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YEARS

Powering Impact, Sustainability
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REPORT

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Opening Ceremony



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List of Abbreviations

AHB	Africa Health Business
KHF	Kenya Healthcare Federation
SHA	Social Health Authority
SSA	Sub-Saharan Africa
UHC	Universal Health Coverage
USD	United States Dollar
WHO	World Health Organization

Investing in Resilience: The Case for Sustainable Health Financing in Africa

Over the past 25 years, Africa has achieved measurable health gains: life expectancy has increased by more than 10 years, under-five mortality has dropped by over 50%, maternal mortality has declined by nearly 40%, and HIV, malaria, and tuberculosis deaths have all fallen significantly thanks to sustained public health action. ^[1]

Despite these gains, sudden reductions in external health aid over the past year have had severe consequences across many countries. Official development assistance declined by approximately 9 percent in 2024 and was projected to fall by up to 17 percent in 2025. ^[2] Development assistance for health from the three largest bilateral donors was also expected to contract by at least 20 percent from 2024 levels. ^[2] Service delivery has been disrupted and vulnerable populations placed at risk. Ongoing support from international partners, including the WHO, has been critical in mitigating these interruptions and sustaining essential services.

Africa's health sector stands at a defining inflection point. Health is being repositioned, at both national policy and global investment levels, from a cost center to a strategic investment asset that drives economic growth, workforce productivity, and long-term societal resilience. This repositioning occurs against a backdrop of structural challenges: declining external assistance, widening financing gaps, critical workforce shortages, and legacy system architectures misaligned with contemporary demands. Africa's young and rapidly growing population simultaneously creates urgency and generates opportunity for system-wide transformation at scale.

The current crisis presents a strategic opportunity to accelerate the transition from aid dependency toward sustainable health financing grounded in domestic resource mobilisation and strengthened national ownership. Realising this transition requires robust institutions, effective policy frameworks, and operationally efficient systems that translate available resources into measurable health and economic outcomes. It further requires deepened collaboration between governments, civil society, and private-sector actors, with particular emphasis on local pharmaceutical manufacturing and digital health innovation.

Integrated by Design: Aligning Investment with Africa's Health Priorities

Across the African continent, health systems are being integrated into national development and economic growth strategies, repositioned as drivers of structural economic transformation rather than standalone social expenditure. Governments are expanding national health insurance coverage, increasing public investment in healthcare infrastructure, and strengthening regulatory frameworks, with comprehensive reforms expected throughout 2025 and beyond.

Within global health leadership, emphasis is shifting decisively from strategic dialogue to operational implementation. The WHO Health Impact Investment Platform is actively supporting member states in mobilising

capital at scale: more than USD 30 million has been raised to date against a broader target of USD 1.5 billion to support health system strengthening and service delivery enhancements across priority markets. ^[3]

Coordinated efforts are underway to convene governments, development finance institutions, and private investors around new financing instruments designed to reduce fragmentation, improve capital efficiency, and align investment flows with national health priorities. Three strategic priorities underpin this transformation:

- **Human capital and economic productivity:** Investment in health is foundational to workforce productivity, social stability, and long-term economic development.
- **Sustainability through domestic systems:** Health financing frameworks must be domestically driven, fiscally efficient, and anchored in strong governance and accountability mechanisms.
- **Public-Private Partnership:** The private sector provides capital, innovation, and delivery capacity; effective regulatory frameworks ensure equity and the creation of measurable public value.

Achieving this transformation requires a decisive shift from fragmented financing structures toward integrated, coherent investment systems. This entails strengthening domestic resource mobilisation frameworks, scaling blended finance instruments, expanding investment in primary healthcare and preventive services, and reinforcing regulatory capacity and local manufacturing ecosystems.

The Coordination Imperative: Private Sector Engagement in Africa's Health Transformation

The private sector is a structural pillar of Africa's health systems delivering a significant share of primary, secondary, and tertiary care while contributing capital, operational capacity, and service innovation. As African countries pursue health transformation and financing reform, the effectiveness of private sector participation hinges on clear regulatory frameworks and institutionalised coordination mechanisms that align private delivery with national health priorities.

Kenya illustrates how such coordination can work in practice. Healthcare delivery has long been shaped by a mixed model of public, non-profit, and commercial providers. To strengthen alignment across sectors, Kenya has established formal engagement structures designed to resolve policy, regulatory, and operational issues through constructive and sustained dialogue.

The Kenya Healthcare Federation (KHF) functions as the primary platform for structured engagement between private sector actors and government on health policy and reform. Complementing this, the Presidential Roundtable provides a senior-level forum that strengthens alignment and reinforces the foundations of sustainable public-private collaboration.

The Kenya Model: Health Reform as Economic Transformation

Kenya demonstrates how coordinated, multi-pillar reform can simultaneously reposition a health system as social infrastructure and as an engine of economic growth. Under its Universal Health Coverage (UHC) agenda, Kenya has structured reforms across four interconnected pillars, each generating both health outcomes and economic co-benefits.

Reform Pillar	Implementation Highlights and Evidence
Sustainable Health Financing	The Social Health Authority (SHA) has enrolled more than 21 million Kenyans as of end of 2024/25, establishing a domestically anchored, contributory financing base and markedly expanding financial risk protection across income groups ^[4]
Primary Healthcare Strengthening	Scaled investment in primary and community health infrastructure is expanding access, improving early-intervention outcomes, reducing tertiary facility demand, and generating healthcare employment across counties.
Local Manufacturing and Health Security	Local Manufacturing and Health Security Domestic vaccine production initiatives, including the establishment of Kenya BioVax, are intended to reduce import dependency, shorten supply chains, and position the health sector as an anchor for industrial and supply chain development.
Digital Health Transformation	Nationwide digital health transformation is set to accelerate clinical efficiency, embed real-time public accountability, and unlock a new frontier of invest ability for digital-health innovators.

Collectively, these reforms are positioning Kenya as a regional hub for health innovation and investment, with commercially viable opportunities spanning infrastructure development, pharmaceuticals, digital health technology, workforce development, and health financing solutions.

Priorities to Practice: Financing Africa's Health Transformation at Scale

With priorities well established, the focus of Africa's health financing agenda has turned firmly toward implementation at scale. From this shared understanding, four clear areas of action have emerged as essential to driving meaningful and lasting system transformation:

- 1. Strengthen Domestic Health Financing:** Governments are accelerating the shift toward sustainable domestic financing through deeper revenue mobilisation, improved public financial management, and more strategic health expenditure allocation. The Abuja Declaration benchmark of 15% of national budgets allocated to health remains an important reference point and an enduring expression of shared commitment to population health.
- 2. Scale Blended Finance Mechanisms:** Development finance institutions and multilateral partners have a vital role in deploying concessional financing, guarantees, and innovative investment instruments strategically and at greater scale-reducing risk, mobilising private capital, and directing investment toward areas of greatest health system need.
- 3. Increase Investment in Primary Healthcare:** Primary healthcare and prevention consistently deliver among the highest returns across health, economic, and social dimensions improving outcomes, containing long-term costs, and sustaining workforce productivity. Sustained prioritisation of these foundational services remains central to achieving durable system transformation.
- 4. Strengthen Public Private Coordination:** Sustained system transformation demands stronger institutional collaboration between governments, the private sector, and civil society underpinned by predictable regulatory frameworks and clear accountability structures. Kenya's model, anchored in the Kenya Healthcare Federation and the Presidential Roundtable, offers a valuable framework for structured, high-level engagement.

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Ministerial Session- Financing Health Futures: Unlocking Investment for Africa's Growth





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List of Abbreviations

AI	Artificial Intelligence
BHCPF	Basic Health Care Provision Fund
GDP	Gross Domestic Product
HPV	Human Papillomavirus
HIV	Human Immunodeficiency Virus
MoH	Ministry of Health
NCD	Non-Communicable Disease
NHI	National Health Insurance (South Africa)
OHSC	Office of Health Standards Compliance (South Africa)
OOP	Out-of-Pocket Expenditure
PHC	Primary Healthcare
PPP	Public-Private Partnership
ROI	Return on Investment
SHA	Social Health Authority (Kenya)
SHIA	Social Health Insurance Act (Kenya, 2024)
SHIF	Social Health Insurance Fund (Kenya)
TB	Tuberculosis
UHC	Universal Health Coverage
WHO	World Health Organization

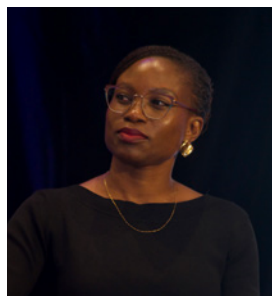
Executive Summary

African governments are navigating a critical inflection point in health financing. Rising healthcare demand, constrained fiscal space, shifting disease burdens, and the accelerating withdrawal of international donor financing are converging to create both urgency and opportunity for structural reform. The experiences shared across participating countries at ministerial level point to a coherent set of strategies that are producing measurable results on the ground.

The evidence converges on a clear finding: the most durable health financing reforms are those anchored in statute rather than policy intent alone. South Africa's National Health Insurance (NHI) Act and Kenya's Social Health Insurance Act (2024) demonstrate that legal grounding protects financing architecture from political volatility and creates enforceable entitlements for populations. Nigeria's Basic Health Care Provision Fund (BHCPF), established under the National Health Act and statutorily financed through a minimum allocation of 1 percent of the Consolidated Revenue Fund recently approved for increase to 2 percent further illustrates this principle. By embedding primary healthcare financing directly in law, Nigeria has created a predictable and protected funding stream for frontline facilities, essential medicines, and emergency response capacity, laying a foundation for more equitable and sustainable health service delivery.

Where legislation is complemented by institutional separation of financing, service delivery, and regulatory oversight, system performance improves measurably. Egypt's tri-authority model has reportedly produced a decline in out-of-pocket expenditure from 60 percent to 24 percent in pilot regions, a reduction with direct implications for household financial protection and poverty impact across the broader population. Cameroon reinforces this institutional logic through a different mechanism: an inter-ministerial platform linking the Ministries of Health, Finance, and Planning to improve cross-sectoral policy alignment and budget coordination. Complementing this, Cameroon is developing a digital health financing platform capable of tracking every transaction and claim at the individual level in real time, an innovation that directly reduces leakage, strengthens fiduciary accountability, and improves resource utilisation efficiency across the system.

Sustaining reform requires more than structural redesign, it requires fiscal conviction. Finance ministries respond to quantified investment cases, not advocacy narratives. Malawi's articulation of a USD 46 per capita financing gap anchored domestic budget negotiations and contributed to reducing aid dependency from 80 percent to 54 percent, demonstrating that evidence-based advocacy produces concrete resource mobilisation outcomes. Alongside this, revenue diversification is emerging as a critical strategy for system resilience. Health systems dependent on single funding streams remain structurally fragile. Senegal's earmarking of emerging oil revenues for health investment and Uganda's commitment to increase health spending from 5.6 percent to 9 percent of Gross Domestic Product (GDP) by 2030 underpinned by a parallel strategy to build domestic pharmaceutical manufacturing capacity and





reduce dependency on imported medicines reflect a broader continental shift toward broadening the financing base and retaining economic value within domestic economies. Where donor financing remains significant, structured and time-bound transition strategies rather than aspirational targets are essential to ensure that service continuity is protected as external support is phased out.

The private sector's contribution to this transition is also evolving in consequential ways. Its most significant function is no longer product supply but strategic technical and financial partnership with governments navigating complex reform agendas. MSD has redirected promotional budgets toward practitioner education and long-term market sustainability, with its Indonesia HPV vaccination partnership mobilising nearly USD 1 billion in financing through a structured investment case - a replicable model for unlocking transformative health financing commitments at scale. Roche Diagnostics addresses the capital barrier to laboratory infrastructure through a managed services model that eliminates large upfront costs and consolidates disease-specific diagnostics, including HIV, TB, and HPV, onto integrated platforms. AstraZeneca engages as a technical architecture partner, deploying AI-driven screening tools and supporting Ministries of Health in designing systems capable of transitioning from donor financing into sustainable national budget allocations.

Across all country and private sector engagements, one imperative is consistent: sustainable Universal Health Coverage (UHC) financing requires the deliberate construction of systems; legal, institutional, fiscal, and partnership-based that are designed to endure beyond project cycles, electoral transitions, and donor commitments. The countries making the most meaningful progress are those treating health financing not as a budgetary line item but as a long-term sovereign investment in economic and social resilience. That reframing, more than any single mechanism or intervention, is the defining strategic insight of this process.

Governing the Transition: Health Financing Reform Strategies in Africa

African governments are deploying structural mechanisms to reform health financing and governance in pursuit of UHC under converging pressures: rising healthcare demand, constrained fiscal space, shifting demographic and epidemiological profiles, and the accelerating withdrawal of international donor financing.

The mechanisms in use include embedding financing reforms in national legislation, redesigning pooling and purchasing arrangements to reduce fragmentation, and strengthening accountability through clearly defined institutional roles and separation of functions. A sustained transition from donor dependence toward greater domestic resource mobilization is underway as the foundation for long-term fiscal sustainability.

Below is a breakdown of the different strategic approaches being deployed across participating countries to strengthen the sustainability, accountability, and resilience of UHC financing systems.

1. Coverage Anchored in Law

The most durable health financing reforms are those embedded in statute. Countries that have legislated their financing frameworks demonstrate greater institutional continuity, more predictable resource flows, and stronger public accountability than those relying on policy directives or ministerial commitments alone.

1.1. South Africa

South Africa's National Health Insurance (NHI) framework, constitutionally grounded in Section 27 of the Constitution, is the country's primary structural instrument to unify fragmented health financing and service delivery. ^[1] South Africa allocates around 9% of GDP on health, placing it among higher-spending African nations. ^[2] This expenditure is heavily skewed: 84% of the population depends on the public sector while commanding a disproportionately smaller share of total health financing. ^[3]

The structural distortion is compounded by the cyclical depletion of private medical aid scheme benefits. Benefits are typically exhausted between August and September each year, at which point scheme members transfer back to public facilities. This surge intensifies toward year-end, coinciding with higher accident rates and seasonal demand peaks, placing pressure on an already constrained public system.

Under NHI, a single national purchasing fund will procure services from accredited public and private providers, ensuring uniform access to a defined package of healthcare services regardless of income or employment status. The Office of Health Standards Compliance (OHSC), established through parliamentary legislation, enforces quality compliance across all facilities. The NHI Bill was signed into law in 2024, providing the statutory foundation for phased implementation. ^[4]

1.2. Kenya

The Social Health Insurance Act (SHIA) of 2024 mandates that all households contribute 2.75% of monthly income to the Social Health Insurance Fund (SHIF). The Social Health Authority (SHA) and the Primary Healthcare Fund administer contributions and govern service coverage design. ^[5]

The reform is designed around citizen co-investment, moving households from passive beneficiary status to active financial participants in the health system. This reflects WHO guidance on sustainable health financing, which identifies broad contribution pools as essential to risk distribution and revenue adequacy.

Kenya has established a Health Policy Platform to curate innovations and structured policy proposals from citizens, private sector actors, and technical institutions, channelling them into formal government planning and budgeting cycles. This mechanism operationalises policy participation without bypassing institutional processes.

1.3. Nigeria

For domestic investments in health to be effective, the government must provide guarantees, enabling mechanisms, and a stable policy environment that builds



confidence among stakeholders. A central example of this is the BHCPF, established under the National Health Act, which ensures access to a Basic Minimum Package of Health Services for all Nigerians. ^[6] The fund is designed to strengthen primary health care and emergency services by channelling resources directly to frontline facilities, thereby improving service delivery and reducing financial barriers to care.

The BHCPF is financed through a statutory allocation of at least 1% of the Consolidated Revenue Fund, with recent approval to increase this to 2%, signalling stronger political commitment to health financing. ^[7] This predictable stream of funding supports essential drugs, facility maintenance, and workforce costs at the primary care level, while also providing emergency response capacity. By embedding the BHCPF within Nigeria's broader reform agenda, the government is laying the foundation for a more sustainable and equitable health financing model that prioritizes universal access to essential services and strengthens system resilience.

