2.7.8.8.2 Maternal mortality was also identified as a persistent challenge requiring greater attention within Africa's preventive health agenda. Similarly, the continued toll of TB, despite the disease being preventable and treatable, highlighted weaknesses in prevention, early diagnosis and treatment.

2.7.8.9 Strengthening community-based healthcare

2.7.8.9.1 Participants identified gaps in community health worker supervision, guidance and support, and called for improved coordination with clinical teams and stronger continuity of care.

2.7.8.10 Traditional medicine and preventive healthcare

2.7.8.10.1 Participants called for further examination of the contribution of traditional medicine to preventive healthcare. While some practices could delay access to appropriate medical treatment, evidence-based traditional remedies might offer preventive benefits. Greater attention was therefore needed to research, recognise and sustainably manage the natural resources used in traditional medicine.

2.7.8.11 Improving the use of disaggregated health data

2.7.8.11.1 Finally, participants emphasised the importance of disaggregated health data to assess intervention outcomes across population groups, identify inequalities in access and guide targeted responses for vulnerable communities.

2.8 SESSION 7 – PILLAR 5: PARTNERSHIPS FOR RESILIENT HEALTH SYSTEMS — COLLABORATION AMONG GOVERNMENTS, PARLIAMENTS, EXPERTS AND PARTNERS

Moderator: Hon Victor Phologolo, Member of Parliament, Botswana

2.8.1 Session Objectives

2.8.1.1 The session explored innovative and effective partnership models through which countries could build on existing progress and strengthen cooperation across the region. It also examined approaches to parliamentary leadership in promoting collaboration among governments, Parliaments, experts and development partners.

2.8.2 Strengthening Partnerships for Preventive Health

2.8.2.1 Hon Phologolo examined how governments, Parliaments, the private sector, academic institutions, experts and development partners could work together to strengthen preventive healthcare and build resilient health systems. The discussion focused on

government and parliamentary leadership, PPPs, and the role of evidence and shared learning.

2.8.2.2 African health systems faced growing pressure from population growth, communicable and NCDs, emerging health threats, inadequate domestic financing and uncertain donor support. A shift from predominantly curative healthcare towards prevention was therefore both a public health and an economic imperative.

2.8.2.3 Resilient health systems required coordinated contributions from all stakeholders. Governments provided policy direction; Parliaments enacted legislation, scrutinised budgets and exercised oversight; the private sector contributed expertise and resources; academic institutions generated evidence; and communities helped shape and implement interventions.

2.8.2.4 Government and parliamentary leadership were essential to aligning stakeholders around common priorities. Through representation, legislation, budget oversight and accountability, Parliaments could ensure that partnerships supported national health plans and delivered measurable improvements. Meaningful community participation in the design of interventions was equally important.

2.8.2.5 PPPs offered opportunities to mobilise private-sector expertise and resources, complement government efforts and extend preventive health services. Countries were encouraged to build on regional experience while adapting partnership arrangements to their national priorities and circumstances.

2.8.2.6 Collaboration among academic institutions, researchers and technical experts was important for generating and sharing evidence. Regional learning could help countries identify effective interventions, strengthen policy decisions and adapt successful approaches, while also learning from programmes that had not achieved their intended results.

2.8.2.7 Sustainable partnerships required shared objectives, clearly defined responsibilities and alignment with national priorities. They should strengthen existing health systems rather than establish fragmented or parallel structures. Parliamentary oversight and predictable financing were necessary to sustain commitments beyond individual projects and funding cycles.

2.8.2.8 Regional and global initiatives demonstrated the value of collective action. These included the Big Catch-Up, launched in April 2023 by WHO, UNICEF, Gavi and partners to address missed vaccinations and strengthen immunisation through primary healthcare, and the UHC2030 platform, which promotes political commitment and multi-stakeholder action towards universal health coverage.

2.8.2.9 The session concluded that resilient health systems depended on sustained collaboration and shared responsibility. Countries were encouraged to strengthen parliamentary engagement, exchange experiences and develop partnerships aligned with national priorities to achieve measurable improvements in population health.

2.8.3 Workplace-Based Prevention: Extending the Reach of the Health System

Presenter: Dr Shamila Fakie, Executive Associate to the Chief Executive Officer, Medscheme

2.8.3.1 Dr Fakie highlighted the potential of workplaces to extend the reach of preventive healthcare and complement national health strategies. Workplaces were described as under-utilised platforms for identifying health risks, enabling early intervention and connecting employees with appropriate healthcare services.

2.8.3.2 Hypertension illustrated the scale of undiagnosed and poorly managed health conditions. The presentation reported that only approximately 10% of people with hypertension in sub-Saharan Africa had controlled blood pressure. A study at a Nigerian university found undiagnosed hypertension in 27.8% of screened staff, while medication non-adherence among treated patients across 27 African countries was reported at 44%. These findings related to different studies and populations and were therefore not directly comparable.

2.8.3.3 Health expenditure was reported at approximately 4.9% of GDP in sub-Saharan Africa, compared with 8.9% in South Africa. Workplace prevention offered an opportunity to identify health risks early and connect employees to care before conditions became more serious.

2.8.3.4 In South Africa, the formal non-agricultural sector employed approximately 10.43 million people in June 2026. Manufacturing, construction and mining accounted for approximately 2.28 million workers, or 22% of formal employment, making these sectors important entry points for workplace health interventions.

2.8.3.5 An industry estimate placed the annual cost of sick-leave absenteeism to the South African economy at R12–19 billion. A two-year study at a South African power plant also reported improvements in blood pressure and cholesterol among participants in the Healthy Choices at Work programme.

2.8.3.6 Occupational health services provided an established foundation for workplace prevention. The International Labour Organization's Occupational Health Services Convention, 1985 (No. 161), recognises their preventive role. However, only approximately 15% of workers globally were reported to have access to specialised occupational health services.

2.8.3.7 Integrating workplace wellness programmes with medical surveillance could reduce duplication and costs. Stronger links between occupational health services and primary healthcare were also important, particularly in extending coverage to small businesses and informal-sector workers.

2.8.3.8 Dr Fakie proposed an integrated workplace health model combining occupational health, chronic disease management, lifestyle programmes, employee assistance and wellness initiatives. Screening should be connected to referral, treatment and follow-up, supported by organisational leadership and adequate time for employees to access services.

2.8.3.9 A government-led partnership involving employers, insurers and healthcare providers was proposed. A shared digital platform could support screening, risk assessment, referrals, follow-up and outcome measurement, subject to appropriate clinical governance and data privacy safeguards.

2.8.3.10 Workplace prevention could improve chronic disease management, reduce absenteeism and disability claims, increase productivity and support earlier return to work. Programmes should therefore be assessed against measurable health and business outcomes rather than participation figures alone.

2.8.3.11 Employers were encouraged to support screening, on-site healthcare, referrals and follow-up; promote psychological safety; train managers; and use aggregated data to identify workforce health risks while protecting individual confidentiality.

2.8.3.12 In relation to the Cape Town Declaration on Preventive Health, the presenter proposed three commitments:

- Recognise employers and occupational health services as partners in national preventive health strategies.

- Establish common standards for consent, privacy, data interoperability and outcome measurement.
- Encourage employers and employees to participate in prevention programmes and remain engaged in care, supported by appropriate incentives where applicable.

2.8.3.13 Strong safeguards were considered essential. Participation should be voluntary and based on informed consent; individual health information should remain confidential; and employers should receive only aggregated, de-identified data. Employees should not be discriminated against because of their participation or health assessment results.

2.8.3.14 The presentation concluded by recommending further consultation with workers and relevant partners to assess the benefits, safeguards and policy options for formally incorporating workplaces into national preventive health strategies.

2.8.4 Government and Parliament: Building Partnerships for Preventive Health

Presenter: Hon Modou Lamin B. Bah, Member of the National Assembly of The Gambia and Chairperson of NEAPACOH

2.8.4.1 Hon Bah examined the role of governments and Parliaments in establishing partnerships that strengthen preventive healthcare and build resilient health systems.