2. Separating Functions Builds Accountability

Functional clarity within health institutions produces measurable improvements in system performance. Where financing, service delivery, and regulatory oversight are structurally separated, accountability is strengthened, conflicts of interest are minimised, and system efficiency improves. The country experiences below provide quantitative evidence for this relationship.

2.1. Egypt

Egypt has reorganised its health financing architecture into three independent functional authorities: one responsible for service delivery, one for health financing, and one for regulatory oversight and quality assurance. ^[8] According to government representatives, the structural separation has yielded measurable results, with Out Of Pocket (OOP) expenditure in the six initial governorate pilot regions reportedly declining from 60% to 24%, a reduction of 36%. Since OOP levels above 15–20% of total health spending reliably predict catastrophic household expenditure and direct poverty impact, this trajectory, if sustained, signals a meaningful reduction in financial hardship at the household level. ^[9]

Country representatives have also cited a return on investment analysis indicating that every dollar invested in healthcare generated an estimated return of USD 10 to USD 35, demonstrating a strong economic multiplier effect associated with health sector investment. In this context, the private sector, including hospitals, insurers, and pharmaceutical companies, served as a key strategic partner in supporting system expansion, improving efficiency, and enabling multisectoral value creation at scale. This is consistent with the Harvard Commission on Investing in Health, which found that scaled health interventions generate USD 9 to USD 20 per dollar invested when full economic benefits, including labour productivity gains, are included. ^[10]

2.2. Cameroon

Cameroon has established an inter-ministerial platform linking the Ministry of Health, Ministry of Finance, and Ministry of Planning to improve cross-sectoral policy alignment and budget coordination. In parallel, a digital health financing platform is being developed to track every transaction and claim at the individual level in real time. ^[11]

Real-time transaction monitoring of this nature reduces leakage and improves fiduciary accountability across health systems. Research on comparable digital health financing implementations confirms measurable improvements in transparency and resource utilisation efficiency. ^[12]

3. Building the Case for Domestic Investment

Finance ministries respond to quantified investment cases, not advocacy narratives. Countries that have successfully increased domestic health financing have done so by presenting measurable financing gaps alongside the economic consequences of underinvestment. The following country experiences provide replicable models for evidence-based domestic budget advocacy.

3.1. Malawi

Malawi's actual health spend stands at USD 41 per capita against a WHO-recommended minimum of USD 86 per capita, representing a financing gap of USD 46 per person per year. ^[13] This quantified gap was used to anchor domestic budget negotiations and shape external partnership strategy.

As a direct result of evidence-based domestic advocacy, aid dependency has been reduced from approximately 80% to 54%, a verifiable shift toward domestically financed health services. ^[14] This trajectory aligns with the Lusaka Agenda, which calls on African governments to increase domestic health financing commitments as a condition for responsible management of global health aid transitions. ^[15]

3.2. Uganda

Uganda has committed to increasing health sector financing from 5.6% to 9% of GDP by 2030 ^[16], reflecting its obligations under the Abuja Declaration, which calls on African Union member states to allocate at least 15% of national budgets to health. ^[10]

A strategic component of Uganda's plan is investment in domestic pharmaceutical manufacturing capacity. Reducing dependency on imported medicines strengthens national supply chain resilience, reduces procurement costs over time, and retains economic value within the domestic economy. This approach is consistent with the African Union's Pharmaceutical Manufacturing Plan for Africa.

4. Strategic Earmarking of Resource Revenues

4.1. Senegal

Senegal is navigating a historic fiscal inflection point driven by emerging oil and gas production revenues. The central governance challenge is ensuring that natural resource revenues are directed toward high-impact public



investment rather than absorbed into general expenditure. Governance frameworks have been established to protect health financing from revenue volatility and misallocation risks associated with resource booms. A defined portion of oil revenues is being earmarked specifically for health sector investment, with strategic emphasis on primary healthcare infrastructure at the community level.^[17]

This approach draws on international best practice in sovereign resource revenue management, including lessons from Norway's Government Pension Fund model.

5. The Strategic Role of the Private Sector

The private sector's most significant contribution to African health systems is no longer in product supply. It is in functioning as a strategic technical and financial partner to governments navigating complex reform agendas. These repositioning changes the nature of public-private engagement from transactional to transformational.

5.1. From Promotion to Partnership: Pharmaceutical Engagement in UHC Financing-Lessons from MSD

A notable shift is underway in how pharmaceutical partners are engaging with health systems. MSD has redirected the majority of its pharmaceutical promotional budgets toward healthcare practitioner education platforms, reflecting a strategic prioritisation of long-term market sustainability over short-term promotional return. On procurement, MSD advocates for leveraging intercountry and intracountry volume aggregation as a viable pathway to reducing per-unit costs and improving affordability across market segments, with the Nigeria Cancer Access Partnership cited as an operational model.

MSD's experience scaling HPV vaccination in Indonesia further illustrates what this longer-term orientation can achieve. Through a five-year collaboration with the Indonesian government, MSD supported the construction of a structured financial investment case that mobilised nearly USD 1 billion in financing to expand the national HPV vaccination programme.^[18] The model demonstrates that combining patient capital with sustained evidence generation can unlock transformative financing commitments offering a replicable framework with clear applicability across comparable health investment contexts.^[18]

5.2. De-risking Diagnostic Infrastructure: Managed Services in Practice-Lessons from Roche Diagnostic

One of the most persistent barriers to diagnostic capacity in public health systems is the high upfront capital cost of laboratory infrastructure, a constraint that limits both access and equity. Roche Diagnostics has responded to this through a managed services model under which diagnostic equipment and integrated platforms are made available without large capital outlays, with ongoing maintenance and servicing obligations absorbed by the private partner rather than the health system.

A further systemic benefit lies in platform integration. Roche's consolidated diagnostic instruments are capable of performing multiple tests including HIV, TB, and HPV on

a single platform. This directly addresses the fragmented, disease-specific procurement model that has long generated duplicative costs and operational inefficiency across health systems, offering a more resource-efficient pathway to broadening diagnostic coverage

5.3. NCD Response at Scale: Digital Tools and System Integration- An AstraZeneca Case Study

Non-communicable diseases (NCDs) now account for 74% of all deaths globally, with low and middle-income countries bearing a disproportionate and growing share of this burden.^[19] Addressing this at scale requires diagnostic and system architecture solutions capable of functioning across large geographies with limited human resource infrastructure, a challenge that digital tools and AI-driven screening platforms are increasingly being deployed to meet

In this context, AstraZeneca has engaged with Ministries of Health not only as a diagnostics provider but as a technical architecture partner supporting the design of health systems capable of transitioning from donor or private sector financing into sustainable, line-item national budget allocations. This is a critical distinction. One of the most persistent failures in global health programming has been the inability to convert time-bound, project-based interventions into institutionalised public services. AstraZeneca's engagement model is structured explicitly to address this transition, building systems designed for absorption into national health architecture from the outset.

5.4. Governing the Partnership: Strategic Insights on Public-Private Health Collaboration

The following findings reflect the convergence of government and private sector experience shared at ministerial level across participating countries.

- **The Technical Partner Model:** The private sector's most significant contribution to health system strengthening lies not in product supply but in helping Ministries of Health construct data-driven, bankable investment cases for presentation to Ministries of Finance. This repositioning fundamentally reframes the public-private relationship moving it from transactional procurement toward transformational co-investment in health system architecture.
- **Institutional Coordination Mechanisms:** Kenya's Health Policy Platform offers a replicable model for integrating private sector innovation and citizen input into formal government planning cycles. Its significance lies in achieving this without bypassing or undermining institutional processes, a critical design principle for governance legitimacy and long-term sustainability.
- **Government Enabling Environment:** Private investment in health is neither attracted nor sustained in the absence of predictable regulatory frameworks, enforceable contractual guarantees, and institutional arrangements that assure the continuity of Public Private Partnership (PPP) commitments across electoral cycles. Governments that provide these conditions create the foundation for durable, investment-grade health partnerships, those that do not risk confining private engagement to short-term, low-commitment arrangements.



Building Systems That Last: Recommendations for Sustainable UHC Financing

The evidence drawn from country delegations and private sector engagements across this process converges on five actionable imperatives for sustainable UHC financing.

- i. Legislation as the foundation of sustainability:** Health financing reforms must be anchored in law rather than policy intent alone. Statutory frameworks create enforceable obligations, define entitlements, and ensure institutional continuity beyond political cycles. When embedded in legislation, mechanisms such as earmarked funds, payroll contributions, and national insurance schemes become both predictable and structurally protected. The experiences of South Africa's NHI Act and Kenya's SHIA (2024) demonstrate that legal grounding is the single strongest driver of reform durability, insulating financing architecture from the volatility of political transition.
- ii. Institutional separation to strengthen accountability:** Financing, service delivery, and regulatory oversight should be structurally separated to improve transparency and reduce conflicts of interest. This functional clarity strengthens checks and balances and enables more effective identification and correction of systemic inefficiencies. According to figures presented by country representatives, Egypt's tri-authority model has produced measurable results in pilot regions, with OOP expenditure reportedly declining from 60 percent to 24 percent, an outcome attributed in part to the clarity introduced by defined institutional roles.
- iii. Use of evidence to drive fiscal commitment:** Health Ministries must translate investment needs into quantified financial terms to secure stronger budget allocations from Ministries of Finance. Financing gaps expressed in per capita terms carry significantly more persuasive weight than policy narratives alone. In Malawi, quantifying a per capita gap of USD 46 between actual and required spending helped reframe health as a fiscal priority contributing to a reduction in aid dependency from 80 percent to 54 percent and demonstrating that evidence-based advocacy produces concrete resource mobilisation outcomes.
- iv. Revenue diversification for system resilience:** Health systems that rely on single funding streams remain structurally vulnerable to economic shocks, donor withdrawal, and fiscal contractions. Broadening the financing base through combinations of payroll contributions, general taxation, natural resource revenues, and pooled health funds expands fiscal space and reduces systemic fragility. Uganda's commitment to increasing health spending from 5.6 percent to 9 percent of GDP by 2030 reflects this diversification logic and signals a deliberate shift toward long-term financing stability.
- v. Structured pathways for aid transition:** Reducing donor dependence requires deliberate, time-bound transition strategies rather than aspirational targets without implementation architecture. Effective transitions

combine phased increases in domestic financing with parallel institutional strengthening and carefully sequenced withdrawal of external support ensuring that service continuity is protected throughout the process. Malawi's trajectory, referenced earlier in the context of evidence-based fiscal advocacy, also illustrates the outcomes of structured transition planning: a reduction in aid dependency from 80 percent to 54 percent achieved without corresponding deterioration in health system performance.

Reform Is Underway - Sustainability Is the Next Frontier

The evidence presented across this process points toward a shared and encouraging conclusion: Africa's transition to sustainable UHC is no longer a distant aspiration - in several countries, it is an active and measurable reality. What distinguishes the countries making meaningful progress is not the availability of additional resources alone, but the quality of the systems being built to deploy, protect, and sustain those resources over time.

No single model will serve every context. Each country faces a distinct combination of fiscal constraints, institutional capacities, and aid dependency profiles. There is, however, a shared direction and the experiences documented here demonstrate that progress along that direction is both achievable and replicable.

What this process has affirmed, above all, is that the will to reform is present. The task now is to ensure that will is matched by the institutional architecture, fiscal commitment, and partnership frameworks required to translate it into lasting change.





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Accelerating Diagnostics for Stronger Health Systems: Detect Early, Treat Better



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List of Abbreviations

Africa CDC	Africa Centres for Disease Control and Prevention
AI	Artificial Intelligence
DRC	Democratic Republic of the Congo
EDL	Essential Diagnostics List
ISO	International Organisation for Standardisation
NCD	Non-Communicable Disease
PPP	Public-Private Partnership
RDT	Rapid Diagnostic Test
TB	Tuberculosis
UHC	Universal Health Coverage
WHO	World Health Organization
WHA	World Health Assembly

Executive Summary

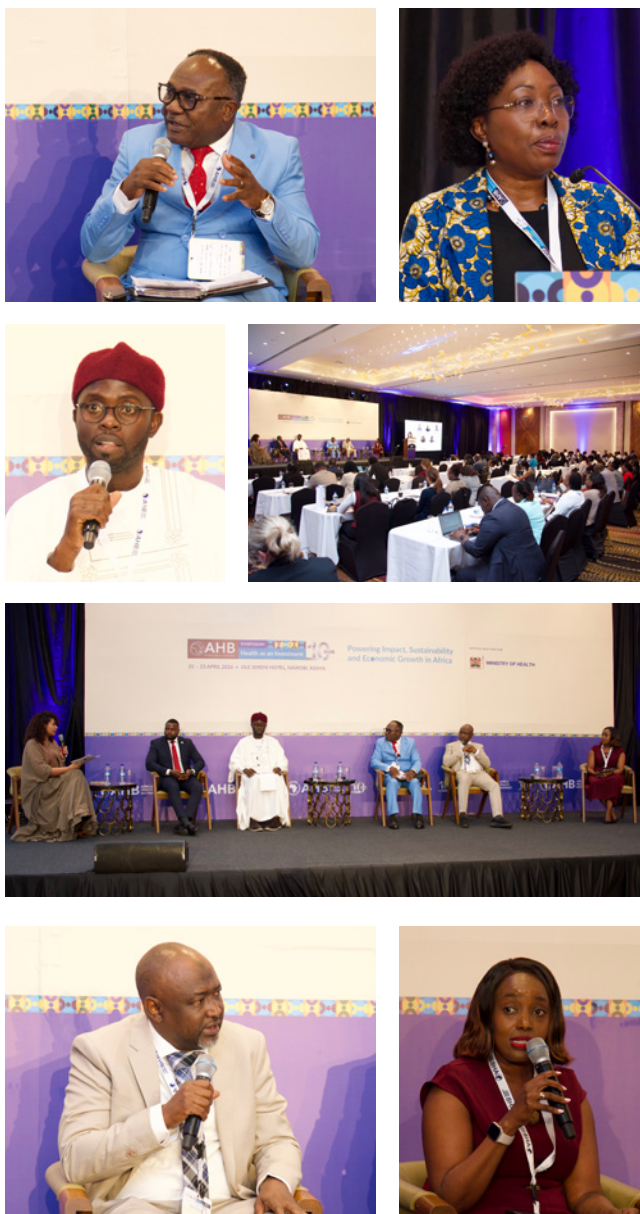
Access to timely, affordable, and quality diagnostics is a foundational requirement for Universal Health Coverage (UHC) and resilient health systems in Africa, yet it remains one of the most underinvested and structurally fragmented components of health delivery. Across the continent, fewer than half of primary health facilities in low- and middle-income countries have access to essential diagnostics, resulting in delayed or missed diagnoses, preventable mortality, and inefficient use of scarce health resources. Despite this, diagnostics consistently demonstrate among the highest returns on investment.

Africa is at a pivotal diagnostic moment, reinforced by World Health Assembly Resolution 76.5, which formally recognises the need to integrate diagnostics into national health systems. Importantly, the continent is not starting from zero. Countries such as Senegal, Cameroon, Nigeria, and Egypt have already demonstrated scalable proof of concept across manufacturing, laboratory infrastructure, financing models, and system-wide disease elimination programmes. These examples collectively show that the building blocks of a functional diagnostic ecosystem already exist within Africa; what is required now is coordination, scale, and sustained political and financial commitment.

A central argument is that diagnostics must be reframed from a clinical input to a fiscal and economic investment. Ministries of Finance, rather than only Ministries of Health, must be engaged through return-on-investment modelling that demonstrates reduced hospitalisation costs, improved workforce productivity, and long-term system efficiency. Without this shift, diagnostics will remain structurally underprioritised despite being essential to the effectiveness of all other health interventions.

There is also a need for integrated, tiered laboratory networks that connect community-level rapid diagnostics with regional laboratories and national reference facilities, supported by digital reporting systems. However, infrastructure alone is insufficient without sustained investment in maintenance, workforce capacity, and supply chains. Similarly, emerging innovations such as AI-assisted diagnostics and solar-powered tools offer transformative potential for last-mile access but must be embedded within strong regulatory, quality assurance, and logistical systems to ensure safe and effective use.

Several systemic enablers are critical for progress: integrating blood services into national diagnostic frameworks; expanding domestic financing for oncology and other non-communicable diseases; strengthening continental procurement mechanisms through the Africa Centre for Disease Control and Prevention (Africa CDC) to unlock economies of scale; and accelerating regulatory harmonisation across regional economic communities to reduce barriers to access and support local manufacturing. The experience of Egypt's Hepatitis C elimination programme further demonstrates that sustained political commitment, domestic financing, and integrated diagnostic infrastructure can deliver rapid, system-wide transformation with lasting institutional benefits.



Diagnostics are not peripheral to Africa's health agenda; they are central to achieving UHC, health security, and economic growth. The evidence base, technical models, and country-level examples already exist. The challenge now is implementation at scale through coordinated policy action, predictable financing, and political will aligned with the urgency of the continent's health needs.

Background

Access to timely, affordable, and quality diagnostics is the cornerstone of UHC and a critical enabler of resilient health systems. However, across Africa, diagnostics remain underfunded, heavily import-dependent and unevenly distributed. Studies show that less than 50% of primary health facilities in low-and-middle income countries (LMICs) have access to diagnostics.^[1] As a result, patients are often diagnosed late or not at all, undermining treatment outcomes and driving preventable deaths.

The World Health Organization (WHO) emphasizes that expanding access to diagnostics in Africa is essential to accelerating progress toward UHC, enabling earlier disease detection and more efficient use of resources.^[2] Economically, diagnostics offer one of the highest returns on investment (ROI) in health, with evidence showing substantial savings through avoided complications and efficient resource allocation. In South Africa, the country's molecular diagnostics programme is estimated to have a 10-year ROI of about USD 13.9 value for each USD 1 invested (across TB, HIV, COVID-19 testing) and to have averted approximately 4.3 million disability-adjusted life years DALYs.^[3] Such evidence reinforces that investments in diagnostics are not just a health priority but a sound economic one.

Africa's Diagnostic Moment: From Resolution to Reality

The continent stands at a pivotal strategic crossroads. Decades of expanded health access and improved outcomes have demonstrated what is possible across many African countries, yet access to timely, affordable, and quality diagnostics remains deeply uneven, continuing to drive delayed diagnoses, preventable deaths, and systemic inefficiencies across health systems.

A turning point came with the adoption of World Health Assembly Resolution 76.5, which marked the first moment of genuine global consensus requiring countries to integrate diagnostics into national health plans and expand access to diagnostic services. For a challenge long treated as peripheral, this represented a fundamental shift in how the world formally recognises the role of diagnostics in health system strengthening.

Crucially, Africa is not starting from zero. Across the continent, countries have already demonstrated compelling proof of concept. Senegal has manufactured diagnostic tools to scale; Cameroon has built ISO-accredited laboratories with advanced biosafety infrastructure; Nigeria is pioneering cancer diagnostics through innovative financing models; and regional institutions are advancing collaborative manufacturing and regulatory harmonisation networks.

The foundational work, in other words, has already begun. What this moment demands is not more innovation, but something equally critical: stronger coordination, sustained investment, and consistent policy—an infrastructure of commitment that turns promising pilots into lasting, systemic change.

Diagnostics as a Fiscal Imperative: Unlocking Economic Returns for National Growth

The economic case for diagnostics is considerably stronger than most national budgets reflect. Evidence from South Africa demonstrates returns of approximately USD 13.90 for every USD 1.00 invested in diagnostic services^[3], a figure consistent with a growing body of global evidence linking early and accurate diagnosis to reduced clinical waste, improved workforce productivity, and stronger treatment outcomes across disease areas. However, diagnostics continue to attract a fraction of the investment directed at clinical interventions, despite enabling those interventions to work.

Closing this gap demands a fundamental shift in how diagnostics are framed within government planning. The argument can no longer be confined to Ministries of Health. It must travel to Ministries of Finance, to treasury officials, and to the cabinet-level decision-makers who ultimately shape national budget priorities. This is not a clinical case; it is a fiscal one. Every dollar withheld from diagnostics is a dollar spent managing the downstream consequences of late, missed, or incorrect diagnosis: longer hospital stays, avoidable complications, and productivity lost to illness that could have been caught sooner.

This reframing carries direct implications for advocacy. Financing requests anchored in measurable economic returns such as reduced hospitalisation rates, improved workforce participation, lower rates of catastrophic health expenditure are demonstrably more likely to succeed than those built on clinical need alone. National diagnostic investment plans must therefore be developed alongside rigorous ROI modelling designed not for clinicians, but for the fiscal planners who hold the purse strings.

From Fragmentation to Flow: Building Integrated Laboratory Networks That Deliver at Every Level

A tiered laboratory network model, demonstrated through West African experience, offers a practical and proven architecture for delivering quality-assured diagnostics across every level of the health system. At the apex sit ISO-accredited, biosafety level three reference laboratories. Regional facilities in secondary cities operate at biosafety levels one and two, while at the community level, rapid diagnostic tests enable point-of-care testing without dependence on sophisticated infrastructure. Critically, digital reporting mechanisms including standard mobile communication tools bind these tiers together, enabling rapid result transmission from peripheral facilities to reference centres and back.

Cameroon's experience makes the model tangible. The country has constructed ISO-accredited laboratories with advanced biosafety infrastructure, supported by regional

accreditation programmes that sustain quality standards across every tier. The defining feature of this architecture is not its technical sophistication but its integrative logic: it does not replace community-level services with centralised ones — it connects them. The result is a system capable of detecting, confirming, and reporting across disease areas with consistency and reliability.

Sustaining this model, however, depends on three enablers that are too often treated as secondary concerns. Infrastructure maintenance chronically underfunded after initial capital investment must be built into recurrent budget lines, not left to deteriorate between donor cycles. Human resource capacity requires deliberate cascade training from tertiary institutions down to community health workers, ensuring that quality is not confined to the top of the system. And logistical continuity-reliable supply chains for reagents, consumables, and equipment must be treated as a strategic priority rather than an operational afterthought. The technical design of a laboratory network is only as strong as the systems that keep it running.

Cancer by Design, Not by Default: Making Oncology Diagnostics a National Priority

Non-communicable diseases (NCDs), and cancer in particular, are rising at a pace that African health systems cannot afford to treat as a future problem. They are a present one. However, oncology diagnostics remain absent from many national diagnostic strategies, despite requiring precisely the kind of sustained, long-term financing commitment that planning cycles should be designed to deliver. The capital investment is higher, the infrastructure more sophisticated, and the workforce training more specialised than for many communicable disease diagnostics but none of these challenges are insurmountable where the political will to prioritise them exists.

Nigeria's response illustrates what that prioritisation looks like in practice. The country has established dedicated domestic financing mechanisms for cancer diagnosis and treatment, directing annual budget allocations to a national cancer research institute not through external aid, but through a deliberate sovereign decision to treat cancer control as a national responsibility. Six centres of excellence for cancer diagnostics have been established across the country, deliberately decentralising access to specialised services beyond major urban centres and making quality cancer diagnosis meaningfully more geographically equitable.

The lesson for other countries is both simple and significant. When cancer control is treated as a domestic funding priority rather than a donor-supported programme, it generates something aid dependency cannot: institutional permanence. Financing becomes predictable, the mandate becomes durable, and the incentive for continued investment is anchored within the national system itself. Countries facing comparable and growing cancer burdens now have a replicable model one that demonstrates that the path to sustainable oncology diagnostics runs not through external goodwill, but through deliberate domestic choice.

From Veins to Value: Integrating Blood Services into the Heart of Health Systems

Across much of Africa, blood services have historically been managed separately from national diagnostic strategies and UHC planning frameworks, an understandable product of how health systems developed, but one that presents a meaningful opportunity for greater coherence. Where blood is treated as a standalone operational function rather than an integrated system, the result is often fragmented planning and missed efficiencies that place unnecessary strain on already stretched health budgets.

There is growing recognition that this approach warrants reconsideration. Blood services, properly understood, encompass an entire value chain from donor recruitment through collection, fractionation, testing for transmissible infections, storage, and distribution to the patient. That chain intersects naturally with maternal health, oncology, trauma care, and infectious disease management. WHO data suggests that where blood services operate in closer alignment with broader national health programmes, the potential for cross-programme synergies increases considerably.

The experience of HIV testing infrastructure offers a compelling illustration of what closer integration could achieve. Across sub-Saharan Africa, the systems built to deliver HIV testing represent decades of investment and institutional development, they are robust, well-resourced, and widely distributed. There is a strong case that integrating blood services within the same national framework could allow those systems to simultaneously screen for transfusion-transmissible infections, generating meaningful additional value from existing capacity at relatively modest incremental cost.

Realising this potential would benefit from progress on three fronts. Formally incorporating blood services into national diagnostic strategies and UHC frameworks would provide the policy foundation necessary for sustained coordination. Dedicated funding streams that reflect the cross-cutting contribution of blood services across maternal health, oncology, trauma, and infectious disease would strengthen the case for investment. And building deliberate institutional linkages between national blood service authorities, public health laboratories, and national health programmes would help translate policy intent into operational reality.

From Capacity to Market: Turning African Diagnostic Manufacturing into a Sustainable Industrial Ecosystem

Senegal's experience in designing, producing, and certifying domestically manufactured diagnostic tools to international standards represents one of the continent's most significant proofs of concept for African manufacturing sovereignty. Several million tests have been produced at price points accessible to low-income health systems, demonstrating that quality and affordability are not in conflict when manufacturing is developed with the right combination of policy intent, financing support, and institutional commitment.



While notable progress has been made in building manufacturing capacity, there remains an opportunity to further develop the domestic demand architecture needed to sustain it. Without predictable procurement commitments, visible demand at scale, and regulatory frameworks that create genuine space for locally manufactured products, even well-designed manufacturing infrastructure risks operating below the threshold of financial viability. Supply without demand is not a value chain- it is a stranded asset.

Closing this gap requires progress on three interconnected conditions. Regulatory harmonisation is perhaps the most foundational: a diagnostic tool registered in one African country should not require full re-registration in neighbouring markets. The current system imposes significant time and cost burdens that structurally disadvantage domestic manufacturers relative to established international suppliers, and slow patient access in the process. Demand aggregation is equally essential; continental procurement bodies must provide the volume visibility that allows manufacturers to plan production runs, attract investment, and price competitively. Structured pathways for technology and knowledge transfer must also be developed, enabling African institutions to replicate and adapt manufacturing capabilities across borders and build a genuinely continental network rather than a collection of isolated national facilities.

Procurement frameworks have a central role to play in sending the demand signals that make this architecture function. UHC benefit packages that specify diagnostic services create the predictable volume commitments that justify sustained investment in domestic production. Where those commitments are absent, manufacturing capacity- however impressive in its own right will remain chronically underutilised, and the case for further investment will be difficult to make. The policy and the procurement must move together.

One Market, One Voice: Turning Africa's Collective Procurement into Health System Power

The Africa CDC's continental procurement initiative represents one of the most consequential tools available to the continent for translating collective scale into genuine market power. By aggregating demand across member states, Africa can attract manufacturers to offer meaningfully lower unit prices, support domestic production at financially viable scale, and systematically reduce the structural dependency on import supply chains that has long constrained health system resilience. The logic is straightforward: what no single country can negotiate alone, the continent can secure together.

The urgency of this work is sharpened by the financing environment. Only a few African countries currently allocate the recommended minimum of 15 percent of national budgets to health, and declining donor funding is compressing available resources further. In this context, continental procurement is not merely a cost-saving mechanism, it is a financing resilience strategy. It enables countries to extract greater value from constrained resources

by eliminating the chronic inefficiencies of fragmented, country-level procurement and redirecting those savings toward expanded access and system strengthening.

The case is reinforced further by the continent's lived experience of supply chain vulnerability. The COVID-19 pandemic demonstrated with uncomfortable clarity that Africa was systematically deprioritised in global diagnostic supply chains precisely when demand surged and need was greatest. Countries carrying the heaviest burden had the least access. That experience should not be allowed to fade into institutional memory without generating structural change. Africa has both the population scale and the growing technical capacity to build self-sustaining supply systems, and the combination of local manufacturing and continental procurement provides the most credible pathway to doing so. This is not simply an economic imperative. It is a health security one.

From Innovation to Impact: Scaling Point-of-Care Diagnostics for Last-Mile Access

The success of rapid diagnostic tests across malaria, HIV, and tuberculosis has established something important: diagnostics do not require laboratories to be transformative. Easy-to-use, affordable, and accurate tools enable frontline health workers to generate reliable results in the communities they serve, reaching populations in resource-limited and geographically isolated settings who would otherwise face significant delays or no diagnosis at all. This is not a workaround for the absence of laboratory infrastructure. For much of Africa, it is the primary architecture of diagnostic access.

Emerging innovations are extending this potential in ways that were not possible even a decade ago. Solar-powered diagnostic equipment addresses the energy access constraints that have long limited deployment of more sophisticated devices in off-grid settings. AI-enabled interpretation tools among them AI-powered chest X-ray analysis for tuberculosis diagnosis- offer the prospect of specialist-level diagnostic accuracy delivered through accessible hardware at primary care level. It is worth stating clearly: these are not speculative or future technologies. They are being implemented now, the evidence base for their effectiveness is growing, and the question is no longer whether they work but how quickly they can be brought to scale.

Technology alone, however, does not deliver last-mile access and this distinction matters enormously. Point-of-care innovations must be embedded within functioning quality assurance systems, appropriate regulatory oversight, sustained workforce training, and reliable supply chains to perform consistently in the field. A rapid diagnostic test that is inaccurate, unavailable, or misinterpreted at the community level is not a neutral outcome- it is a liability, capable of generating false confidence, inappropriate treatment, and erosion of trust in health services. The enabling environment that surrounds a technology is not secondary to the technology itself. In many respects, it is the technology that counts.



Beyond Elimination: Egypt's Blueprint for Turning Diagnostics into Lasting Health System Strength

Egypt's national Hepatitis C elimination campaign stands as the most compelling demonstration in recent global health history of what political commitment, domestic financing, and integrated diagnostic infrastructure can achieve together. By 2015, Egypt carried one of the highest Hepatitis C prevalence rates in the world, affecting between seven and ten percent of the population. Within four years, the country had screened 60 million people through a network deployed nationally, placed four million people on treatment, and by 2023 received WHO certification of elimination—a trajectory that would have seemed ambitious as a twenty-year goal, let alone a four-year one. ^[4]

The programme succeeded not because of any single intervention but because of the coherence of its design. Political will, cross-sector collaboration, locally manufactured diagnostics, domestically produced therapies, and structured capacity building for health professionals were brought together within a unified national framework. Crucially, this was not a vertical programme funded externally and administered in parallel to the health system—it was a national mobilisation that worked through existing institutions, strengthened them in the process, and left them more capable than it found them. That distinction is not incidental. It is the reason the gains proved durable.

What happened after the elimination target was reached may be the most instructive part of the story. The diagnostic platforms and institutional capabilities developed for Hepatitis C did not sit idle; they were subsequently applied to COVID-19 response, Hepatitis B monitoring, and cervical cancer screening. This multiplier dynamic, in which diagnostic infrastructure built for one disease serves multiple others, is one of the strongest arguments available for investing in diagnostic systems rather than disease-specific programmes. The return on investment extends well beyond the original objective, and it compounds over time. It is the institutions that remain after the campaign ends, the laboratories, the trained workforce, the procurement relationships and the data systems that determine whether that return is fully captured or quietly lost.

This model is replicable, and the conditions for its success are not beyond reach. Political commitment, domestic financing, local manufacturing, and integrated capacity building are achievable in other African countries facing comparable disease burdens. The evidence exists. The architecture is understood. The question is not whether it can be done, but whether the decision to do it will be made.

Conclusion

Diagnostics are not a peripheral concern in African health systems, they are the foundation on which every other health system ambition rests. Without reliable, accessible, and affordable diagnostics, the continent's goals in health financing, pharmaceutical development, digital health, and UHC will remain perpetually out of reach. Every strategy that depends on knowing what a patient has, and knowing it in time to act, depends first on diagnostics.