2.8.4.2 Preventive health required a whole-of-government and whole-of-society approach. Health outcomes were influenced by sectors beyond healthcare, including education, water and sanitation, housing, transport, agriculture, workplaces and social protection. Effective prevention therefore depended on coordinated government action and collaboration with communities and other stakeholders.

2.8.4.3 The presentation outlined the complementary responsibilities of key stakeholders. Governments set priorities and coordinate policy; Parliaments legislate, approve budgets and exercise oversight; civil society and communities build trust and connect interventions to local needs; while experts and academic institutions provide evidence and technical support.

2.8.4.4 Effective partnerships required more than bringing stakeholders together. They needed shared objectives, clearly defined responsibilities and mechanisms to address duplication, implementation gaps and coordination challenges across government.

2.8.4.5 Five parliamentary instruments were identified as central to effective partnerships:

- **Legislation:** Establish clear responsibilities, standards, reporting requirements and safeguards, including data protection, transparency and fair procurement.
- **Budgeting:** Provide identifiable and sustainable funding for preventive health, including resources for local service delivery and multi-year programmes.
- **Oversight:** Monitor service coverage, quality, equity, outcomes and value for money, using disaggregated indicators to identify populations being left behind.
- **Deliberation:** Use parliamentary hearings and constituency engagement to gather evidence from communities, health workers and service providers and identify practical solutions.
- **Safeguarding integrity:** Ensure transparency in partnership agreements, funding and performance measures; manage conflicts of interest; and protect public institutions' authority over policy and standards.

2.8.4.6 A five-step process for establishing partnerships was proposed: identify shared health priorities; map stakeholders and available resources; agree on a partnership compact defining responsibilities, resources, timelines and performance indicators; implement

activities through existing systems; and regularly review results and make necessary adjustments. Agreements should also address data management, safeguarding and complaints mechanisms.

2.8.4.7 Partnerships should strengthen national systems rather than create parallel structures that divert resources and personnel. Regular monitoring, public reporting and corrective action were essential to sustaining progress beyond initial commitments and meetings.

2.8.4.8 Communities should be treated as co-designers rather than passive beneficiaries of health interventions. Their involvement could reveal barriers overlooked by national data, including transport costs, disability access, documentation requirements, stigma and negative experiences with healthcare services. Community participation could consequently improve trust, access and responsiveness.

2.8.4.9 Patient groups, youth organisations, organisations of persons with disabilities, women's groups, traditional and faith leaders, and local CSOs were identified as important partners. Their participation should be inclusive and representative, strengthening accountability without replacing the State's responsibility for healthcare provision and professional standards.

2.8.4.10 The presenter outlined three calls to action for governments and Parliaments:

- Anchor partnerships in legislation, policy and budgets to ensure long-term sustainability.
- Convene partners regularly across government and sectors to review progress, resolve challenges and agree on corrective action.
- Publish accessible information on funding, service coverage, quality and health outcomes, while providing opportunities for community feedback.

2.8.4.11 In conclusion, effective preventive healthcare depended on strong public leadership and sustained collaboration. Governments should provide direction; Parliaments should ensure legislation, financing and accountability; communities should contribute local knowledge and trust; and experts and partners should provide technical support. These complementary roles were essential to ensuring that partnerships delivered measurable and sustainable improvements in health.

2.8.5 Public-Private Partnerships for Preventive Health

Presenter: Hon Dr Robert Pukose, Member of Parliament, National Assembly of Kenya

2.8.5.1 Hon Dr Pukose examined how PPPs could strengthen preventive healthcare by combining public accountability with private-sector expertise, technology, infrastructure, financing and service-delivery capacity.

2.8.5.2 He emphasised that partnerships did not transfer government's responsibility for public health. Government remained accountable for setting priorities, standards and regulations, and ensuring equitable access, quality and financial protection. Private-sector involvement should be pursued where it offered clear advantages over available public-sector alternatives.

2.8.5.3 Four areas of private-sector contribution were identified:

- **Financing and investment:** Co-investment and blended financing could support laboratories, cold-chain equipment, digital systems and health facilities. Governments should, however, assess long-term costs and financial obligations.

- **Technology:** Digital platforms could improve patient records, appointment reminders, referrals, stock management and health planning, provided that connectivity, cybersecurity, interoperability and data protection were addressed.
- **Infrastructure and supply chains:** Private laboratories, diagnostic networks and distribution systems could expand service capacity and improve access, subject to clear quality, maintenance and continuity requirements.
- **Workforce and service delivery:** Employers, pharmacies and accredited providers could extend screening, health promotion and preventive services within national standards and referral systems.

2.8.5.4 Five partnership models were proposed: strategic purchasing of services from private providers; performance-based payments linked to coverage and quality; inclusion of prevention in insurance benefit packages; workplace-based screening and referral programmes; and shared use of infrastructure, diagnostic equipment and digital platforms.

2.8.5.5 The choice of partnership model should be guided by the public health objective and the simplest arrangement capable of achieving it. Transparent service contracts or framework agreements could, in some circumstances, be more appropriate than complex, long-term PPPs.

2.8.5.6 Six key risks requiring effective management were highlighted: unequal access; poor long-term value for money; fragmented services and information systems; disruption when providers withdraw; commercial interference in clinical decisions; and inadequate government capacity to negotiate and monitor agreements.

2.8.5.7 Government should define the public health objectives, target populations and payment arrangements, provide predictable regulation, and ensure timely payment of verified obligations. Private partners, in turn, should offer transparent pricing, assume appropriate operational and financial risks, and contribute to local skills development and technical capacity.

2.8.5.8 The presenter stressed the importance of incorporating feedback from patients and frontline health workers into partnership reviews. Their experiences could reveal hidden costs, referral failures and access barriers not captured by routine performance data, thereby informing decisions on contract improvements and renewal.

2.8.5.9 In conclusion, PPPs could expand preventive health services and support universal health coverage, provided they were guided by clear public health objectives, transparent agreements, appropriate regulation and effective government oversight. Private-sector participation should strengthen public health systems while keeping the public interest and accountability at the centre of every partnership.

2.8.6 *Evidence and Learning: Academic and Technical Partnerships in Evidence-Informed Policymaking*

Presenter: Hon Dr Tebogo Kgosietsile Solomon Letlape, Member of the Portfolio Committee on Health, National Assembly of South Africa

2.8.6.1 Hon Dr Letlape examined how academic and technical partners could generate evidence, support implementation and promote continuous learning within health systems.

2.8.6.2 He emphasised that evidence was valuable only when translated into practical action. He outlined a five-stage learning process: defining the policy question, gathering evidence, developing policy options, supporting implementation and evaluating results to inform future decisions.

2.8.6.3 Policy questions should address clearly defined priorities, such as improving service uptake, reaching underserved populations, strengthening continuity of care and reducing avoidable costs. Clearly framed questions help ensure that research responds to policy and service-delivery needs.

2.8.6.4 Evidence should draw on multiple sources, including epidemiological and administrative data, economic analysis, implementation research, frontline health workers and community perspectives. Referring to the WHO's 2021 Framework for Strengthening the Use of Evidence, Information and Research for Policymaking in the African Region, the presenter highlighted the importance of reliable data and knowledge in advancing UHC and the Sustainable Development Goals. He also noted persistent gaps in locally relevant research and institutional capacity.

2.8.6.5 Research findings should be translated into practical policy options that outline expected benefits, costs, uncertainties, distributional effects and implementation requirements. Decision-makers should distinguish established findings from areas of uncertainty and identify where further testing is necessary.

2.8.6.6 Effective implementation required technical assistance, workforce development, appropriate procurement, communication and adaptation to local conditions. Routine data and feedback should guide adjustments, while evaluation should assess outcomes, beneficiaries, costs, implementation conditions and unintended effects. Findings should then inform future budgets, guidelines and implementation plans.