Africa has already demonstrated that it can meet this challenge. Senegal has proven that manufacturing sovereignty is achievable. Nigeria has shown that domestic financing for cancer diagnostics is a political choice, not an impossible aspiration. Cameroon has built laboratory infrastructure that meets international quality standards. Egypt has demonstrated what happens when political commitment and domestic resource mobilisation are sustained at scale and over time. These are not isolated experiments, they are the building blocks of a continental architecture that is already taking shape.

What the moment demands now is the discipline to connect these experiences through consistent policy, the resolve to finance them at the scale their impact justifies, and the political courage to move at the pace that Africa's health needs require. The evidence is not the constraint. The frameworks are not the constraint. The only remaining question is whether the will to act will prove equal to the opportunity and to the urgency that this moment presents.

Key Recommendations

1. **Reposition diagnostics as a strategic economic investment:** National diagnostic investment plans should be accompanied by return-on-investment modelling designed explicitly for Ministries of Finance and cabinet-level decision-makers. The advocacy conversation must move decisively beyond clinical need to fiscal performance, framing diagnostics not as a health expenditure but as a driver of economic productivity, reduced hospitalisation costs, and long-term health system efficiency.
2. **Adopt and implement national Essential Diagnostics Lists (EDLs):** EDLs should serve as the operational foundation for procurement decisions, equitable access planning, and diagnostic coverage within UHC benefit packages. Where EDLs exist on paper but not in practice, the priority is implementation -ensuring they shape budget allocations and service delivery at every level of the health system.
3. **Integrate blood services into national diagnostic and UHC frameworks:** Blood services should be structurally linked to public health laboratory programmes and incorporated into national health plans as a core component, not an operational footnote. Dedicated and sustained funding must reflect their cross-cutting contribution across maternal health, oncology, trauma care, and infectious disease and institutional linkages between blood service authorities, laboratories, and national programmes should be formalised and resourced.
4. **Build domestic demand architecture to sustain local manufacturing:** Manufacturing capacity without demand is a stranded asset. Procurement frameworks should create deliberate preference for domestically produced diagnostics, and UHC benefit packages should specify diagnostic services in sufficient detail to generate the predictable volume commitments that justify sustained investment in local production. The demand signal must be clear, consistent, and credible.

5. **Accelerate regulatory harmonisation across regional economic communities:** A diagnostic tool registered in one African country should be recognised in neighbouring markets without the burden of full re-registration. Regulatory harmonisation across regional economic communities is among the highest-leverage actions available to reduce time-to-access, lower costs for domestic manufacturers, and enable products to reach patients across the continent efficiently.
6. **Strengthen the Africa CDC continental procurement initiative:** Country participation in the Africa CDC's continental procurement initiative should be broadened and commitment volumes increased. Converting fragmented national procurement into coordinated continental leverage is one of the most practical mechanisms available for lowering unit costs, supporting domestic manufacturing at viable scale, and reducing the import dependency that leaves health systems exposed to global supply chain disruption.
7. **Invest in point-of-care innovation and its enabling environment:** Solar-powered diagnostic equipment, AI-assisted interpretation tools, and community health worker training and accreditation should be funded as an integrated system, not as isolated technology deployments. The technology exists and is proven; what determines whether it delivers at the last mile is the quality assurance, regulatory oversight, supply chain reliability, and workforce capacity that surrounds it.
8. **Replicate the integrated elimination model for other high-burden conditions:** The architecture that drove Egypt's Hepatitis C elimination; political commitment, domestic financing, local manufacturing, and integrated capacity building offers a replicable model for other African countries facing comparable disease burdens. Critically, planning should be designed from the outset to leverage diagnostic infrastructure across multiple disease areas, ensuring that the institutions and capabilities built for one campaign continue to generate returns long after its immediate objective is achieved.

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Access for All: Scaling Comprehensive Quality Healthcare Services Across Africa



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List of Abbreviations

Africa CDC	Africa Centres for Disease Control and Prevention
CHP	Community Health Provider
ECCIF	Emergency, Chronic, and Critical Illness Fund
EAC	East African Community
NCD	Non-Communicable Disease
NHI	National Health Insurance
PHC	Primary Health Care
PHF	Primary Healthcare Fund
PPP	Public-Private Partnership
SHA	Social Health Authority
SHIF	Social Health Insurance Fund
UHC	Universal Health Coverage
UPA	Unified Procurement Agency
WHO	World Health Organization



Executive Summary

Universal Health Coverage (UHC) is a commitment to ensuring that all individuals can access quality health services without financial hardship. Across Africa, important progress has been made over the past two decades, including increased service coverage, declining maternal and child mortality, and reduced deaths from communicable and non-communicable diseases (NCDs). These gains reflect sustained investments in health systems and expanded access to care.

While Africa has made meaningful progress, current trajectories suggest that additional acceleration will be needed to achieve UHC by 2030. Coverage levels are still well below the global average, and significant gaps persist between policy commitments and equitable access to services. The core challenge is no longer ambition, but implementation—translating reforms into functioning systems that deliver meaningful outcomes for all populations.

A key issue lies in how access is defined. Physical proximity to a health facility does not guarantee care. Financial barriers, workforce shortages, and geographic and social inequalities continue to limit access, particularly for rural and low-income communities. Measuring progress through people-centred outcomes such as financial protection and improved health status offers a more accurate reflection of system performance than infrastructure or service availability alone.

Health financing remains central to this transition. Framing health as an economic investment rather than a cost highlights its role in supporting productivity, human capital, and long-term growth. As external funding declines, countries face increasing pressure to build sustainable domestic financing models and strengthen engagement between health and finance sectors.

At the same time, shifting disease patterns require structural adaptation. The growing burden of NCDs demands integrated, continuous care models anchored in primary health care, rather than systems designed primarily for acute, episodic treatment.

Experiences across the continent demonstrate that progress is achievable. Legislative reform, phased implementation approaches, and equity-driven financing models are enabling countries to expand coverage while strengthening system foundations. Central to these efforts is investment in primary health care and community-based delivery, which has shown measurable impact in improving outcomes and extending access.

Persistent challenges remain. Health workforce shortages, particularly in underserved areas, continue to constrain service delivery, while women's health needs remain under-prioritised in system design and financing. Addressing these gaps requires deliberate policy choices, including integrating services across the life course and leveraging existing care platforms more effectively.

Well-structured Public–Private Partnerships (PPPs) are also playing an increasingly important role. When designed with clear accountability and aligned incentives, these collaborations can expand access, build local capacity, and

deliver sustainable impact. Complementary innovations, including digital health and supply chain solutions, further strengthen system performance.

Accelerating progress toward UHC will require sustained focus on several priorities: redefining success through people-centred outcomes; strengthening legal and financing frameworks; investing in primary health care; integrating chronic disease management; applying a gender lens to health systems; leveraging public–private collaboration; and streamlining regulatory processes to improve access to proven health technologies.

UHC in Africa is no longer an abstract goal. Practical models and proven approaches already exist. The task ahead is to scale these efforts with urgency and equity, ensuring that the benefits of stronger health systems reach every population.

Background

UHC is the global commitment to ensuring that every individual, regardless of where they live, can access the full spectrum of quality health services they need from health promotion and disease prevention through to treatment, rehabilitation, and palliative care without facing financial hardship. More than a health target, UHC is a guarantee of dignity and well-being across every stage of life. ^[1]

Africa has made measurable progress toward this vision. The WHO Service Coverage Index for the region nearly doubled over two decades, rising from 23 in 2000 to 44 in 2021, reflecting sustained gains across multiple health domains. ^[2] Maternal mortality declined by approximately 40 percent between 2000 and 2023, falling from around 727 to 442 deaths per 100,000 live births. ^[3] Under-five mortality dropped by roughly 58 percent between 1990 and 2017, though Africa still accounts for more than half of the 5.4 million under-five deaths recorded globally in that year. ^[4]

Age-standardized mortality from NCDs fell by around 18 percent between 2000 and 2019, while HIV-related deaths declined by more than 55 percent, gains attributable to expanded vaccine coverage, improved treatment access, and stronger health system investments. ^[5] ^[6] Several countries have also significantly scaled up primary care infrastructure over this period.

These achievements are real, hard-won, and significant. Yet with less than five years remaining until the 2030 deadline, Africa's Service Coverage Index of 44 remains well below the global average of 68, and the continent is only midway toward full service coverage. ^[2] The gap between political commitment and on-the-ground implementation has become increasingly difficult to ignore.

Heads of State and Ministers have formally endorsed UHC through high-level UN declarations, and many countries have enacted meaningful legislative and structural reforms. Others, however, continue to struggle to translate policy into functional, equitably accessible services.

By UHC's own definition, access for everyone, everywhere, the goal in Africa has yet to be achieved. What the evidence makes clear, however, is that the distance between where

the continent stands and where it needs to be is not insurmountable. The progress documented across diverse health systems, contexts, and resource environments points to concrete and replicable pathways for closing the gap and for doing so within the time that remains.

Beyond the Facility: Redefining Access in African Health Systems

Access is not a binary. The existence of a health facility within a defined geographic radius does not constitute access for the communities it theoretically serves. Meaningful access requires that every person regardless of location, income, gender, or social status can receive timely, quality care without the risk of financial catastrophe. By this standard, most African health systems fall significantly short: not because services are absent, but because the financial, geographic, social, and structural barriers between those services and the people who need them most remain largely unresolved.

The financial dimension alone is acute. Out-of-Pocket (OOP) expenditure accounts for a substantial share of total health spending across much of the continent, and the formal protection mechanisms designed to cushion that burden; insurance schemes, subsidised care pathways and emergency funds remain out of reach for the majority of the population, particularly in rural and low-income communities. A system can record high utilisation figures while systematically excluding its poorest and most geographically isolated citizens. Aggregate data often conceals the inequity that lives within it.

This framing carries direct implications for how progress is defined and measured. Shifting to people-centred metrics—not facilities built, but maternal deaths prevented; not insurance schemes launched, but households protected from catastrophic expenditure changes both the nature of accountability and the design of interventions. Governments and partners that commit to this standard are not simply adopting a different methodology. They are committing to a fundamentally different kind of health system: one oriented not around the provision of services, but around the experiences and outcomes of the people those services exist to serve.

Financing the Future: Health as the Foundation of Economic Resilience

Health spending has often been framed within government budgets as a cost to be managed rather than an investment to be optimised. This framing, while understandable given competing fiscal pressures, does not fully reflect the economic evidence. Investments in maternal and child health, nutrition, and health system strengthening generate returns that extend well beyond the health sector: in human capital formation, workforce productivity, and long-term economic growth. These returns do not accrue to the health budget alone, they accrue to the national economy as a whole.

The fiscal case runs in both directions, and both deserve careful consideration. A population carrying a significant burden of preventable disease with segments of the workforce unable to participate fully in economic life due to ill health, faces real constraints on productivity

and growth that compound over time. Viewed through this lens, strengthening health systems is not simply a social priority but a sound economic strategy, one whose benefits are felt across sectors and generations. Engaging Ministries of Finance as partners in this framing rather than as gatekeepers of a separate social budget is among the more important conversations facing health leaders across the continent.

This conversation is particularly timely given the current financing environment. Official development assistance is declining, and a number of donor programmes are being restructured or phased down. Countries that have depended on external support to sustain core health programmes are navigating a genuine transition, and doing so requires building domestic financing architecture that is both sustainable and sufficient. Those that make this transition most successfully are likely to be those that have invested early in making the broader economic and development case for health, not as a competing claim on limited resources, but as a foundational condition for the growth and resilience that every national budget ultimately depends on.

Beyond Infections: Preparing Health Systems for Chronic Care

NCDs now represent over one third of Africa's total disease burden, and their share is rising.^[7] Diabetes, hypertension, cardiovascular disease, and cancer are no longer conditions primarily associated with high-income countries they are central to the health challenge facing every African government. This shift is not marginal or distant. It is already reshaping patterns of illness, mortality, and health system demand across the continent, and it is doing so against a structural backdrop that was never designed to accommodate it.

Most African health systems were built, financed, and staffed around a model designed primarily to address acute infectious disease: episodic in nature, often curative in focus, and oriented toward hospital-based intervention. That model reflected the health priorities of its time, and the progress it enabled in reducing communicable disease burden represents a genuine and significant achievement. The challenge today is that the evolving disease landscape calls for a different kind of response. NCD patients need regular contact with the health system over years and decades. They need reliable access to medicines, diagnostic monitoring, and where necessary, specialist support. They need health information and the tools for self-management. Delivering these services well requires health system designs, financing arrangements, and care models that most countries are still in the process of developing and that represent a meaningful, though entirely achievable, evolution from current configurations.

Addressing this transition requires more than programme expansion. It requires structural adaptation. Integrating NCD services into primary health care frameworks not as an add-on, but as a core component of what community-level providers are trained and resourced to deliver is an essential first step. Equally important are financing models designed around continuity of care, including insurance benefit packages that account for chronic conditions rather



than discrete episodes of treatment. Countries that make these adaptations proactively, rather than in response to a crisis already in progress, will be considerably better placed to manage the NCD burden over the decades ahead.

From Legislation to Transformation: Kenya's Path to UHC

Kenya's health reform programme represents one of the most ambitious and structurally coherent legislative efforts toward UHC undertaken in Africa in recent years. Since 2023, four transformative health laws have been enacted: the Social Health Insurance Financing Act, the Digital Health Act, the Primary Health Care Act, and the Facility Improvement Financing Act. A fifth, the Quality of Health Care and Patient Safety Bill, is currently progressing through the legislative process.

At the centre of this architecture is the Social Health Authority, which oversees a three-fund financing structure designed to provide layered protection across different health needs and population groups. The Primary Healthcare Fund provides registration-based access to primary care services at no point-of-service cost. The Social Health Insurance Fund is financed through a 2.75 percent payroll contribution from formal sector employees, with active efforts underway to extend meaningful coverage to the informal sector. ^[8] The Emergency, Chronic, and Critical Illness Fund addresses catastrophic health expenditure including cancer treatment, kidney dialysis, and intensive care drawing on national exchequer resources to protect households from the most financially devastating health events.

Underpinning the system at the community level is a network of more than 107,000 Community Health Providers, each responsible for a defined catchment population and connected to facility-level services through digital platforms. ^[9] This community layer is integral to the reform's primary care ambitions, providing a structured interface between households and the health system that previous configurations largely lacked.

The reform has faced real implementation challenges. Political contestation, programme delays, and persistently low insurance uptake in the informal sector remain significant concerns that will require sustained attention. At the same time, the underlying architecture combining universal registration, tiered financing, community-anchored primary care, and catastrophic expenditure protection reflects a coherent and evidence-informed systems logic. Early indicators suggest that access to high-acuity services is improving, and Kenya's experience is increasingly being studied as a reference model for UHC implementation across the continent.

The Architecture of Scale: Inside Egypt's UHC Transformation

Egypt's approach to UHC offers a contrasting but equally instructive model: a deliberately sequenced, phase based implementation strategy designed to demonstrate measurable results within a defined geography before committing to national scale. The legislative foundation was established in 2014, when Egypt's new constitution placed health at the center of national priorities. This was followed

by the introduction of the Universal Health Insurance Law in 2018, which marked a significant structural reform by separating health financing, service provision, and quality assurance into three independent entities, each with a distinct mandate and accountability framework. Two supporting institutions reinforced this architecture: the Unified Procurement Agency, responsible for medicine and supply sustainability, and the Egypt Drug Authority, charged with pharmaceutical quality regulation.

Implementation began in 2019 across six governorates in the first phase, allowing the system to be tested, adjusted, and validated in real conditions before expansion. Phase two is now underway, beginning with a single governorate whose population is equivalent in size to all six phase one governorates combined. This sequencing is not a constraint, it is a deliberate policy choice, reflecting a programme design philosophy that prioritises depth of coverage and system integrity over the pace of geographic rollout. The system is organised around the family health model, treating the family unit rather than the individual patient as the fundamental unit of care, supported by civil registration systems that provide a complete and continuously updated population register.

This population-level data infrastructure enables one of the reform's most significant features: the transition from tax-based, supply-side budgeting to strategic purchasing. Rather than acting as an administrative funder allocating resources to public facilities by default, the government now functions as an active purchaser of services—contracting with both public and private providers against defined quality and performance standards. This shift in the government-provider relationship, combined with digital platforms that enable real-time data flows across the system, creates accountability mechanisms that strengthen both efficiency and financial risk protection in ways that traditional budget-based systems structurally cannot.

The Equity Imperative: Inside South Africa's NHI Reform

South Africa's National Health Insurance (NHI) framework seeks to operationalise a constitutional right: that access to quality health care should not be determined by income, geography, or economic circumstance. This principle enshrined in the South African Constitution is the normative foundation on which the NHI is being built, and it sets a standard of equity that goes beyond administrative coverage to address the structural conditions that have historically shaped who receives care and who does not.

Progress toward implementation has been gradual, and the reform has attracted significant debate across political, legal, and commercial spheres. A central tension lies in the relationship between the public and private health sectors, which have historically operated on parallel tracks serving largely separate populations. The private sector, which serves a minority of the population but accounts for a disproportionate share of health expenditure and infrastructure, has raised substantive concerns about the NHI's financing model, governance architecture, and transition timelines. These concerns deserve engagement, both because some reflect legitimate implementation questions and because the success of the NHI will ultimately



depend on a private sector that is a constructive participant in the reformed system rather than an opponent of it.

The NHI seeks to address this structural divide by establishing uniform standards of care across accredited public and private providers, enabling patients to access services on the basis of clinical need rather than the status of their medical aid cover. Achieving this transition will require strong governance frameworks, sustained political will, and accountability mechanisms capable of holding both public facilities and private providers to common standards. It will also require carefully managing a transition period in which private providers adapt their operating models and public facilities continue to build capacity. The principle at the heart of the NHI is not in dispute within the South African policy framework. The challenge and the work lies in implementation at the pace, scale, and quality that a constitutional commitment of this magnitude demands.

Primary Health Care: The Foundation of Strong Health Systems

African health systems have historically been oriented around a curative, hospital-centric model that responds to illness rather than preventing it. While that model has served important functions, it has proven costly, difficult to scale equitably, and increasingly misaligned with the complexity and distribution of the health challenges now facing the continent. Primary health care-preventive, community-level, and continuity-focused is not an alternative to hospital services. It is the foundation on which effective hospital services depend, and without which they are perpetually overwhelmed.

The practical impact of intentional primary health care investment is well illustrated by experience in Kisumu County, Kenya. A structured community health model deploying trained community health workers across defined catchment areas, connected to facilities through digital platforms and clinical supervision led to a substantial increase in skilled birth attendance over a measurable period. This change was accompanied by a marked reduction in maternal mortality. The scale of these improvements reflects something beyond programme success; it reflects what becomes possible when primary care is treated as a core system function rather than a peripheral service.

The workforce dimension of this challenge is significant and deserves particular attention. Africa carries approximately 25 percent of the global disease burden while accounting for roughly three percent of the global health workforce a structural imbalance that cannot be resolved through recruitment alone. ^[10] Complementary strategies are essential: task-sharing models that enable community health workers and lower-cadre clinicians to manage a broader range of conditions safely and effectively, and digital tools that extend the reach of specialist expertise to the primary care level, reducing the concentration of clinical capacity in urban hospital settings.

Retention is as important as recruitment, and the two challenges are connected. Health workers trained at public expense who migrate abroad or transition to private facilities represent a compounding loss of investment, of institutional knowledge, and of system capacity. Creating the conditions under which skilled health workers choose to remain in

public systems through competitive remuneration, clear career pathways, functional working environments, and effective management is not a peripheral concern. It is a prerequisite for building the stable, sufficient workforce that equitable health coverage requires.

Women's Health as a Systems Imperative

The UHC agenda is universal in aspiration, but in practice the specific health needs of women have not always received proportionate attention in system design, benefit package development, or research investment. Sub-Saharan Africa accounts for approximately 70 percent of global maternal deaths-a figure that reflects not only the scale of clinical need but the consequences of health systems that have historically underweighted conditions affecting women. ^[11] Obstetric complications, cervical and breast cancer, uterine fibroids, osteoporosis, and autoimmune conditions are underrepresented in benefit packages, underinvested in research, and inadequately supported in service delivery design. Where these gaps persist, they are not a reflection of lower burden. They are a reflection of lower prioritisation and closing them is both a health imperative and an equity obligation.

A genuine life-course approach to women's health does not necessarily require new infrastructure. It requires using existing contact points more intentionally. When a woman attends an antenatal clinic, she is already in the health system – at a moment that generates high attendance and strong community trust. That contact is an opportunity to conduct a breast cancer screen, a cervical cancer screen, a blood pressure check, and a blood glucose assessment. The marginal cost of integrating these services into an existing visit is modest. The cost of missing a cancer diagnosis or an undetected hypertension at that moment in human terms and in downstream health system expenditure is considerably greater. These are design choices, and they are within reach.

Social and cultural dimensions of women's health require equal attention alongside clinical ones. Conditions such as uterine fibroids, which affect a significant proportion of women of African descent at some point during their reproductive years, are frequently normalised within families and communities understood as an expected experience rather than a medical condition requiring diagnosis and care. This normalisation delays presentation, contributes to disease progression, and increases the likelihood of surgical intervention that earlier diagnosis might have avoided. Community health workers, properly trained and supported, are well-positioned to provide accurate health information, gently challenge harmful norms, and connect women to appropriate services before conditions become complex.

Extending that reach through digital health tools holds considerable promise, but regulatory frameworks have not always kept pace. A tool that has completed WHO pre-qualification may still be subject to six to twelve months of additional national verification requirements in each country – a process that, within the East African Community alone, must be repeated independently for every member state. Consolidated regulatory recognition frameworks, treating WHO pre-qualification as a sufficient basis for regional approval, would meaningfully reduce the



time between validated evidence and patient access, and would do so without compromising safety standards. This is a tractable reform, and one whose benefits would extend well beyond women's health alone.

Bridging the Divide: How Public-Private Collaboration is Expanding Access and Building Capacity

The private sector's role in African health systems is a subject that often attracts strongly held positions from concerns about the accessibility and equity implications of market-driven care, to recognition of the capacity, innovation, and resources that private actors can bring to health system strengthening. Both perspectives reflect genuine experience, and both deserve serious engagement. What the evidence increasingly suggests is that well-structured PPPs can mobilise resources, build institutional capacity, extend access, and generate outcomes that neither sector could achieve working independently and that the conditions enabling this are worth understanding carefully.

A paediatric open heart surgery programme in Kenya demonstrates the impact of well-designed collaboration. Over the last few years, a private tertiary hospital working alongside international medical teams, the Kenya Cardiac Society, and medical device suppliers has achieved a high twelve-month success rate for complex cardiac procedures. Each year, a substantial number of children are screened, including many who would otherwise lack access to cardiac surgery. The financing model combines hospital contributions, self-funded international volunteer teams, supplier support through donated consumables, and community fundraising a structure that distributes both cost and commitment across multiple stakeholders in a way that has proven sustainable over time.

What distinguishes this programme is its orientation toward building lasting local capacity. Kenyan cardiac surgeons and intensivists can now independently perform procedures that previously required full international team presence. This progression from supported delivery toward self-sustaining clinical excellence reflects an approach to partnership that prioritises long-term system strengthening over continued external dependency. The ambition, ultimately, is not a permanent arrangement but a permanent capability embedded within the national health system.

The programme has also demonstrated that how partnerships are communicated and sustained matters alongside how they are structured. By thoughtfully documenting and sharing the experiences of children who have received care and returned to healthy lives, the programme has broadened its donor base, maintained international volunteer engagement, and encouraged referrals from health workers at partner facilities. The trust and goodwill generated through this kind of purposeful communication help sustain partnerships through the inevitable challenges that arise over time a dimension of partnership design that deserves greater recognition in how such arrangements are planned and evaluated.

Beyond this example, a range of other collaborative models illustrate the breadth of what well-aligned public-private engagement can contribute. Drone-based supply

chain systems are helping to address last-mile distribution challenges in areas where conventional logistics have faced consistent difficulty. Diagnostic partnerships bringing private operators and equipment into public facilities are expanding service capability while reducing the capital burden on government. These arrangements reflect a shared design principle: identifying areas where public and private interests align, structuring agreements that serve both parties, and ensuring that accountability frameworks are sufficiently robust to protect the public interest and maintain trust on all sides. It is this combination aligned incentives, clear accountability, and mutual benefit that characterises partnerships most likely to deliver sustained value for health systems and the communities they serve.

Conclusion

UHC is not an aspirational ideal deferred to a more favourable future. It is a policy deliverable one already being built, tested, and validated across the continent. The proof is concrete: Kenya's legislative architecture, Egypt's phased implementation, Kisumu County's maternal health outcomes, and the paediatric cardiac programme in Nairobi. The evidence is neither theoretical nor distant. It is real, measurable, and available to every government that chooses to act on it.

The frameworks exist. The commitments have been made at the highest levels of political leadership, and they reflect a genuine and widely shared recognition that equitable access to health care is foundational to human dignity and national development. What this moment calls for is the sustained discipline of implementation adequately financed, rigorously accountable, and oriented toward what matters most: the health outcomes and financial security of the people that health systems exist to serve.

The path forward is neither simple nor without cost. But the experience documented across this continent makes one thing clear: the question is no longer whether universal health coverage is achievable. It is how quickly, and how equitably, its promise can be extended to every person it has not yet reached.

Key Recommendations

The following strategic recommendations outline priority actions for governments, development partners, the private sector, and civil society:

1. **Reframing progress around people-centred health systems:** UHC strategies should adopt people-centred metrics that reflect lived experience rather than system supply-measuring maternal deaths prevented, households protected from catastrophic expenditure, and patients reached in underserved communities. Progress defined by facilities constructed or services theoretically available obscures the inequities that aggregate data consistently conceals.
2. **Anchor political commitment in funded, time-bound legal frameworks:** UHC commitments require translation into specific legislative and regulatory instruments with dedicated financing streams and enforceable implementation timelines. Kenya's four health acts demonstrate that a coherent, interlocking



legislative architecture is achievable and adaptable to diverse national contexts and that legal frameworks, once enacted, create accountability that declarations alone cannot.

3. **Make the economic case for health investment to those who control fiscal decisions:** Ministries of Health must engage Ministries of Finance and national planning bodies as strategic partners, presenting evidence-based return-on-investment analyses that quantify the fiscal cost of inaction alongside the economic returns generated by prevention, primary care, and financial protection. Health investment reframed as economic strategy rather than social expenditure commands a fundamentally different conversation at the budget table.
4. **Build primary health care and community health systems as the foundation of UHC:** Community health workers should be deployed within structured, digitally connected models that include sustainable remuneration, continuous training, and clear performance accountability. Workforce strategies must address both expansion and retention with equal rigour recognising that competitive working conditions, functional environments, and defined career pathways are prerequisites for a stable and sufficient health workforce, not peripheral benefits.
5. **Integrate NCD prevention and management into primary care as a core system function:** Benefit packages, facility staffing configurations, and community health worker training curricula should incorporate NCD prevention, screening, and longitudinal management as standard primary care responsibilities rather than specialist referral pathways. Addressing the rising NCD burden within sustainable financing structures requires that chronic disease management begins and is largely resolved at the community level.
6. **Apply a systematic gender lens to health system design, financing, and measurement:** Women's full life-course health needs including reproductive, oncological, and chronic conditions that disproportionately or exclusively affect women should be explicitly integrated into UHC benefit packages, facility design, workforce training, and budget allocations. Existing high-attendance contact points such as antenatal care should be leveraged for multi-condition screening. Regulatory harmonisation frameworks should be designed to accelerate access to evidence-based tools for women's health across national markets.
7. **Design public-private partnerships to generate equity outcomes and transfer capacity:** PPP frameworks should establish explicit standards for equity of access, uniform accreditation requirements across public and private providers, and accountability mechanisms directly tied to measurable improvements in coverage and outcomes. Capacity transfer to local institutions; clinical, managerial, and technical should be a formal and monitored programme objective, with partnership success assessed not only by services delivered but by the institutional strength left behind.
8. **Accelerate regulatory harmonisation to reduce the distance between evidence and access:** WHO pre-qualification should be recognised as the basis for regional regulatory approval within economic communities, eliminating redundant country-by-country re-verification processes that delay access to validated health tools-particularly in digital health and women's health. Streamlining these pathways is a high-return, low-cost reform that regional bodies are well-positioned to lead.



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Strengthening Africa's Pharmaceutical Eco-system for Health Security



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List of Abbreviations

AMA	African Medicines Agency
AU	African Union
Africa CDC	Africa Centres for Disease Control and Prevention
DFI	Development Finance Institution
GDP	Gross Domestic Product
GMP	Good Manufacturing Practice
ML3	Maturity Level 3
R&D	Research and Development
UHC	Universal Health Coverage
WHO	World Health Organization



Executive Summary

Africa's pharmaceutical ecosystem remains significantly dependent on imports, with more than 70% of medicines, 99% of vaccines, and over 99% of diagnostics sourced from outside the continent. The COVID-19 pandemic brought the implications of this dependency into sharp focus: despite mobilising approximately USD 2 billion, African countries had secured no vaccine doses within the first ten months of the crisis, and less than 2% of promised doses were delivered within the first year. The Mpox outbreak underscored that the challenges experienced were structural in nature rather than circumstantial. With hundreds of disease outbreaks recorded across the continent annually, addressing this vulnerability is a matter of considerable urgency.

Sustained reliance on external sources for essential health commodities presents challenges that extend beyond economic efficiency. It constrains the continent's ability to respond effectively to health emergencies, limits national sovereignty over critical health decisions, and contributes to outcomes that could be avoided with greater local manufacturing capacity. Encouragingly, this is a condition that can be meaningfully addressed through coordinated policy and investment. The Africa Centre for Disease Control and Prevention (Africa CDC) target of producing 60% of routine immunisation needs and other essential health products locally by 2040 is ambitious but well-founded, with the experiences of Egypt, South Africa, and Korea demonstrating that transformative progress is achievable when policy, financing, and human capital development are pursued in alignment.

Realising this ambition will require sustained and coordinated action across five interconnected areas: continental market integration; regulatory harmonisation through the African Medicines Agency (AMA); sustainable financing and demand guarantees; human capital development and research and development investment; and consistent political commitment oriented toward implementation. The continent has a strong foundation of existing frameworks among them Agenda 2063, the Abuja Declaration, and the Pharmaceutical Manufacturing Plan for Africa and the central opportunity lies in translating these into concrete, coordinated action.

Three areas warrant particular and immediate attention. Regulatory harmonisation should be advanced through AMA, with WHO Maturity Level 3 (ML3) for vaccine regulation established as an explicit and time-bound continental priority. Pooled procurement mechanisms should be permanently institutionalised as standing continental infrastructure, supported by long-term advance purchase commitments that provide manufacturers with the demand certainty necessary to attract private sector investment. University curricula should be reformed to align more closely with industrialisation needs, accompanied by structured programmes to retain skilled professionals and facilitate the return of diaspora talent.

The foundations for progress are in place. The precedents are encouraging, the frameworks are established, and the potential returns in health security, economic development, and continental resilience are substantial. The priority now is to move from ambition to implementation.

Background

Africa's pharmaceutical ecosystem remains significantly dependent on imports, with more than 70% of medicines and 99% of vaccines sourced from outside the continent. ^[1] The COVID-19 pandemic brought the implications of this dependency into sharp focus. Ten months into the crisis, despite lower income countries mobilising approximately USD 2 billion, African countries had secured zero vaccine doses. ^[2] When supply eventually materialised, less than 2% of promised doses were delivered within the first year. ^[3] During subsequent outbreaks, including Mpox, similar challenges recurred, underscoring that the difficulties experienced were structural in nature rather than circumstantial.

This dependency presents challenges that extend beyond economic efficiency. Limited local manufacturing capacity constrains Africa's ability to respond effectively to health emergencies and reduces the continent's resilience in the face of external supply disruptions. Addressing this vulnerability is a matter of both public health and long-term development strategy.