2.8.6.7 Three areas of government-expert collaboration were identified. First, academic and technical partners should generate evidence aligned with national priorities by working with ministries, Parliaments, service managers and communities. Research independence should be protected through transparent methods, conflict-of-interest management and the freedom to report findings, including those that challenge existing policies.

2.8.6.8 Second, partnerships should strengthen institutional capacity through sustained collaboration between researchers, analysts and programme teams. Examples included universities supporting routine data systems and parliamentary researchers translating technical evidence for committees. The objective should be to enable national institutions to independently commission, assess and apply evidence.

2.8.6.9 Third, evaluation should be independent, transparent and integrated into programme design, with baselines, indicators and data arrangements established from the outset. Findings should be published in accessible formats and discussed with implementers. Parliaments could strengthen accountability by requiring public responses to significant recommendations, including clearly assigned responsibilities and follow-up actions.

2.8.6.10 Experts should communicate uncertainty responsibly by explaining assumptions, possible outcomes and the circumstances under which decisions might need to be reconsidered. Governments, in turn, should support credible technical advice through fair research commissioning, appropriate data access, transparent methods and respect for professional independence.

2.8.6.11 On regional learning, the presenter noted that African countries could benefit from sharing experiences in addressing common health challenges. However, interventions should be adapted to national circumstances, including financing, workforce capacity, geography, public trust and institutional arrangements.

2.8.6.12 Three principles for effective cross-country learning were proposed: compare underlying problems before adopting solutions; share both successes and failures, including

implementation challenges and costs; and adapt interventions to local contexts while preserving their intended purpose and assessing their effectiveness.

2.8.6.13 Regional platforms and shared research infrastructure could improve access to evidence and reduce duplication. The presenter cited the African Health Observatory Platform on Health Systems and Policies as a resource for comparative studies, policy briefs and country health-system profiles. He also highlighted the value of shared ethical review arrangements, secure data access, common definitions, research registries and evidence repositories. Regional cooperation was particularly important in addressing disease outbreaks, medicine supply chains, workforce mobility and health information.

2.8.6.14 A four-stage process for scaling up health interventions was proposed:

- **Pilot:** Test a clearly defined intervention against established indicators and determine its policy purpose and recurrent costs.
- **Evaluate:** Independently assess effectiveness, equity, affordability and implementation requirements.
- **Adapt:** Test the intervention under routine conditions and across different contexts, making necessary adjustments.
- **Scale:** Expand at a pace that maintains service quality and incorporates recurrent costs into national budgets.

2.8.6.15 Dr Letlape cautioned against pilot projects becoming isolated programmes dependent on exceptional staffing and external funding, without a pathway into national systems. Scaling up should be based on credible evaluation, effectiveness under routine conditions, population reach and sustainable financing. Where national expansion was unaffordable, lessons should inform more cost-effective approaches.

2.8.6.16 Three recommendations were made: commission evidence early to inform programme design; strengthen cross-border learning, including lessons from unsuccessful interventions; and embed learning in programmes through appropriate indicators, data systems, evaluation responsibilities and dedicated budgets for adaptation.

2.8.6.17 He concluded that evidence should inform, rather than replace, political decision-making. Technical expertise should strengthen democratic processes, while regional learning should help countries develop effective interventions suited to their national circumstances.

2.8.7 Open Discussion

2.8.7.1 The discussion emphasised the need for clear actions and stronger intersectoral budgeting across government ministries. Participants observed that existing annual allocations were not translating into sufficient impact at community level, underscoring the importance of aligning resources with measurable preventive health outcomes.

2.8.7.2 Partnerships with CSOs were considered important for sustaining the preventive health agenda. Given the limited terms of Members of Parliament, strong relationships with CSOs could help preserve institutional continuity and ensure that initiatives extended beyond individual parliamentary terms.

2.8.7.3 Participants highlighted the need to identify effective approaches for changing public attitudes and strengthening commitment to preventive health. This included understanding the factors that influence behaviour and identifying appropriate strategies to encourage prevention-oriented choices.

2.8.7.4 Solidarity was identified as essential to addressing shared public health challenges. The discussion also raised the issue of mandatory enrolment of public servants in public

health schemes, citing South Africa as an example. The policy implications and applicability of such arrangements in other countries were noted as matters for consideration.

2.8.7.5 Health Committees and governments were encouraged to engage constructively with industry and recognise their responsibility to serve all sectors of society. Participants called for health policies to balance public health priorities with economic growth, job creation and a supportive environment for viable businesses, while acknowledging the contributions of citizens and businesses to public resources.

2.8.7.6 The importance of preserving parliamentary institutional memory was emphasised. Legacy reports documenting the work and achievements of outgoing parliamentary cohorts could help incoming Members understand previous initiatives, maintain continuity and build on their predecessors' contributions.

2.8.7.7 Participants also highlighted gaps in recognising occupational health and safety as an integral component of preventive healthcare. Examples included inadequate provision or recognition of helmets and personal protective equipment for waste handlers. Addressing such shortcomings through appropriate planning, workplace standards and enforcement was considered essential to effective prevention.

CHAPTER 3 – CAPE TOWN DECLARATION ON PREVENTIVE HEALTH AND CLOSING CEREMONY

3.1 SESSION 8: PRESENTATION AND ADOPTION OF THE CAPE TOWN DECLARATION ON PREVENTIVE HEALTH

Moderator: Hon Sandile Nxumalo, Chairperson of the Health Committee, Parliament of Eswatini

3.1.1 Introduction to the Declaration

3.1.1.1 Hon Sandile Nxumalo introduced the session by reflecting on the Summit's discussions and shared experiences. He highlighted the common call to place preventive health at the centre of national planning, financing, resource allocation and healthcare delivery.

3.1.1.2 He explained that the draft Cape Town Declaration on Preventive Health consolidated the Summit's deliberations into a set of collective commitments and provided a framework for taking its priorities to national Parliaments, governments and communities. Although voluntary and non-binding, the Declaration was intended to encourage ownership and implementation by participating countries and stakeholders within their respective mandates.

3.1.1.3 The draft reflected the Summit's five thematic pillars: resilient and sustainable health systems; sustainable health financing; African-led implementation and governance; innovation, data and accountability; and partnerships for resilient health systems. Delegates were invited to review the document, identify omissions and propose amendments to ensure that it reflected their collective views.

3.1.1.4 The session reaffirmed that preventive health was an investment in healthier populations, stronger health systems and sustainable development. The Declaration was intended to translate this shared commitment into practical action.

3.1.2 Presentation of the Cape Town Declaration on Preventive Health

Presenter: Mr Patrick Mugirwa, Acting Regional Director, PPD ARO, and Head of the NEAPACOH Secretariat

3.1.2.1 Mr Patrick Mugirwa presented the Cape Town Declaration on Preventive Health, under the theme *"Preventive Health: National Healthcare System Sustainability and the Role of Preventive Health".* The Declaration emerged from the African Summit on Preventive Health, held on 29–30 October 2026, which brought together 64 parliamentary committee members responsible for health and budget from 13 African countries, alongside international representatives, development partners, technical experts, private-sector representatives, academics and CSOs.

3.1.2.2 The Summit was hosted by AHPA, with support from NEAPACOH, PPD ARO, AFIDEP, WACI Health, the University of Cape Town, the Tony Blair Institute for Global Change, the University of Basel and Afrocentric.

3.1.2.3 The Cape Town Declaration on Preventive Health recognised Africa's persistent burden of disease and mortality, particularly among children, young people and women, as well as limited access to quality healthcare. It affirmed prevention, early detection and health promotion as essential to reducing disease risks and improving population wellbeing. It also acknowledged the influence of social determinants of health, including income, housing, education, transport and food security.