Africa CDC has set an ambitious target of producing 60% of routine immunisation needs and other essential health products by 2040. ^[4] Achieving this objective is within reach, but will require coordinated and sustained action across five interconnected pillars:

- Continental market integration to address fragmentation and build economies of scale
- Regulatory harmonisation through the AMA
- Sustainable financing and demand guarantee to reduce investment risk
- Human capital development and strengthened Research & Development (R&D) ecosystems
- Policy consistency and sustained political commitment focused towards implementation

Africa does not lack strategies or policy frameworks. The primary challenge lies in translating these into concrete, coordinated action. Success stories from countries such as Egypt and South Africa, alongside international examples such as Korea, demonstrate that rapid transformation is possible when policy, financing, and human capital investments are aligned. Health is not a cost, it is a strategic economic investment capable of driving industrialisation, job creation, and long term resilience. The priority now is to move from ambition to implementation.

The Dependency Crisis: Import Reliance as a Security Threat

Africa imports more than 70% of its pharmaceuticals, 99% of its vaccines, and over 99% of its diagnostics, making the continent among the most import-dependent regions in the world for essential health commodities. ^[1] During the COVID-19 pandemic, this dependency carried severe consequences. African nations were informed that global vaccine supply for 2021 had been fully committed and that the continent would be allocated no more than 20% of available doses. Despite significant financing efforts, less

than 2% of promised doses were delivered within the first year. ^[3] The Mpox outbreak subsequently followed the same pattern, confirming that the challenges experienced during COVID-19 were not exceptional, they were predictable features of structural dependency.

The continent records hundreds of disease outbreaks annually. Any one of them carries the potential to escalate into a pandemic that would, under current conditions, place Africa once again at the end of global supply queues. Continued reliance on external sources for essential health commodities is therefore not merely an economic concern. It represents a threat to public health security, a constraint on national sovereignty, and a direct contributor to preventable mortality. So long as Africa remains a consumer rather than a producer of the medicines and vaccines its populations require, this vulnerability will persist.

Market Fragmentation and the Need for Continental Coordination

Africa's fifty-four nations frequently operate as fifty-four separate markets, undermining economies of scale and generating counterproductive competition. Many countries aspire to manufacture the same products, resulting in overcapacity in low-value formulations and insufficient guaranteed demand to sustain viable production.

A more effective model is regional specialisation. Drawing on approaches seen in industries such as aerospace where different facilities contribute distinct components and one site manages final assembly, African countries could build a continental value chain in which each nation contributes according to its comparative advantage, rather than replicating the same narrow product range across borders.

Fragmentation also drives up costs. Disparate regulatory frameworks, non-harmonised tariffs, and weak regional logistics mean it can cost more to transport a medicine from Kenya to Uganda than to import the same product from Europe. Under these conditions, African manufacturers compete against one another rather than building collective market power against international suppliers.

Correcting this will require a coordinated continental industrial policy that maps comparative advantage by country and product, supported by pooled procurement mechanisms that aggregate demand across borders and provide manufacturers with the market certainty needed to invest at scale.

Regulatory Harmonisation: Unlocking a Single Market

Fragmented regulatory systems remain a primary bottleneck to expanding local pharmaceutical manufacturing. A vaccine approved in one African country may require years of duplicative review before it can be marketed in another, adding cost and uncertainty that undermine intra-continental trade.

AMA presents a significant opportunity to establish a coherent continental framework for regulatory convergence, reliance, and mutual recognition across all fifty-four member states. Progress is nonetheless constrained by uneven

regulatory capacity. Only nine African countries have attained WHO Maturity Level 3 – the internationally recognised benchmark for a stable, well-functioning regulatory authority. [5] [6] Achieving ML3 for vaccine regulation should therefore be established as an explicit continental priority, pursued in a structured and phased manner. Egypt's attainment of ML3 demonstrates that this trajectory is achievable and offers a practical reference point for other countries.

Trust in locally manufactured products remains a critical internal barrier. Many African governments continue to preferentially procure from European or North American suppliers, perceiving local products as inferior. This creates a direct contradiction: without domestic procurement commitments, manufacturers cannot achieve the volumes required for WHO prequalification or global market access. African countries must have confidence in their own manufacturing capacity, and that confidence must be reflected in procurement policies that actively support local production.

Financing and Derisking: Making Manufacturing Bankable

Vaccine manufacturing is capital-intensive, technically complex, and carries significant financial risk-characteristics that lead traditional financiers to classify such projects as unbankable, directing investment instead toward sectors such as energy or infrastructure where returns are more predictable. This perception presents a structural barrier to private sector participation and must be actively addressed through risk-sharing mechanisms and demand-side interventions.

Kenya illustrates both the opportunity and the challenge. The Ministry of Health has announced a strategic commitment to scaling local pharmaceutical manufacturing as a central pillar of its health security and Universal Health Coverage (UHC) agenda-signaling the kind of political will that is a prerequisite for attracting investment. [7] Translating that commitment into viable projects, however, requires financing instruments that reduce the risk profile of manufacturing ventures sufficiently to attract private capital.

Central to this is the establishment of long-term advance purchase commitments. Without guaranteed demand, manufacturers cannot justify the upfront capital expenditure required to build or expand production capacity. Pooled procurement mechanisms such as the African Medical Supply Platform, which demonstrated its value during the COVID-19 pandemic provide precisely this kind of demand certainty. The critical lesson from that experience is that such platforms must be institutionalised as permanent continental infrastructure, rather than activated in response to crises and wound down once the immediate emergency has passed.

Barrier	Proposed Solution
Perceived high risk of vaccine manufacturing	Government backed advance purchase agreements

Barrier	Proposed Solution
Lack of bankable projects	Viability gap funding and patient capital
Fragmented demand across countries	Regional pooled procurement mechanisms
Short term donor funding	Domestic budget allocation and sovereign wealth funds

Table 1: Key Financing Barriers and Proposed Solutions

Human Capital, R&D, and Infrastructure as an Inseparable Triad

Training scientists without building facilities leads to brain drain; building facilities without trained staff leads to failure. Africa's pharmaceutical ambitions therefore rest equally on human capital and infrastructure and on developing both in deliberate alignment. Africa currently invests less than 1% of its gross domestic product (GDP) on R&D, falling short of Abuja Declaration's 1% target and well below levels sustained by successful pharmaceutical nations. [8] [9] Korea offers a compelling reference point: within two decades, the country transformed from relying heavily on external vaccine supply to becoming a major domestic vaccine producer, including manufacturing large volumes of a leading COVID-19 vaccine. The driving factors were education, human capital development, financing, and research and development pursued in coordination.

Africa faces three interconnected human capital challenges: brain drain, through the loss of trained scientists to high-income countries; reverse brain drain, through insufficient mechanisms to attract diaspora talent back to the continent; and brain circulation, reflecting the movement of skilled professionals within Africa. Intra-African labour mobility for health scientists remains significantly restricted, further undermining continental integration.

University curricula remain misaligned with industrialisation needs. Postgraduate programmes in clinical trials, biochemical engineering, and vaccine processing are rare, and many graduates enter the workforce with no clear pathway into the pharmaceutical industry. Countries that have made progress such as Egypt, Rwanda, and South Africa have addressed this by reforming curricula to embed industrialisation and innovation priorities.

Political Will, Policy Consistency, and Implementation

Africa does not lack policy frameworks. Agenda 2063, the Abuja Declaration, the Pharmaceutical Manufacturing Plan for Africa, and numerous regional strategies provide a substantial foundation for continental action. The central challenge is not the absence of direction-it is implementation. A recurring pattern undermines progress: during crises such as COVID-19, African institutions

demonstrate a notable capacity for rapid coordination and pooled procurement. Once the immediate emergency subsides, however, countries tend to revert to national approaches, forfeiting collective bargaining power and allowing fragmentation to return.

Structural and institutional factors present additional challenges. In some instances, national legislative frameworks have constrained participation in regional pooled procurement arrangements, resulting in bilateral agreements that may not optimise value at the continental level. In others, well-intentioned policies have produced unintended consequences: tendering frameworks that mandate the lowest-cost bid can systematically disadvantage local manufacturers relative to multinational suppliers. The solution is not to abandon competitive tendering, but to redesign procurement policy to incorporate local content requirements, for example, reserving 30% to 50% of eligible tenders for locally manufactured products.

Lessons from Success Stories: Egypt, South Africa, and Korea

The feasibility of Africa's pharmaceutical manufacturing ambitions is best understood not through projections, but through precedent. Three country examples; Egypt, South Africa, and Korea demonstrate that meaningful transformation is achievable when policy, investment, and human capital development are aligned.

Egypt has operated government-owned vaccine manufacturing for over 75 years, providing a foundation of institutional knowledge and infrastructure that few countries on the continent can match. Manufacturers operate within a coordinated national framework that prevents counterproductive internal competition and directs capacity toward collective goals. Egypt has achieved WHO Maturity Level 3 regulatory status for vaccines- the highest available designation and invests above the 1% GDP threshold in R&D and has reformed university curricula to align graduate output with the needs of its pharmaceutical and biotechnology industries. ^[10]

South Africa's experience with Biovac illustrates the importance of sequencing. The government deliberately invested in infrastructure and workforce development before introducing private sector participation creating the conditions under which private investment could succeed rather than assuming it would materialise independently. South Africa has also cultivated a strong clinical research environment, with established local investigators and regulatory expertise that continue to attract global pharmaceutical companies to the country.

Korea offers a compelling non-African reference point. Two decades ago, Korea relied heavily on imported vaccines, with limited domestic manufacturing capacity. Since then, sustained public investment and industrial policy have significantly strengthened local production, with domestic vaccine self-sufficiency rising in recent years. During the COVID-19 pandemic, Korea emerged as a major manufacturing hub, producing large volumes of vaccines through global partnerships. This transformation was the result of sustained, coordinated investment in education,

human capital development, financing, and research and development precisely the areas in which Africa currently underinvests and where the most urgent action is required.

Conclusion

Africa's pharmaceutical dependency is a condition of policy and investment choices-not an inevitability. The goal of producing 60% of routine immunisation needs and other essential health products locally by 2040 is ambitious, but the evidence presented in this report demonstrates that it is achievable. What is required is a deliberate shift: from fragmented national ambitions to a coordinated continental strategy; from reactive crisis response to proactive peacetime system building; and from well-articulated declarations to bankable, implemented plans.

Three actions are immediate priorities. First, regulatory harmonisation must be advanced through the AMA, supported by a phased and targeted push to bring more countries to WHO Maturity Level 3 for vaccine regulation. Second, pooled procurement mechanisms must be institutionalised as permanent continental infrastructure, accompanied by long-term purchase guarantees that reduce the risk profile of manufacturing investment sufficiently to attract private capital. Third, university curricula must be realigned with industrialisation needs, and scaled programmes developed to retain skilled professionals on the continent and repatriate those who have left.

The cost of inaction is not abstract. Without these measures, the conditions that left Africa without access to vaccines in 2020 will persist and the next health emergency will produce the same outcome. With sustained commitment to these priorities, Africa has the opportunity to build a resilient and competitive pharmaceutical ecosystem that delivers genuine health security, supports broad-based economic growth, and ensures equitable access to essential medicines for all its people. The frameworks exist, the precedents are established, and the imperative is clear. What remains is the will to implement.

Key Recommendations

- 1. Advance regulatory harmonisation:** Regulatory harmonisation is a foundational prerequisite for continental pharmaceutical market integration. AMA should be operationalised as the primary framework for regulatory convergence, reliance, and mutual recognition across all fifty-four member states. Achieving WHO Maturity Level 3 for vaccine regulation should be established as an explicit, time-bound continental priority, pursued through a structured and phased national capacity-building programme. Egypt's attainment of Maturity Level 3 provides a practical and replicable reference model that other countries can adapt to their own contexts.
- 2. Institutionalise pooled procurement:** Pooled procurement must transition from a crisis response tool to a permanent feature of continental health commodity management. Mechanisms such as the African Medical Supply Platform demonstrated their value during the COVID-19 pandemic and should be

institutionalised as standing continental infrastructure with dedicated governance, financing, and operational capacity. This must be accompanied by the establishment of long-term advance purchase commitments that provide manufacturers with the demand certainty required to justify large-scale capital investment in local production.

3. **Coordinate continental industrial policy:** Africa's fifty-four markets must be brought into strategic alignment through a coordinated continental industrial policy that identifies and formalises each country's comparative advantage by product category. Rather than replicating the same narrow product ranges across borders, countries should be positioned within a regional specialisation framework in which distinct manufacturing functions contribute to a shared continental value chain. Demand aggregation through cross-border pooled procurement is essential to creating the market scale that makes this model financially viable.
4. **Reform procurement policy:** Procurement frameworks must be redesigned to actively support local manufacturing without compromising standards or transparency. Tendering policies that mandate selection of the lowest-cost bid systematically disadvantage local manufacturers relative to established multinational suppliers and should be reformed to incorporate local content requirements. Reserving between 30% and 50% of eligible tenders for locally manufactured products is a practical and internationally precedented mechanism for building domestic market share. National legislative barriers that constrain participation in regional procurement arrangements should also be reviewed and addressed as a matter of priority.
5. **Mobilise sustainable financing:** Attracting private capital into pharmaceutical manufacturing requires a deliberate shift in how investment risk is structured and shared. Risk-sharing mechanisms, blended finance instruments, and credit guarantees should be deployed to improve the bankability of manufacturing projects that would otherwise be considered too uncertain for commercial financing. Dedicated project preparation facilities are needed to bring early-stage manufacturing initiatives to investment-ready status, closing the gap

between policy intent and financeable proposals. Equally, financing structures must shift away from short-term donor cycles toward long-term, predictable capital instruments aligned with the multi-year investment horizons that manufacturing capacity development demands.

6. **Invest in human capital and research and development:** Human capital development and infrastructure investment must be pursued together and in deliberate alignment—neither is sufficient without the other. University curricula, particularly at postgraduate level, should be reformed to prioritise programmes in clinical trials, biochemical engineering, and vaccine processing, creating clear pathways from education into the pharmaceutical industry. Scaled programmes are needed to retain skilled scientists on the continent, attract diaspora talent back, and facilitate the movement of health professionals within Africa by removing existing restrictions on intra-African labour mobility. All member states should commit to meeting the Abuja Declaration target of investing 1% of gross domestic product in research and development, recognising that sustained R&D investment is inseparable from long-term manufacturing competitiveness.
7. **Sustain political commitment and ensure implementation:** Africa's challenge is not a shortage of frameworks or strategies; it is the consistent translation of commitments into implemented action. Existing instruments, including Agenda 2063, the Abuja Declaration, and the Pharmaceutical Manufacturing Plan for Africa, should be converted into concrete, time-bound implementation plans with clear accountability mechanisms and measurable milestones. The coordination and collective action that African institutions demonstrated during the COVID-19 pandemic must be sustained as a peacetime standard rather than reserved for emergencies. Political commitment must ultimately be expressed not only in declarations, but in domestic procurement policies, budget allocations, and legislative reforms that consistently and demonstrably support the development of local manufacturing capacity.



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Digital Health Revolution: Harnessing Technology for Impact





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List of Abbreviations

AHB	Africa Health Business	NCD	Non- Communicable Disease
AI	Artificial Intelligence	PMTCT	Prevention of Mother- to- Child Transmission
ANC	Antenatal Care	PPP	Public- Private Partnership
DPI	Digital Public Infrastructure	UHC	Universal Health Coverage
DHIS	District Health Information System	USSD	Unstructured Supplementary Service Data
EMR	Electronic Medical Record	WHO	World Health Organization
HIS	Health Information System		





Executive Summary

Africa is experiencing a rapid digital transformation, with health systems playing a central role in this evolution. High mobile phone penetration and expanding digital infrastructure create significant opportunities to improve access, efficiency, and quality of care. However, structural constraints particularly fragmented systems, weak interoperability, limited financing models, and governance gaps continue to limit large-scale impact.