3.1.2.4 Preventive health was positioned as an investment in human capital and socio-economic development. The Cape Town Declaration on Preventive Health called for essential preventive services, including vaccination, to be safe, accessible and affordable without exposing individuals and households to financial hardship. It reaffirmed the critical role of parliamentarians in advancing equitable, responsive, resilient and sustainable health systems.

3.1.2.5 The Cape Town Declaration on Preventive Health set out six areas of commitment:

- **Resilient, Responsive and Sustainable Health Systems:** Integrate prevention, health promotion and early intervention into national health plans; promote evidence-informed policies and healthier environments; and strengthen preparedness for epidemics, climate-related risks and other shocks through primary healthcare, disease surveillance, laboratory capacity and resilient supply chains.
- **Sustainable Health Financing:** Incorporate costed preventive health priorities into national plans and budgets; strengthen domestic resource mobilisation, efficiency, equity and accountability; promote dialogue among Ministries of Health and Finance and Parliaments; and advance financing arrangements that reduce financial hardship and support preventive services.
- **African-Led Implementation, Policy and Governance:** Translate commitments into country-owned plans with clear responsibilities, timelines and targets; strengthen parliamentary oversight and community participation; promote South-South cooperation and learning; and support implementation through local authorities, frontline health workers, civil society, traditional and community leaders, young people and affected communities.
- **Innovation, Data and Accountability:** Strengthen interoperable health information systems, disease surveillance and disaggregated data; promote responsible digital innovation with appropriate privacy and equity safeguards; and use health technology assessments, disease-burden evidence, programme evaluations and economic analysis to inform policy and resource allocation.
- **Partnerships for Resilient Health Systems:** Build coordinated and sustainable partnerships among governments, Parliaments, communities, regional institutions, civil society, academia, development partners, technical experts and the private sector. Partnerships should be aligned with national priorities and guided by shared responsibilities and mutual accountability.
- **Implementation and Accountability:** Establish an Expert Group on Preventive Health to support implementation, evidence exchange, peer learning and progress reporting. Strengthen regional parliamentary cooperation through existing networks and institutions, including the EAC, SADC, ECOWAS, NEAPACOH, IPU and CPA. Review and report on progress, preferably annually, through existing national and regional mechanisms, ensuring transparency and parliamentary oversight.

3.1.3 Consideration and Adoption of the Cape Town Declaration on Preventive Health

3.1.3.1 Delegates considered the draft Cape Town Declaration on Preventive Health and proposed amendments to strengthen its content and broaden its scope. The proposed changes included:

- Recognising occupational health as an integral component of preventive health.
- Strengthening the multisectoral approach and coordination across government ministries.
- Replacing the word “appreciating” to avoid repetition.

- Including “mainstreaming” to emphasise the integration and ownership of preventive health across ministries.
- Incorporating basic science and preventive health education into school curricula.
- Recognising government’s responsibility to address the social determinants of health.
- Including maternal health as a key component of preventive health.
- Ensuring that the wording referred appropriately to both representatives and participants.

3.1.3.2 Following consideration of the proposed amendments, the Cape Town Declaration on Preventive Health was unanimously adopted with amendments. It called on African governments, Parliaments, continental and regional institutions, communities and partners to provide sustained political leadership, financing and accountability to implement its commitments.

3.1.3.3 Delegates also expressed appreciation to the Government and people of South Africa, particularly the Parliament of South Africa, AHPA and its partners, for hosting and organising the Summit.

3.1.4 Proposed Way Forward and Post-Summit Actions

3.1.4.1 The Summit concluded with a proposed framework for translating the Cape Town Declaration on Preventive Health into practical parliamentary and policy action. The approach was summarised as **“Adopt, Implement and Review”**, underscoring the importance of keeping the Cape Town Declaration on Preventive Health as an active framework for collective action rather than a one-off statement of intent.

3.1.4.2 Eight priority actions were proposed for the post-Summit period:

- **Adoption and Dissemination of the Cape Town Declaration on Preventive Health:** Confirm the final text and formal adoption and endorsement process. Disseminate the agreed Cape Town Declaration on Preventive Health to participating delegations and partners and submit it to national Parliaments for consideration and follow-up action.
- **Establishment of an Expert Group:** Invite participating countries and partners to nominate representatives to the Expert Group on Preventive Health, agree on its membership and terms of reference, and convene its inaugural meeting to develop a practical 12-month work plan.
- **Engagement of Parliamentary Networks:** Strengthen joint advocacy and coordinated action through existing parliamentary networks, including NEAPACOH, the Commonwealth Parliamentary Association (CPA), the Inter-Parliamentary Union (IPU), the SADC Parliamentary Forum and the ECOWAS Parliament.
- **Promotion of National Parliamentary Action:** Encourage participating delegations to brief their national parliamentary counterparts, engage parliamentary health committees and caucuses, identify priority policy and financing issues, and report on progress and challenges in implementing the Cape Town Declaration on Preventive Health.
- **Sharing of Summit Outputs:** Disseminate Summit materials, including presentations, photographs and the final report, to participating countries and partners to sustain engagement and facilitate the exchange of experiences.
- **Continued Dialogue and Francophone Outreach:** Maintain online discussions to facilitate the exchange of practical experiences and monitor follow-up activities.

Expand engagement with Francophone countries through targeted outreach and improved access to French-language materials.

- **Annual Review and Continuity:** Reconvene the Summit annually to assess progress, share lessons, adapt approaches and renew commitments. The annual platform would provide an opportunity for accountability, continued learning and review of implementation.
- **Monitoring and Reporting:** Document progress, identify implementation challenges, share lessons and report on follow-up activities through the proposed expert and parliamentary coordination mechanisms. This would support continuous review and adaptation of interventions to national circumstances.

3.1.4.3 These proposed actions were intended to ensure that the Summit's commitments translated into sustained activity through national parliamentary engagement, expert support, regional partnerships, information-sharing and periodic review. The annual Summit would provide a platform for participating countries and partners to report on progress, address implementation challenges, share lessons and renew their collective commitment to preventive health.

3.2 CLOSING CEREMONY

Moderator: Hon Dr Sebastian Ngmenenso Sandaare, Member of Parliament, Ghana

3.2.1 Closing Reflections

3.2.1.1 In his closing reflections, Hon Dr Sebastian Ngmenenso Sandaare observed that a consistent message had emerged throughout the Summit: preventive health was a core public health imperative and a shared investment in healthier populations, stronger health systems and more resilient economies. It was essential to improving health outcomes, supporting sustainable public finances and advancing human development.

3.2.1.2 He recapped the five thematic areas addressed during the Summit:

- **Resilient, responsive and sustainable health systems:** Prevention should be integrated into primary healthcare and delivered through community-based services, close to where people live.
- **Sustainable health financing and fiscal management:** Prevention was a long-term investment, with benefits accruing over time and across sectors.
- **African regional perspectives and implementation:** Countries shared experiences and examined approaches to implementing preventive health across the continent.
- **Innovation, data and accountability:** Digital tools, evidence and reliable information could strengthen early detection, inform decisions and demonstrate results.
- **Partnerships for resilient health systems:** Governments, Parliaments, experts and partners needed to build on existing progress and strengthen cooperation across the region.

3.2.1.3 Hon Dr Sandaare noted that, despite differences in national circumstances and stages of health-system development, participating countries shared a common objective. The priority was to translate the understanding and commitments developed during the Summit into practical action.

3.2.1.4 He welcomed the adoption of the Cape Town Declaration on Preventive Health, incorporating amendments, and noted that Dr Kenneth Jacobs would outline the proposed follow-up actions in his closing address.

3.2.1.5 Encouraging delegates to take the outcomes back to their respective institutions, he stated:

3.2.1.6 “I would encourage each of us to take what we have learned back to our own institutions: to share it with colleagues and committees, to consider how it can inform legislation, budgets and oversight, and to keep the conversation going.”

3.2.2 Acknowledgement of the Organisers

3.2.2.1 Hon Dr Sandaare expressed his sincere appreciation to AHPA, the organising team and all those who had contributed to the successful delivery of the African Summit on Preventive Health.

3.2.2.2 He acknowledged the considerable dedication, commitment, teamwork and attention to detail required to organise a Summit of this nature. He recognised the efforts of those who had worked behind the scenes, from the initial planning and coordination to the logistical arrangements and execution of the programme.

3.2.2.3 He noted that the successful gathering of parliamentary leaders, policymakers, experts and stakeholders from across Africa reflected the collective effort and commitment of the entire team. He commended the organisers for their professionalism, resilience and willingness to go beyond their responsibilities to ensure the Summit’s success.

3.2.2.4 He concluded by expressing gratitude to everyone involved and encouraged the team to take pride in the achievement, while building on the Summit’s outcomes through continued collaboration and follow-up.

3.3 NEXT STEPS AND IMPLEMENTATION OF THE CAPE TOWN DECLARATION ON PREVENTIVE HEALTH

3.3.1 Closing Address by the Managing Director of AHPA

3.3.1.1 Dr Kenneth Jacobs, Managing Director of AHPA, delivered the closing address, reflecting on the Summit’s key themes and outlining priorities for implementing the Cape Town Declaration on Preventive Health.

3.3.1.2 He reiterated that preventive health was a shared investment in healthier populations, stronger health systems and resilient economies. It contributed not only to improved health outcomes but also to sustainable public finances, productivity and human development.

3.3.1.3 Reflecting on the Summit’s deliberations, Dr Jacobs highlighted the importance of integrating preventive services into primary healthcare and bringing care closer to communities. He also emphasised the need for sustainable financing and sound fiscal management, recognising prevention as a long-term investment with benefits extending beyond the health sector.

3.3.1.4 He further highlighted the value of regional approaches to preventive health, the contribution of innovation and digital technologies, and the importance of reliable data and accountability in informing policy and supporting early detection. Partnerships among governments, Parliaments, experts, development partners and the private sector were identified as essential to advancing implementation.

3.3.1.5 Acknowledging the different stages of health-system development across participating countries, Dr Jacobs noted that they shared a common commitment to healthier populations and more resilient systems. The priority was to translate the Summit's commitments into action, guided by the Cape Town Declaration on Preventive Health at national and regional levels.

3.3.2 Priorities for Implementation

3.3.2.1 Dr Jacobs outlined the following priorities for translating the Declaration into parliamentary and policy action:

- **Adoption of the Cape Town Declaration on Preventive Health:** Formalise the adoption of the Cape Town Declaration on Preventive Health as the collective commitment of participating parliamentarians and stakeholders.
- **Establishment of an Expert Group on Preventive Health:** Nominate members, agree on its mandate and timeframe, and convene its inaugural meeting within one week to support implementation and ongoing technical engagement.
- **Dissemination of Summit outputs:** Share the Declaration, Summit report and other outcomes with participating institutions, national counterparts and relevant stakeholders to support follow-up action.
- **Engagement with parliamentary networks and development partners:** Strengthen collaboration with inter-parliamentary organisations, parliamentary networks—including the EAC, SADC, ECOWAS, NEAPACOH, IPU and CPA—and partners such as AHPA, Afrocentric, AFIDEP, WACI Health and the Global TB Caucus (GTBC), among others.
- **Engagement with national Parliaments:** Present the Declaration to national Parliaments, brief relevant counterparts, engage health committees and caucuses, identify policy and financing priorities, and report on implementation progress and challenges.
- **Continued knowledge exchange:** Sustain the sharing of experiences, evidence and lessons among participating countries and stakeholders.

3.3.2.2 He encouraged delegates to take the Summit outcomes to their respective institutions and ensure that they informed legislation, budget decisions and parliamentary oversight. He also stressed the importance of maintaining relationships and dialogue among parliamentarians, governments, experts and partners.

3.3.2.3 Dr Jacobs concluded that the Summit's success would ultimately be measured by its ability to translate commitments into sustained action. He then invited Hon Esther Nicholus Matiko of the Tanzania Parliamentary Association on Population and Development to deliver the vote of thanks and formally close the Summit.

3.4 VOTE OF THANKS

3.4.1 Hon Esther Nicholus Matiko, representing the Tanzania Parliamentary Association on Population and Development, delivered the vote of thanks. She expressed appreciation to the Government and people of South Africa for their hospitality and noted that the two-day Summit had provided an important opportunity for delegates to exchange experiences, engage in constructive dialogue and identify shared priorities for advancing preventive health across Africa.

3.4.2 She reiterated that preventive health was an investment in human capital, national development and sustainable public finances. Health systems should be assessed not

only by their capacity to treat illness, but also by their ability to prevent disease and promote the wellbeing of communities.

3.4.3 Hon Matiko highlighted the Summit's discussions on resilient health systems, community-based primary healthcare, sustainable financing, innovation, data, accountability and partnerships. She underscored the importance of reliable information and appropriate technologies in supporting early detection, informed policymaking and improved health outcomes.

3.4.4 She called on African governments to prioritise preventive health and use limited public resources efficiently and sustainably. Achieving these objectives required coordinated action among governments, Parliaments, experts, development partners and other stakeholders.

3.4.5 Acknowledging that countries were at different stages of health-system development, she emphasised their shared commitment to healthier populations and resilient health systems. She encouraged parliamentarians to take the Summit's outcomes back to their respective institutions and advance implementation through legislation, budgeting, oversight and collaboration.

3.4.6 Hon Matiko thanked AHPA for convening the Summit and bringing together parliamentarians, health leaders and experts from across the continent. She also expressed appreciation to the Government and people of South Africa, the City of Cape Town, moderators, speakers, delegates, the Secretariat, technical and audio-visual teams, venue staff and all others who had contributed to the event's success.

3.4.7 She concluded that the adoption of the Cape Town Declaration on Preventive Health marked an important step from dialogue towards implementation. Its success, she emphasised, would depend on sustained collective action and continued commitment by all stakeholders. She thanked the delegates and wished them safe travels to their respective countries.

CHAPTER 4 – CONCLUSION AND WAY FORWARD

4.1 The African Summit on Preventive Health, convened by AHPA on 29–30 October 2026 in Cape Town, South Africa, provided an important platform for African parliamentarians, policymakers, health experts and development partners to examine the role of preventive health in building resilient, responsive and sustainable health systems. The participation of 64 delegates from 13 African countries reflected a shared recognition of the need to reposition preventive health as a central priority in national health policies, planning and resource allocation.

4.2 The deliberations highlighted the mounting pressures facing African health systems, including the persistent burden of communicable diseases, the growing prevalence of NCDs, rising healthcare costs, constrained public finances and changing development assistance. Against this backdrop, the Summit reaffirmed that greater investment in prevention, early detection and timely intervention is essential to reducing avoidable illness, improving population health and ensuring the long-term sustainability of health systems. Preventive health must therefore be recognised not simply as a healthcare intervention, but as a strategic investment in human capital, economic productivity and socio-economic development.

4.3 Discussions across the five thematic pillars demonstrated that effective preventive healthcare depends on an integrated, coordinated and adequately resourced approach. Key priorities included strengthening primary healthcare and community-based services; securing predictable and sustainable financing; translating evidence and country experiences into effective implementation; leveraging innovation, digital technologies and reliable health information systems; and building partnerships among governments, Parliaments, development partners, academic institutions, civil society and the private sector. The deliberations also reinforced that prevention, early diagnosis, treatment and continuity of care are interconnected elements of a functioning health system and must be strengthened together.

4.4 A significant outcome of the Summit was the adoption, by consensus and with amendments, of the **Cape Town Declaration on Preventive Health**. The Declaration provides a common framework for advancing preventive health through stronger health systems, sustainable financing, African-led implementation and governance, innovation and data, partnerships, and accountability. Although voluntary and non-binding, it represents a collective commitment by participating parliamentarians and stakeholders to elevate preventive health on national, regional and continental policy agendas.