There is a clear transition from standalone digital tools toward integrated, interoperable systems enabled by Digital Public Infrastructure (DPI). DPI provides shared standards, registries, and data exchange frameworks that allow existing systems to connect, improving continuity of care, system efficiency, and visibility across patient journeys. Practical experience, such as the Kisumu County model, demonstrates that integration can deliver measurable improvements in accountability, maternal and child health outcomes, and real-time decision-making.

Sustainability depends not only on technology, but on system design and alignment with real-world needs. Effective digital health solutions must prioritise usability for frontline health workers, support decision-making, and balance value across the “Three Ps”: Patient, Payer, and Pocket. Many innovations fail to scale due to weak evidence of impact, unclear financing models, and limited integration into national systems.

Emerging technologies such as artificial intelligence (AI) show strong potential to improve efficiency and reduce clinical errors, but their impact depends on strong data systems, interoperability, and governance. At the same time, regulation and trust remain central, requiring adaptive, co-created frameworks and clear data governance to ensure transparency and adoption.

Overall, digital health is shifting from experimentation to execution. The priority now is scaling proven models, strengthening enabling environments, and building interoperable, sustainable systems. Digital health is becoming a foundational infrastructure for resilient, efficient, and equitable health systems.

Background

Africa is undergoing rapid digital transformation, with health systems at the centre of this shift. With approximately 82% of the population owning a mobile phone, there is significant potential to leverage digital tools to improve access, efficiency, and quality of care. [1] Technologies such as telemedicine, electronic health records, AI, big data analytics, and interoperable platforms are increasingly shaping how health services are delivered and managed.

The economic opportunity is substantial. The African Development Bank estimates that digitalization could add \$300 billion annually to Africa’s economy by 2030, with health among the sectors poised to benefit most. [2] Beyond efficiency gains, digital health is driving job creation, attracting private sector investment, and strengthening resilience to public health shocks.

Despite this progress, structural constraints persist. Fragmented platforms, weak data governance, limited financing, and gaps in workforce capacity continue to constrain large-scale implementation, particularly in settings where disease burden remains high relative to available resources. [3, 4] The focus is now shifting from identifying priorities to operationalizing them, translating connectivity, capacity, collaboration, capital, and community into integrated and functioning systems and is increasingly reflected in continental digital health strategies focused on interoperability and system integration. [5]

From Silos to Systems: Enabling Interoperable Digital Health

The central barrier to progress is not the absence of digital solutions, but the limited ability of systems to communicate with one another. Across contexts, health systems generate significant volumes of data; however, this data often remains siloed within individual facilities, programmes, or platforms.

The focus is therefore shifting from the introduction of new tools toward strengthening interoperability across existing systems. Improved integration enables continuity of care, enhances system efficiency, and provides end-to-end visibility of patient journeys.

Digital Public Infrastructure (DPI) is increasingly recognised as a foundational enabler of this shift. By establishing shared registries, common standards, and interoperable data exchange frameworks, DPI allows diverse systems to connect without requiring the replacement of existing platforms.

This approach creates the conditions for new models of care, financing, and coordination. It also supports the broader transition toward decentralised care delivery, where services extend beyond traditional facilities into communities through digital platforms, bringing the vision of accessible and continuous care closer to reality.

Designing Sustainable Digital Health: The Three Ps and Beyond

The sustainability of digital health solutions can be assessed through the “Three Ps”:

- **Patient:** ensuring that digital systems improve access, user experience, and health outcomes
- **Payer:** enabling efficient, transparent, and scalable financing mechanisms
- **Pocket:** ensuring affordability and long-term economic value for users and households

When digital solutions fail to balance these three dimensions, they risk reinforcing existing inequities rather than reducing them.

Equally important is system design. Many digital tools underperform because they prioritise reporting and administrative requirements over the needs of frontline





health workers. Effective systems are instead grounded in real-world clinical workflows, featuring simple interfaces, offline functionality, and clear clinical utility.

Design must also be anchored in decision-making. Data collection should be purpose-driven, with clear linkages to specific decisions at defined levels of the health system. This ensures that digital tools enable timely action and service improvement, rather than generating information without practical application.

Scaling Digital Health in Practice: The Kisumu County Experience

Kisumu County provides a practical example of how integrated digital health systems can be implemented in resource-constrained settings. The transformation has been driven by the need to improve accountability and health outcomes in maternal and child health, particularly in a context where fragmented systems previously limited coordination and visibility across service delivery points.

A structured digital transformation roadmap, launched in 2024, has guided progress from foundational infrastructure development to system optimisation. Key investments include the digitisation of community health services, the deployment of electronic medical records across most health facilities, the introduction of mobile-based digital financing mechanisms, and the strengthening of enabling infrastructure such as data centres and connectivity solutions.

At the centre of this model is the Kisumu County Maternal and Child Health Information Platform, which links community, facility, and financing systems in real time. By prioritising interoperability rather than replacing existing systems, the platform enables continuous tracking of patients across both public and private providers.

This integration has contributed to measurable improvements, including reductions in anaemia prevalence, enhanced real-time disease surveillance, and strengthened accountability for maternal and child health outcomes. The model is now being scaled across all sub-counties and extended to additional priority health areas.

A key enabler of this progress is the establishment of coordinated care networks. Community health workers, primary care providers, and supervisors operate within a connected ecosystem, using real-time data to inform decision-making and service delivery.

From Data to Decisions: Rethinking Digital Health Design

The effectiveness of digital health systems is strongly determined by their usability in real-world settings. Frontline health workers often operate under significant constraints, including limited connectivity, high workloads, and restricted access to devices. Systems that do not account for these conditions are unlikely to be adopted or sustained. Effective solutions therefore prioritise simplicity, offline functionality, and alignment with existing clinical and administrative workflows.

A persistent challenge remains the disconnect between data collection and decision-making. Many systems are designed to capture large volumes of data without clearly defining how that information will be used in practice.

Effective digital design begins with decision-making requirements. It requires clarity on who needs information, at what level of the health system, and within what timeframe. By prioritising relevance over volume, digital systems can better enable timely, actionable insights and support improved service delivery.

Building for Scale: Investment, Equity, and Sustainability in Digital Health

Moving from pilot initiatives to sustainable systems remains a critical challenge. The constraint is less about the availability of capital and more about aligning investment with solutions that are viable, scalable, and context-appropriate.

Many innovations fail to scale due to limited transparency, weak documentation of impact, and unclear or unsustainable revenue models. Sustainable digital health solutions must therefore demonstrate measurable outcomes, articulate clear value propositions, and define credible pathways to financial viability.

The role of the private sector is also evolving. Beyond traditional corporate social responsibility, private actors are increasingly positioning themselves as long-term partners in health system investment and delivery. This shift is essential for unlocking sustained financing and enabling scale. At the same time, strengthening local innovation ecosystems is critical to ensuring that solutions are designed, scaled, and sustained within African contexts. ^[6]

Equity considerations remain central. Digital-only approaches risk excluding populations with limited connectivity, affordability constraints, or low digital literacy. Hybrid models that integrate digital platforms with physical infrastructure such as clinics, pharmacies, and community health systems are essential to ensure inclusive and equitable access.

Artificial Intelligence as a Force Multiplier in Healthcare Delivery

AI is increasingly being deployed as a practical tool to address workforce constraints and strengthen decision-making across health systems. In contexts where demand for services exceeds available human resources, AI can support both clinical and operational functions.

Applications span clinical decision support, supply chain optimisation, revenue cycle management, and system-level analytics. These tools enable health workers to make more accurate decisions, reduce errors, and improve operational efficiency.

Evidence from implementation reinforces this potential. A study conducted across 15 clinics, involving 106 physicians and 40,000 patients, found a 32 percent reduction in clinical note errors, a 13 percent reduction in treatment errors, and a 16 percent reduction in diagnostic errors. ^[7]





As costs continue to decline, accessibility is expected to increase. However, the effectiveness of AI is contingent on strong data systems, interoperability, and robust governance frameworks. Without these enabling foundations, its impact will remain constrained.

Enabling Innovation, Ensuring Trust: The Future of Digital Health Regulation

Digital transformation requires regulatory approaches that are both enabling and protective. Traditional regulatory models often struggle to keep pace with technological change, creating a need for more adaptive and collaborative governance frameworks.

There is growing recognition that regulation cannot be developed in isolation. Co-creation between policymakers, innovators, and implementers is essential to ensure that regulatory frameworks are both practical and responsive to rapidly evolving technologies.

Key priorities include regulatory harmonisation, interoperability standards, and robust data protection mechanisms. In addition, controlled environments for testing and validating innovations play an important role in enabling safe experimentation and accelerating responsible adoption.

Trust remains central to the success of digital health systems. While policies increasingly recognise patient ownership of data, implementation gaps persist. In some contexts, institutional practices that treat data as proprietary can undermine transparency and slow progress. Building trust therefore requires clear governance on how data is collected, accessed, and shared, alongside consistent adherence to agreed principles.

Conclusion

Digital health is entering a phase defined by integration, scale, and system-level transformation. Practical examples demonstrate that meaningful progress is achievable when digital solutions are embedded within broader health system strategies rather than implemented as standalone interventions.

The priority now is execution. Scaling proven models, strengthening enabling environments, and aligning stakeholders will determine whether digital health delivers sustained impact. This requires moving beyond fragmented approaches toward coordinated systems that are interoperable, financially sustainable, and designed around real-world needs.

Digital health is no longer an add-on. It is a foundational infrastructure for resilient, efficient, and equitable health systems.

Key Recommendations

1. Prioritise interoperability as the foundation of digital health systems: Governments and implementers should shift investment away from isolated digital tools toward interoperable systems enabled by shared standards, registries, and data exchange frameworks. DPI should be adopted as the backbone for integration across public and private health systems.

2. Strengthen system design around real-world use and decision-making: Digital health solutions should be designed from the perspective of frontline users and operational realities. This includes prioritising simplicity, offline functionality, and alignment with clinical workflows. In addition, all data systems should be explicitly linked to defined decision points to ensure that data collection directly informs action at facility, sub-national, and national levels.

3. Adopt sustainable financing and scale pathways from the outset: Digital health innovations should move beyond pilot dependency by embedding clear value propositions, measurable outcomes, and sustainable revenue models. Investment decisions should prioritise scalability, transparency of impact, and long-term financial viability rather than short-term implementation success.

4. Strengthen public-private collaboration and local innovation ecosystems: Governments should foster structured, long-term partnerships with the private sector that go beyond corporate social responsibility models. At the same time, local innovation ecosystems should be strengthened to ensure that solutions are developed, tested, and scaled within African contexts, ensuring contextual relevance and sustainability.

5. Embed equity and inclusion into digital health design: Digital transformation strategies must actively address exclusion risks linked to connectivity gaps, affordability constraints, and low digital literacy. Hybrid service delivery models that combine digital platforms with physical infrastructure such as clinics, pharmacies, and community health systems should be prioritised to ensure equitable access.

6. Invest in strong data governance, trust, and regulatory alignment: Robust data governance frameworks should be established to define clear rules for data ownership, access, sharing, and protection. Regulatory systems should be harmonised and made more adaptive through co-creation between policymakers, innovators, and implementers. Trust-building must be treated as a core system requirement, not an afterthought.

7. Build enabling environments for responsible innovation, including AI: Countries should create controlled environments (such as regulatory sandboxes) to safely test and scale digital innovations, including artificial intelligence. AI deployment should be supported by strong data infrastructure, interoperability, and governance frameworks to ensure safety, effectiveness, and scalability.

8. Accelerate transition from pilots to scaled national systems: Successful digital health models (such as integrated county-level platforms) should be systematically identified, evaluated, and scaled. National and sub-national strategies should prioritise replication of proven models, supported by coordinated financing, technical assistance, and governance alignment.



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Unfiltered-Industry Leaders Exchange



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Health, Wellness & Nutrition
Nairobi County



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List of Abbreviations

CEC	County Executive Committee Member
DPI	Digital Public Infrastructure
NCD	Non Communicable Disease
PHC	Primary Health Care
SHA	Social Health Authority (Kenya)
UHC	Universal Health Coverage
WHO	World Health Organization



Executive Summary

Health systems across Africa are at a critical inflection point, shaped by evolving disease burdens, demographic transitions, financing dynamics, and increasing recognition that health outcomes are influenced by factors extending beyond clinical service delivery. The central challenge is not the absence of solutions, but the fragmentation of efforts across sectors, institutions, and stakeholders.

Historically, health has largely been approached as a standalone sector, primarily situated within Ministries of Health, hospitals, and externally supported programmes. While this framing has supported important gains, it has also limited the extent to which health is systematically integrated into broader economic and social policy domains such as manufacturing, transport, education, labour, and urban development. Given the clear link between population health and economic performance, there is growing recognition of the value of positioning health as a cross-cutting contributor to productivity, workforce stability, and national development.

Prevention remains an area of significant opportunity. Current workplace health approaches are often oriented toward regulatory compliance and curative coverage, with comparatively less emphasis on proactive wellbeing and risk reduction. Employers, particularly in labour-intensive sectors, are increasingly recognised as important partners in advancing workplace health and productivity. This can be further supported through enabling policy environments, including appropriate incentives, standards, and coordination mechanisms. The potential for prevention also extends into schools and community settings, where more distributed and technology-enabled approaches may help bring services closer to daily life.

Primary healthcare continues to be widely acknowledged as a foundational component of both routine service delivery and epidemic preparedness. Evidence consistently highlights the importance of early detection and community-level response in managing public health risks. Strengthening primary care systems, including investments in frontline facilities, workforce capacity, diagnostics, and community health workers, remains a key priority for improving system responsiveness and resilience.

Financing considerations remain central to ongoing reforms, particularly in the context of evolving external support landscapes. Many countries are exploring domestic financing approaches, including taxation and insurance-based mechanisms, to strengthen resource mobilisation. While these reforms are contributing to improved funding flows, continued efforts to enhance efficiency across different levels of care may further support system performance, equity, and sustainability objectives.

Evidence from cancer care delivery highlights that delays in diagnosis are often associated with a combination of factors, including financial barriers, access to diagnostic services, transport constraints, and referral system challenges. This underscores the importance of complementing awareness initiatives with interventions that strengthen access pathways, including service affordability, patient navigation, and improved coordination across levels of care.

Across all areas, the importance of collaboration among stakeholders remains evident. Effective health system strengthening requires coordinated engagement between governments, the private sector, development partners, and civil society, supported by clearly defined roles and shared performance expectations. Regional institutions can also continue to play an important role in advancing harmonisation, coordination, and capacity strengthening across member states.

Collectively, these considerations point to an important shift in how health is understood and operationalized, not as a discrete sector, but as an enabling system embedded across economic and social structures, with implications for how policy, financing, and service delivery are designed and aligned.

Breaking the Silos: Why Health Cannot Afford to Stay in Isolation

Health conversations have historically been confined to Ministries of Health, hospitals, and donor meetings. Meanwhile, sectors such as manufacturing, employing millions across Africa—remain largely absent from these discussions.

This disconnect stems from a persistent misconception: health is viewed as a cost centre rather than a driver of productivity. In reality, the economic consequences of poor health are immediate and tangible. A factory that loses skilled workers to preventable illnesses incur production delays and increased training costs. A logistics company with a workforce burdened by chronic disease faces reduced efficiency and competitiveness. The more relevant question is not what health costs, but what it costs to operate with an unhealthy workforce.

Health does not begin at the clinic door. It is shaped long before that at home, in workplaces, and through the conditions that define daily life. Workplace ergonomics, air quality, mental wellbeing, and access to proper nutrition are all critical determinants of health, yet they are rarely prioritised, financed, or measured within health strategies.

What is needed is a fundamental reset. Health must no longer be treated as a vertical sector, siloed within public systems and donor agendas. Instead, it should be recognised as a horizontal enabler of economic growth—integral to workforce productivity, business performance, and national development. Governments and the private sector alike have a role to play in embedding health across all sectors of the economy.

Prevention Over Cure: Redefining the Role of Employers

Prevention is frequently emphasised in health discourse, yet rarely operationalised in practice. The reasons are largely structural. Workplace health programmes where they exist tend to focus on compliance with occupational safety standards or the provision of insurance for curative care. Far less attention is given to the more fundamental question: how can illness be prevented before it occurs? For employers, particularly in labour-intensive sectors, this

is not a peripheral concern. It is a core business issue. Poor health within the workforce directly affects productivity, absenteeism, and retention. However, prevention remains underinvested because its returns, while substantial, are often less immediate and less visible than treatment.