4.5 The Summit underscored the critical role of Parliaments in translating these commitments into tangible action. Through their legislative, budgetary and oversight responsibilities, Members of Parliament can ensure that preventive health is embedded in national policies, legislation, strategic plans and public expenditure frameworks. The participation of both Health; and Finance and Budget Committee representatives reinforced the importance of closer collaboration between these portfolios to secure sustainable financing, strengthen accountability and establish prevention as a long-term national investment priority.

4.6 The exchange of country experiences demonstrated the value of African-led solutions, regional cooperation and shared learning in addressing common health challenges. Examples and lessons from participating countries provided opportunities to identify effective approaches, adapt interventions to national circumstances and strengthen implementation. The discussions reaffirmed that sustainable progress depends on government leadership and national ownership, with development partners and other

stakeholders complementing, rather than substituting for, national health-system responsibilities.

4.7 While the adoption of the Cape Town Declaration on Preventive Health marked an important milestone, its significance will ultimately be determined by the extent to which its commitments are implemented. Priority follow-up actions include establishing the proposed Expert Group on Preventive Health, disseminating the Declaration and Summit Report, engaging national Parliaments and relevant parliamentary networks, and sustaining collaboration with regional and continental institutions. Regular engagement, monitoring and periodic review will be essential to track progress, identify implementation challenges, share lessons and strengthen accountability.

4.8 Participating parliamentarians and stakeholders are therefore encouraged to take the Summit's outcomes to their respective institutions and countries and champion the integration of preventive health into national development priorities, health-sector strategies and public expenditure frameworks. Continued engagement through existing parliamentary networks and partnerships, including NEAPACOH, the AU and other regional and continental platforms, will be important in advancing a coordinated African approach. This engagement should translate into practical parliamentary action, including policy development, budget scrutiny, oversight and advocacy for sustained investment in prevention.

4.9 AHPA, as the convenor of the Summit, has an important role in sustaining the momentum generated by the deliberations. This includes facilitating continued policy dialogue, supporting evidence-informed parliamentary engagement, strengthening collaboration among African institutions and partners, and helping to monitor progress towards the commitments made. The proposed annual Summit and related knowledge-sharing platforms could provide opportunities for participating countries to review implementation, exchange experiences and renew their collective commitment to preventive health.

4.10 Ultimately, the success of the African Summit on Preventive Health will not be measured solely by the quality of its deliberations or the adoption of the Cape Town Declaration on Preventive Health, but by the policies adopted, resources mobilised, programmes implemented and improvements in population health that follow. The Summit has established a foundation for sustained continental engagement and collective action towards health systems that prioritise prevention, protect communities and promote healthier populations.

The challenge now is to move from commitment to implementation, from dialogue to measurable action, and from a predominantly treatment-oriented approach to building healthier and more resilient societies across Africa.

ANNEXES

Annex 1: African Summit on Preventive Health Programme

Annex 2: Cape Town Declaration on Preventive Health

Annex 3: Participants Present from 29th to 30th October 2026

Annex 1: African Summit on Preventive Health Programme

AFRICAN SUMMIT ON PREVENTIVE HEALTH

Preventive Care: National Healthcare System Sustainability and the Role of Preventive Care

Sun Square City Bowl Hotel, Cape Town, South Africa | 29–30 October 2026

AFRICAN SUMMIT ON PREVENTIVE HEALTH AGENDA

AGENDA AT A GLANCE – DAY 1: THURSDAY, OCTOBER 29, 2026

Time	Agenda Item
8:00 – 9.00 am	Registration
9:00 – 10:00 am	**Session 1** **Opening and Welcome: Programme Director: Hon Mokhothu Makhalanyane, Chair of Chairs in the National Assembly of Lesotho (10 min)** SA Anthem AU Anthem 1. Welcoming by Member of Portfolio Committee on Health: Hon Masello Senne, National Assembly, Parliament of South Africa (15min) 2. Introduction to, and outline of, the Summit's objectives and showcasing of the agenda: Dr Kenneth Jacobs, Managing Director, African Health Policy Alliance (12 min) 3. Opening remarks: Hon Dr Charles Ayume Minister of State for Health (Primary Health Care), Government of Uganda (12 min)
10:00 – 10:20 am	**Session 2** Introduction of keynote speaker by Hon Mokhothu Makhalanyane Keynote Address: Hon Cedric Frolick, House Chairperson, National Assembly, Parliament of South Africa (15 min) Message of Support: Her Excellency Wang Xiao, Acting Consul General of the People's Republic of China in Cape Town
10:20 – 11:00 am	Group Photo, Coffee/Tea Break
11:00 – 11:45 am	**Session 3** **Session Moderator: Hon Gerhardine Katjingisiua, National Assembly of Namibia (5 min)** **Pillar #1: Advancing Resilient, Responsive and Sustainable Health Systems for Socio-Economic Transformation: The Criticality of Preventive Care.** **Session Objectives:** The Session will introduce preventive health as a core health imperative that impacts on stronger and sustainable public health outcomes, long-term fiscal sustainability, and human capital development **Presenters:** Prof Tasleem Ras, Head of Department of Family, Community and Emergency Care, University of Cape Town (30min) **Interventions/Discussants** Hon Dr James Nyikal, Chair of the Committee of Health, National Assembly of Kenya (15min)
11:45 am – 12:50 pm	Open Discussion, Q&A
12:50 – 13:45 pm	Lunch Break

Time	Agenda Item
13:45 – 14:45 pm	**Session 4** **Session Moderator: Hon Bandile Masuku, Chair Portfolio Committee on Community Safety, TB Caucus Convenor, Gauteng Provincial Legislature** **Pillar #2: Sustainable Health Financing and Fiscal Management/ Position prevention as a long-term investment** **Session Objectives:** To discuss and have a better understanding and appreciation of the criticality of preventive care to sustainable health financing and fiscal management. The session will address the following topics: • Macroeconomic conditions and evolution of health financing strategies in the region. • Domestic resource mobilisation strategies, successes and challenges. • Effective investment in human capital, capability and systems. • The translation of micro-level health benefits into macro-fiscal outcomes. • The evidence base on preventive health ROI (health-economic and macroeconomic) **Presenters:** 1. Prof John Deanfield, Professorial Research Fellow, University College London, Clinical Science, contributor and expert affiliated with the **Tony Blair Institute for Global Change (TBI)** (30 min) 2. Dr Sansia Blackmore Independent Tax Policy Specialist, AHPA Policy Advisor – "The road to socially benefical taxation: Linking domestic resource mobilisation with responsive governance and quality health care" (15 min) **Interventions/Discussant.** Hon Fortune Daniel Molokele-Tsiye, Member of the Parliament of Zimbabwe, Co-Chair, Pan African Parliamentary Taskforce on Domestic Financing for Health, Caucus on Tuberculosis (15 min)
14:45 – 15:45 pm	Open Discussion, Q&A
15:45 – 16:45pm	**Session 5** **Session Moderator: Hon Discent Bajila Chair Committee of Health, Parliament of Zimbabwe** **Pillar #3: Implementation—African Regional Perspectives on preventive care** • Presentation of report on online dialogues • African Regional Perspectives: South Africa ROI Study **Session Objectives:** To discuss and have a better understanding and appreciation of Africa Region responses to preventive care, best/innovative practices that have worked, remaining challenges and opportunities. The session will address the following topics: • Adopting an Africa-focused approach led at the local, national, regional, and continental levels. • Assessing the clinical and fiscal dimensions of preventive health across Africa, including the current status in different countries, successful initiatives, and persistent challenges. • Identifying ways for countries to build on progress to date and strengthen collaboration with partners across the region. • Ensuring that implementation strategies are tailored to regional and national contexts and remain feasible. **Presenter(s):** 1. Report on online dialogues: Dr Kenneth Jacobs, African Health Policy Alliance (15 min) 2. African Regional perspectives – Evidence from Malawi: Hon Dr Anthony Masamba, Chair of the Committee of Health, Parliament of Malawi (15 min) 3. African Regional perspectives – South African ROI study: Dr Kenneth Jacobs, African Health Policy Alliance (15 min) 4. African Regional perspectives – Evidence from Zambia: Hon Dr Joseph Musanje, Member of Parliament, Parliament of Zambia (15 min)
16:45 – 17:35 pm	**Breakaway Session** **Session Moderator: Hon Dr Monday Rude, Chair of Committee of Health, Parliament of Uganda (5 min)** **Session Objectives:** The Breakaway Sessions will make deep-dive discussions in understanding Africa Region responses to preventive care. The topics that will guide the discussions are: 1) preventive care approaches at the local, national, regional and continental levels; 2) understanding both clinical and fiscal perspectives across Africa; and 3) the current status of preventive health across countries – what is working well versus where challenges remain in preventive care?
	Wrap- up for the day

Time	Agenda Item
17:35 – 17:45 pm	Coffee/Tea Break – Close of Day 1

AGENDA AT A GLANCE – DAY 2: FRIDAY, OCTOBER 30,2026

Time	Agenda Item
08:00 – 08:30	**Welcome Back Session** **Moderator: Dr Brenda Mungai, Senior Research and Policy Analyst – Global Health, AFIDEP (5 min)** Feedback on Breakaway Sessions
08:30 – 09:30 am	**Session 6** **Session Moderator: Hon Chaatila Chibulo, Member of Parliament, Parliament of Zambia (5 min)** **Pillar #4: Innovation, Data & Accountability: Improving health outcomes through evidence, technology and accountability** **Session Objectives:** To present and discuss some of the potential, yet untapped opportunities, for improving health outcomes presented by digital health innovations, evidence-based preventive care, community, technological and data-driven approaches. The session will address the following topics: • Digital Health Innovation & Early Detection • Evidence-Based Preventive Care & Tech Assessment • Data-Driven Surveillance & Epidemiological Systems **Presenter(s):** 1. Prof Niklaus Labhardt, University of Basel, Switzerland *"Digital support enabling lay community health workers to independently prescribe and titrate medication for hypertension and diabetes:* (5 min) **Interventions/Discussants** 1. Hon Mokhothu Makhalanyane, Chair of Chairs in the National Assembly of Lesotho (5 min) 2. Hon Stephen Mule, Chair Global TB Caucus, National Assembly of Kenya (5 min)
9:30 – 10:30 am	Open Discussion, Q&A
10:30 – 10:50 am	Coffee/Tea Break
10:50 – 11:50 am	**Session 7** **Session Moderator: Hon Victor Phologolo Member of Parliament, Parliament of Botswana (5 min)** **Pillar #5: Partnerships for Resilient Health Systems. Mobilise collaboration among governments, Parliaments, experts and partners** **Session Objectives:** The session will explore and identify innovative and effective models for partnerships – benchmarked on how countries can capitalise on progress to date and on co-operation with partners across the region The session will further explore structures and approaches for effective Parliamentary Leadership for Strengthening collaboration among governments, Parliaments, experts and partners **Not necessarily presentation/ case studies** **Speakers:** 1. Speaker representing Afrocentric (25min) 2. Hon Modou Lamin B. Bah, Chairperson, Committee of Health, Parliament of The Gambia (15 min) 3. Hon Dr Robert Pukose, Member of Parliament, National Assembly of Kenya (15 min)
11:50 am – 12:50 pm	Open Discussion, Q&A
12:50 – 13:20 pm	**Session 8** **Session Moderator: Hon Sandile Nxumalo, Chair of Health Committee, Parliament of Eswatini (5 min)** **The Cape Town Declaration on Preventive Health**

Time	Agenda Item
	Presentation and adoption of the Cape Town Declaration on Preventive Health Presentation, discussions and feedback to the Cape Town Declaration on Preventive Health will be handled concurrently **Speaker/Speaker** Patrick Mugirwa, Secretariat of NEAPACOH (5 min)
13:20 – 13:40 pm	**Session 9** **Closing Ceremony** Next Steps / Implementation Dr Kenneth Jacobs, AHPA (5 min) Vote of Thanks: Hon Matiko Esther Nicholas, Parliament of Tanzania, Member of Tanzania Parliamentary Association on Population and Development (5 min)
13:40 - 14:00 pm	Group photos, networking and relationship building Press conference Media interviews Social media outlets
14:00 -	Lunch Break
	Participants Depart at leisure

Annex 2: Cape Town Declaration on Preventive Health

African Health Policy Alliance

CAPE TOWN DECLARATION ON PREVENTIVE HEALTH

AFRICAN SUMMIT ON PREVENTIVE HEALTH

Preventive Health: National Healthcare System Sustainability and the Role of Preventive Health

Sun Square City Bowl Hotel, Cape Town, South Africa,

29–30 October 2026

The African Summit on Preventive Health was held on 29–30 October 2026. The Summit convened 64 members of parliamentary committees who are responsible for health and budget within their own nations, as well as delegates from 13 African countries (Eswatini, Kenya, Lesotho, Malawi, Tanzania, The Gambia, Uganda, Zimbabwe, Zambia, Namibia, Botswana, Ghana and South Africa). Other participants at the summit included representatives from China, the United Kingdom and Switzerland, alongside development partners, technical experts, the private sector, researchers, academics and Civil Society Organisations who shared experiences and contributed to the drafting and adoption of the Cape Town Declaration on Preventive Health.

The Summit was organised under the theme “Preventive Health: National Healthcare System Sustainability and the Role of Preventive Health”.

The Summit provided a platform for African parliamentarians and other stakeholders to get acquainted with the pivotal role of preventive health as a cornerstone of resilient, responsive and sustainable health systems and socio-economic transformation in the African region. It established a platform for engagement, reflection and constructive dialogue on policy, funding, programme and partnership priorities, enabling the exchange of country perspectives on preventive health as a driver of resilient and sustainable health systems.

The Summit was hosted by the African Health Policy Alliance (AHPA), with technical support from the following partners: Network of African Parliamentary Committees of Health (NEAPACOH) Secretariat, Partners in Population and Development Africa Regional Office (PPD ARO), African Institute for Development Policy (AFIDEP) and WACI Health. Speakers included participants from the University of Cape Town; the Tony Blair Institute for Global Change; the University of Basel; Afrocentric and African Health Policy Alliance.

WHEREFORE:

WE, the parliamentarians and other stakeholders convened at the African Summit on Preventive Health under the theme “National Healthcare System Sustainability and the Role of Preventive Health in Africa”,

COGNISANT that the health status of the people of Africa remains a matter of concern, with unacceptably high morbidity and mortality rates, especially among children, young people and women, as a result of limited access to quality health services;

COGNISANT that maternal health is a key component in preventive health;

COGNISANT that preventive health involves taking proactive measures to detect health issues early, reduce disease risks and maintain overall well-being before symptoms appear;

COGNISANT that the social determinants of health — such as income, housing, education, transportation and food security—have a direct bearing on whether, when and how people access preventive health care services;

AWARE that preventive health is an investment in human capital and social and economic development, contributing to the full realisation of human potential and significantly promoting and protecting human rights and dignity, as well as empowering all people;

NOTING that promotive and preventive health services, including vaccination, are as important as curative, rehabilitative and palliative services, and that they therefore need to be safe, accessible and affordable without exposing users to financial hardship;

NOTING that the health challenges facing Africa are vast, but so too are the opportunities for meaningful change through collective commitment and leadership;

UNDERSCORING the need to build strong, resilient, functional and well-governed health systems, essential for quality service delivery;

ACKNOWLEDGING that parliamentarians are central architects of the health ecosystem and play a pivotal role in resetting the continent's health agenda to strengthen health systems for emergency response, equity, resilience and sustainability in the context of achieving the aspirations of Agenda 2063;

HEREBY adopt and commit ourselves to this Cape Town Declaration on Preventive Health on this 30th day of October 2026, and declare our commitment to the following:

Under Resilient, Responsive and Sustainable Health Systems

1. Mainstream prevention, health promotion and early intervention into national planning and development frameworks, recognising that healthier populations strengthen human capital, productivity, community resilience and inclusive socio-economic development.
2. Promote evidence-based informed policies and environments that enable individuals and communities to make healthier choices and adopt healthier behaviours - for example, in relation to alcohol and tobacco use and the consumption of sugar-sweetened beverages and salt - throughout the life course, to support immediate and long-term population health.
3. Improve preparedness for epidemics, climate-related health risks and other shocks by including science education as a foundation for preventive health, and linking routine primary care with surveillance, laboratory capacity, emergency preparedness and resilient supply chains.
4. Promote preventive health in the workplace, recognising workplaces as underused entry points for preventive care.