Large manufacturers are well positioned to lead this shift. Many already apply continuous improvement methodologies such as Kaizen to optimise efficiency, reduce waste, and improve output. These same principles can and should be extended to workforce health: redesigning workstations to improve ergonomics, addressing fatigue and stress, and fostering environments that support physical and mental wellbeing. A healthy workforce is not an externality to production; it is a prerequisite for it.

However, scaling prevention across small and medium-sized enterprises which form the backbone of most African economies requires more than voluntary action. It calls for a redefinition of the government's role. Beyond regulation, governments must act as enablers of prevention by creating the right incentives and infrastructure. This includes targeted training programmes, tax incentives for workplace wellness investments, and the establishment of minimum standards that extend beyond safety to encompass holistic health.

Extending the logic of prevention further, a more systemic opportunity emerges. If health is to be embedded in daily life, it must also be embedded in the institutions people interact with most consistently. Schools represent one of the most powerful yet underutilised platforms in this regard. A bold but practical proposition is to equip every school in Kenya and ultimately across Africa with a basic health facility.

With over 450,000 schools across the continent, such an approach could create one of the largest distributed primary care networks.^[1] Supported by digital tools and AI-assisted diagnostics, these facilities could screen a significant proportion of common conditions at an early stage, reducing pressure on higher-level health systems and improving long-term outcomes. In doing so, prevention would move from rhetoric to reality-embedded not only in workplaces, but across the fabric of everyday life.

Policy Innovation: The Case for Menstrual Leave and Workplace Dignity

In 2025, Nairobi City County introduced two days of paid menstrual leave for its 19,000 employees, approximately half of whom are women.^[2] The policy directly addressed a persistent but often overlooked challenge: presenteeism; the reality of employees being physically present at work but unable to perform at full capacity.

Prior to the policy, many women managed menstrual pain by taking unplanned leave without formal disclosure, contributing to unpredictable absenteeism and operational inefficiencies. By formalising this reality, the county reformed the issue not as a matter of accommodation, but of productivity and workforce management.

The results have been notable. More than a year into implementation, there has been no evidence of widespread misuse. Leave is declared in advance, workflows are

adjusted accordingly, and service delivery continues with minimal disruption. More importantly, the policy has reduced hidden absenteeism, improved planning, and fostered a workplace culture that recognises dignity and wellbeing as integral to performance.

At present, the policy applies only to employees of Nairobi City County Government, as labour regulation remains a national function. However, ongoing engagement with the Ministry of Labour and Social Protection Kenya signals potential for broader adoption. The opportunity is not limited to menstrual leave alone but extends to a wider set of flexible workplace policies including mental health days and adaptive working arrangements that reflect the realities of a modern workforce.

This case underscores a broader lesson: meaningful health policy innovation does not always require significant financial investment. Rather, it depends on political will, institutional trust, and a shift towards measuring outcomes such as productivity, retention, and wellbeing over rigid inputs and traditional assumptions about work.

Strengthening Primary Healthcare: The Ground Zero for Pandemic Readiness

The COVID-19 pandemic exposed structural weaknesses across health systems worldwide. In many African countries, relatively younger populations helped mitigate the most severe mortality outcomes seen elsewhere. However, this demographic advantage is neither uniform nor guaranteed to protect against future threats.

The continent faces a high and growing burden of public health risks. Hundreds of outbreaks are reported each year, including Ebola, Cholera, Yellow Fever, and Lassa Fever.^[3] At the same time, Antimicrobial Resistance is emerging as a slower-moving but potentially more devastating crisis. Across all of these threats, one constant remains: the first—and most decisive line of defence is primary healthcare.

When a community health worker can detect a suspected case early, initiate isolation, and trigger a response within hours, outbreaks can be contained at source. When detection is delayed until patients present at district or referral hospitals, the opportunity for containment is often lost.

Despite this, primary healthcare remains chronically under-resourced. Political attention and capital investment continue to favour large tertiary hospitals—highly visible and often politically attractive, while frontline facilities that serve the majority of the population struggle with gaps in diagnostics, essential medicines, workforce capacity, and even basic infrastructure such as water and sanitation.

Pandemic preparedness is not built in specialised referral centres alone. It is built in communities, in the short distance between a patient's home and their nearest primary care facility. When that first point of contact is functional, trusted, and equipped, it reduces transmission risk, strengthens referral pathways, and prevents unnecessary pressure on higher levels of care. When it fails, patients bypass the system entirely, overwhelming services that are neither designed nor resourced to provide first-contact care.



Strengthening primary healthcare is therefore not a secondary or long-term aspiration. It is the most immediate and cost-effective investment governments can make to improve routine health outcomes while building resilience against future pandemics.

Community Voice and Cancer Care: What Data Actually Shows

The Africa Cancer Foundation has spent the past 15 years conducting community-based screening for breast, prostate, and cervical cancers across 27 counties, reaching more than 36,000 individuals.^[4] The findings are consistent and deeply instructive.

Across settings, late presentation remains a persistent challenge. However, the underlying driver is often misunderstood. Evidence from community outreach and hospital-based studies, including ongoing work at Jaramogi Teaching and Referral Hospital (now a Level 6 facility), shows that delayed diagnosis is less about lack of awareness and more about structural barriers to access.

Patients, particularly women with early signs of breast cancer often first present at primary healthcare facilities. At that stage, symptoms may not be severe enough to prompt urgent action. However, financial constraints, particularly transport costs and out-of-pocket diagnostic expenses, lead many to delay further investigation. Over time, this delay translates into late-stage presentation, often when the disease has already progressed significantly.

This pattern underscores a critical misconception in many health strategies: awareness alone is insufficient to change outcomes when access barriers remain unaddressed. The dominant narrative of lack of knowledge does not align with the data. The more consistent barrier is affordability within the diagnostic and referral pathway.

The policy implication is clear. Improving outcomes requires shifting focus from awareness campaigns to system enablers: subsidised transport to facilities, coverage of diagnostic services, and structured patient navigation systems that actively guide individuals through the continuum of care. Where such interventions have been introduced, screening programmes are increasingly detecting smaller lesions and earlier-stage disease, improving survival prospects and reducing long-term treatment costs.

This evidence also reinforces a broader systems lesson: community experience must be treated as a core source of health system design, not an external input. The individuals most affected by system failures are often absent from formal policy discussions. Embedding their perspectives requires more than periodic consultations. It requires institutionalising community health workers, patient navigators, and structured feedback loops that continuously inform service design and delivery.

Collaboration as the New Innovation

Across all themes explored, one consistent principle emerges: no single actor can address these challenges alone. Governments cannot finance or implement everything. The private sector cannot self-regulate at scale. Donors cannot design sustainable national systems.

Philanthropy, while important, cannot substitute for long-term institutional capacity.

What is required is a shift from fragmented action to coordinated systems thinking, where each actor operates within clearly defined comparative strengths and shared accountability for outcomes.

This also requires a rethinking of how health cooperation is framed. Rather than relying solely on traditional global health architectures, there is growing need to strengthen transnational health systems structures rooted in African contexts, priorities, and realities. Institutions such as the Africa Centres for Disease Control and Prevention (Africa CDD) and the African Medicines Agency (AMA) represent important steps in this direction. However, their effectiveness will depend on sustained political backing, predictable financing, and operational autonomy—not as replicas of external models, but as institutions designed for African health and governance systems.

The challenge is not a lack of partnerships, but the quality of those partnerships. Many initiatives are launched with visibility and optimism, yet weaken over time due to misaligned incentives, unclear responsibilities, and limited accountability for results. In some cases, coordination fatigue replaces coordination itself.

Reversing this trend requires greater discipline in how partnerships are designed and managed: clearly defined roles from the outset, shared metrics of success, and governance structures that prioritise outcomes over visibility. It also requires a culture of honest engagement, where all actors including governments are constructively held accountable when policies underperform or implementation gaps emerge.

Ultimately, collaboration is not a soft ideal. It is a structural requirement for system performance. In the next phase of health system development, the most important innovation will not be technological or financial, it will be institutional: the ability to align diverse actors around shared outcomes and sustain that alignment over time.

Conclusion

Across prevention, financing, primary healthcare, cancer care, workplace innovation, and collaboration, a single pattern is evident: Africa's health challenge is not a shortage of ideas, but a fragmentation of systems.

Health is still too often treated as a standalone sector, when in reality it is an outcome of decisions made across workplaces, schools, communities, and national economies. The cost of this fragmentation is visible in delayed diagnoses, preventable outbreaks, underutilised prevention opportunities, and inefficient resource allocation across levels of care.

However, the evidence presented also points to something more important: solutions already exist. Whether it is employer-led prevention, decentralised school-based health access, restructured primary care financing, or community-informed cancer pathways, the direction of reform is increasingly clear. What is missing is not proof of concept, but scale, alignment, and institutional discipline.



The next phase of health system transformation will therefore not be defined by isolated interventions, but by whether countries can shift from fragmented programmes to integrated systems where financing, service delivery, and accountability are aligned around people rather than institutions. In this sense, the most important shift is conceptual: health must move from being a sector to being a system-wide capability embedded across the economy and society.

Key Recommendations

1. **Reframe health as a cross-sector economic enabler:** Health should be positioned as a core driver of economic productivity rather than a welfare cost. This requires integrating health indicators into economic planning, industrial policy, and labour strategies, while embedding health considerations across non-health ministries, including finance, education, transport, and industry. Workforce health should be treated as a measurable productivity asset within both public and private sector performance frameworks.
2. **Institutionalise prevention as a core delivery pillar:** Prevention should be established as a core pillar of health systems by embedding it within the institutions people engage with daily. This includes scaling workplace wellness programmes, introducing fiscal incentives for employer-led prevention, and leveraging schools, workplaces, and community settings as continuous delivery platforms for early screening, risk reduction, and health promotion.
3. **Promote inclusive and productivity-aligned workplace policies:** Governments and employers should advance workplace policies that directly address health-related barriers to productivity. This includes formalising approaches such as menstrual health leave, mental health days, and flexible working arrangements, while recognising dignity, wellbeing, and workforce performance as mutually reinforcing outcomes.
4. **Strengthen and fully resource primary healthcare systems:** Primary healthcare should be prioritised as the foundation of both routine service delivery and epidemic preparedness. This requires sustained investment in frontline facilities, access to essential diagnostics and medicines, and the formal integration and support of community health workers to enable early detection, rapid response, and effective referral pathways.
5. **Shift from awareness to access-driven health interventions:** Health strategies should move beyond awareness campaigns to directly address structural barriers to care. Priority should be given to expanding access to diagnostics, subsidising transport to health facilities, and establishing patient navigation systems that support individuals across the continuum of care, particularly at the point of referral.
6. **Accelerate domestic health financing reform:** Governments should strengthen domestic health financing through expanded revenue mobilisation, more effective insurance and reimbursement systems, and timely provider payments. Financing models should prioritise primary healthcare, preventive services, and diagnostic access to ensure financial sustainability and reduce out-of-pocket burdens.
7. **Build accountable, outcome-driven partnerships:** Health partnerships should be restructured around clearly defined roles, shared metrics, and mutual accountability for outcomes. Governments, the private sector, donors, and civil society must align around measurable results rather than activities. Regional institutions such as Africa CDC and the AMA should be strengthened through predictable financing, operational autonomy, and sustained political commitment.
8. **Embed community voice into continuous system design:** Community perspectives should be institutionalised within health systems through continuous feedback loops rather than one-off consultations. This includes formalising the roles of community health workers and patient navigators, and systematically integrating lived experience into policy design, implementation, and evaluation to ensure services are responsive to real-world needs.

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Closing Ceremony



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A clear shift is underway in Africa's health landscape—one defined not by dialogue alone, but by coordinated implementation at scale. Across sectors, the focus is increasingly on integration of systems, financing, data, and partnerships as the foundation for resilient and equitable health systems.

A Continental Step Forward: The Africa Oncology Care Network

A significant milestone was marked by the formal launch of the Africa Oncology Care Network (AOCN) and the signing of its founding Memorandum of Understanding (MOU), signalling a transition from fragmented efforts toward structured, multi-country collaboration in cancer control. Originating from a multi-stakeholder convening in late 2025, the network brings together governments, clinicians, researchers, and private sector partners under a shared vision: to expand access to high-quality, affordable cancer care across Africa.

Rather than operating as a standalone initiative, the AOCN is designed as a platform for alignment, anchored in five priority areas: policy coordination, health system strengthening, data and research, equitable access to oncology services, and integrated referral pathways. This reflects a broader recognition that addressing non-communicable diseases requires systems thinking, long-term investment, and cross-border cooperation.

Nigeria confirmed its role as host of the AOCN Secretariat, reinforcing its position as a continental anchor for cancer control. The MOU was signed by representatives from Africa Health Business and the Federal Ministry of Health and Social Welfare of Nigeria, including the National Institute for Cancer Research and Treatment (NICRAT).

The establishment of a continental secretariat further reinforces the shift toward sustained institutional coordination, positioning the network as a vehicle for translating commitments into measurable progress.

Connected Systems as the Backbone of Modern Healthcare

The transformation of health systems increasingly depends on the ability to connect data, services, and stakeholders. Digital Public Infrastructure (DPI) emerges as a critical

enabler of this transformation, offering a pathway to move beyond fragmented, facility-based care toward continuous, patient-centred systems.

At its core, the challenge is not the absence of data, but the inability of systems to communicate. Fragmented records limit continuity of care, weaken supply chains, and constrain effective decision-making. DPI addresses this by creating a shared digital foundation, built on interoperable standards, secure data exchange and inclusive governance frameworks.

This approach opens the door to new models of care and financing, including data-driven insurance systems, more transparent supply chains, and scalable digital solutions that can reach underserved populations. As implementation advances, the success of DPI will depend on sustained collaboration across governments, technology providers, and healthcare stakeholders.

Health Financing in Transition: From Aid Dependency to Investment

A recurring theme is the urgent need to reposition health financing. Declining external aid is no longer viewed solely as a constraint, but as a catalyst for change prompting countries to rethink how health systems are funded and sustained.

The case for investing in health is increasingly clear: strategic investments in priority areas, particularly non-communicable diseases, yield significant economic returns through improved productivity and reduced long-term costs. This reframing positions health not as a social expense, but as a driver of economic growth and national development.

At the same time, there is growing recognition that traditional, fragmented funding approaches are insufficient. The future lies in blended and diversified financing models, where public resources are complemented by private sector investment, and where partnerships move beyond short-term support toward long-term system strengthening.

A Decade of Convening: Strengthening Africa's Health Ecosystem Through Collaboration

Over time, Africa's health ecosystem has evolved from fragmented engagement toward more structured and intentional collaboration. Governments, private sector leaders, and development partners are increasingly engaging not as isolated actors, but as co-creators of solutions.

This shift is underpinned by a clearer understanding of complementary roles where public institutions provide stewardship, the private sector drives innovation and efficiency, and civil society strengthens accountability and



community engagement. Together, these actors form a more cohesive and responsive health ecosystem.

At the same time, shifts in the global financing landscape are accelerating the move toward domestic resource mobilisation. Countries are exploring innovative approaches from targeted levies to insurance reforms to build more sustainable and locally driven health financing systems.

Looking ahead, the importance of preparedness and resilience is also brought into focus. Emerging plans for regional health emergency infrastructure highlight both the urgency of strengthening response capacity and the opportunity to mobilise new forms of capital, including private and philanthropic investment.

Toward an Integrated and Investable Health Ecosystem

Current discussions reinforce a fundamental shift in Africa's health trajectory. The focus is no longer on isolated interventions, but on building integrated systems that can deliver sustained impact at scale.

This requires alignment across policy, financing, and implementation; stronger coordination between stakeholders; and a continued commitment to innovation and partnership. It also demands clear recognition that health is central to economic growth, social stability, and long-term development.

The path forward is defined not by new ideas alone, but by the collective ability to translate commitments into action—building a health ecosystem that is connected, resilient, and designed to serve all.



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