Under Sustainable Health Financing

1. Integrate clearly costed preventive health priorities into national development plans, health strategies, medium-term expenditure frameworks and annual budgets, and

improve the alignment between policy commitments, budget allocations, timely disbursement and implementation.

2. Strengthen domestic resource mobilisation for health while improving efficiency, equity, transparency, cost effectiveness and protecting priority preventive and primary healthcare services during periods of fiscal constraint and external financing volatility.
3. Promote regular, evidence-based dialogue between ministries of health, ministries of finance, Parliaments and other relevant agencies to ensure that health priorities are reflected in fiscal planning and realistic, sustainable health plans.
4. Support financing arrangements that reduce financial hardship, including pooled and predictable funding, and align purchaser and provider incentives with preventive health needs.

Under African-Led Implementation, Policy and Governance

1. Translate commitments into country-owned plans with clear responsibilities, realistic timelines and measurable targets, supported by stronger parliamentary legislation and oversight, as well as meaningful community participation, to embed evidence-based approaches.
2. Promote South–South learning and exchanges of practical African experience through regional economic communities, parliamentary networks, public health institutions and peer-learning platforms.
3. Strengthen implementation at subnational and community levels by involving local authorities, frontline workers, civil society, professional bodies, traditional and community leaders, young people and affected communities in the design and review of preventive programmes.

Under Innovation, Data and Accountability

1. Improve the interoperability of health information systems, strengthen disease surveillance and use disaggregated monitoring data to improve programme effectiveness.
2. Advance responsible digital health innovation, with safeguards for privacy and equity, to inform policy, financing and service delivery.
3. Promote health technology assessment, burden-of-disease evidence, programme evaluation and context-appropriate economic analysis to inform priority-setting while safeguarding equity and access.

Under Partnerships for Resilient Health Systems

1. Build coordinated partnerships among governments, parliaments, communities, regional institutions, civil society, academia, development partners and the private sector.
2. Build and support durable partnerships grounded in national priorities and mutual accountability, bringing together governments, parliaments, technical experts, regional and continental institutions, civil society, communities, academia, development partners and the private sector, where appropriate.

Under Implementation and Accountability

1. Establish an Expert Group on Preventive Health with relevant regional and multidisciplinary expertise to support implementation, evidence exchange, peer learning and progress reporting.
2. Enhance regional parliamentary coordination by utilising regional legislative networks (EAC, SADC, ECOWAS, NEAPACOH, IPU, CPA, etc.) to develop and harmonise laws and policies, strengthen accountability mechanisms, and monitor the implementation of the Declaration across Africa.
3. Review and report on progress regularly, preferably annually, through existing national and regional mechanisms, ensuring public transparency and parliamentary oversight.

In the same spirit, the participants in the African Summit on Preventive Health collectively and individually express their sincere appreciation and gratitude to the people and Government of the Republic of South Africa, especially the Parliament of South Africa, the African Health Policy Alliance and its partners, for the successful organisation and hosting of the Summit.

We call upon African governments, parliaments, continental and regional bodies, communities and partners to provide sustained political leadership, financing and accountability to translate this Declaration into practical action that improves health outcomes and advances Africa's sustainable development.

– End –

Annex 3: Participants Present from 29th to 30th October 2026

No.	Title	Participant Name	Country / Organisation
1	Dr	Brenda Mungai	AFIDEP
2	Hon	Victor Phologolo	Botswana
3	H.E.	Wang Xiao	China
4	Hon	Sandile Nxumalo	Eswatini
5	Dr	Sebastian Ngmenenso Sandaare	Ghana
6	Hon	Frank Asiedu Bekoe	Ghana
7	Hon Dr	James Wambura Nyikal	Kenya
8	Mrs	Evaline Kibuchi	Kenya
9	Hon	Stephen Mule	Kenya
10	Hon Dr	Robert Pukose	Kenya
11	Hon	Sagine Chritine Mabella	Kenya
12	Hon	Mokhothu Joseph Makhalanyane	Lesotho
13	Hon Dr	Anthony Masamba	Malawi
14	Mr	Sunge Kalumo	Malawi
15	Hon	Gerhardine Katjingisiua	Namibia
16	Hon	Helalia Mukapuli	Namibia
17	Mr	Gotthard Kasuto	Namibia
18	Mr	Mark Nabasa	PPD ARO
19	Mr	Patrick Mugirwa	PPD ARO
20	Hon Dr	Bandile Masuku	South Africa
21	Hon Dr	Tebogo Kgosietsile Letlape	South Africa
22	Hon	Masello Senne	South Africa
23	Hon	Juliet Khumalo	South Africa
24	Hon Dr	Karl du Pre' Le Roux	South Africa
25	Hon	Moshome Motubatse	South Africa
26	Dr	Sansia Blackmore	South Africa
27	Prof	Tasleem Ras	South Africa

No.	Title	Participant Name	Country / Organisation
28	Dr	Kenneth Jacobs	South Africa
29	Mrs	Xavier Jacobs	South Africa
30	Hon	Cedric Frolick	South Africa
31	Mr	Gershwin Balie	South Africa
32	Mr	Johan Booys	South Africa
33	Mr	Alex Williams	South Africa
34	Mr	Lee Roy Arendse	South Africa
35	Mrs	Shenay Balie	South Africa
36	Mr	Mathew Johnson	South Africa
37	Mr	Lucian Schroeder	South Africa
38	Mr	Duwayne Gillion	South Africa
39	Mr	David de Villiers	South Africa
40	Mr	Ashwin Mars	South Africa
41	Prof	Niklaus Labhardt	Switzerland
42	Hon	Hawa Mchafu Chakoma	Tanzania
43	Hon	Esther Nicholas Matiko	Tanzania
44	Hon	Alhagie S. Darboe	The Gambia
45	Hon	Modou Lamin B. Bah	The Gambia
46	Hon Dr	Monday Julius Rude	Uganda
47	Hon Dr	Charles Ayume	Uganda
48	Hon Dr	Kiti Peter	Uganda
49	Hon	Rwakimari Beatrice	Uganda
50	Hon	Lokoru Stephenson Yoyo	Uganda
51	Mr	Etyang Gerald	Uganda
52	Ms	Lillian Angell Nsubuga	Uganda
53	Hon Dr	Michael Bukenya	Uganda
54	Mr	Bagaga Ronald	Uganda
55	Hon	Owino Martin Peters	Uganda

No.	Title	Participant Name	Country / Organisation
56	Prof	John Deanfield	United Kingdom
57	Mrs	Nombaza Gxuluwe	WACI
58	Mr	Luke Jacobs	South Africa
59	Dr	Liam Jacobs	South Africa
60	Hon	Joseph Munsanje	Zambia
61	Hon	Chaatila Chibulo	Zambia
62	Hon	Fortune Daniel Molokele-Tsiye	Zimbabwe
63	Hon	Discent Bajila	Zimbabwe
64	Dr	Shamila Fakie	Afrocentric