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Health, Agenda 2030 and the Future of Africa's Development

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> Any social and economic development programme is primarily based on the availability and potential of human capital, which is needed for developing various sectors of a country's economy; its industry and its agriculture productivity depends to a considerable extent on the health and wellbeing of the labour force, because in order to mobilise human resources, there must exist the precondition that they are physically fit to be mobilised. Ill health, undernourishment, poor environmental conditions and debility affect the development process.[1]

Introduction

It is now widely recognised that health is central to sustainable development. This is attested by its inclusion in the 2030 Agenda for sustainable development, adopted by the United Nations General Assembly in September 2015. The new Agenda aims to eradicate poverty, eliminate inequalities and protect environmental resources for social and economic development. It is crystallised in a comprehensive and integrated set of 17 sustainable development goals with a total of 169 targets. The 2030 Agenda for

sustainable development recognised from the start the importance of health. Paragraph 26 addresses health as follows:

> To promote physical and mental health and well-being and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care. No one must be left behind. We commit to accelerating the progress made to date in reducing newborn, child and maternal mortality by ending all such preventable deaths before 2030. We are committed to ensuring universal access to sexual and reproductive health care services, including for family planning, information and education. We will equally accelerate the pace of progress made in fighting malaria, HIV/AIDS, tuberculosis, hepatitis, Ebola and other communicable diseases and epidemics, including by addressing growing anti-microbial resistance and the problem of unattended diseases affecting developing countries. We are committed to the prevention and treatment of non-communicable diseases, including behavioural, developmental and neurological disorders, which constitute a major challenge for sustainable development.[2]

Health is covered under SDG; 3 'Ensure healthy lives and promote wellbeing for all ages'. It has 13 proposed targets. It is also critical to the delivery of other sustainable development goals largely because good health is fundamental to the realisation of human potentials.

The profusion of academic and policy discourse surrounding the links between health and development over the past two decades has been both abundant and wide-ranging. A common thread in the literature, however, is the interdependence and mutually reinforcing nature of the two concepts. Writing in 1991, Robert Fogel argued that Britain's early industrial breakthrough was largely due to the mastery of high mortality and morbidity as a result of improvement in nutritional status and conquest of many contagious diseases from the late 18th century onwards.[3] In a similar vein, a United States intelligence community assessment for National Intelligence Council concluded in 2008 that:

> considerable empirical and theoretical studies have been done on the relationship between health and economic growth and development. The clearest evidence of a causal link has been the economic impact of high profile infectious diseases. Historically, progress on health issues has correlated in a number of countries with improved economic development

> and growth by expanding the pool of healthy and productive workers … attention to health issues is a key determinant as to whether countries can escape poverty[4]

To be sure, good health strengthens development because it increases productivity, strengthens people's capabilities, increases savings and investments, and promotes positive behaviour. The recognition of the fact that poor health impeded development and thus helped to keep poor states poor has informed increased World Bank lending for health development.[5] Mills and Shillcutt, on the other hand, has demonstrated that economic development can also ease financing of environmental, health and sanitation campaigns for education, immunisation and screening. [6] Also, social development, especially in the field of education, has been associated with improved health status through improved nutrition and reproductive health. Scholars have also shown that the attendant gains from economic development may not occur in all situations, as macroeconomic changes may not filter down to benefit the whole population. Many sound policies in economic terms, notably structural adjustment policies have had devastating health effects.[7]

The linkages between health and development are, particularly, noticeable in Africa when the region is viewed alongside other world regions. Since the early 1980s, all economic and social indicators showed that Africa had been left behind. The continent ranked last among the world regions in indications for health. According to the World Health Statistics (2015), life expectancy for African region is 58 years, which is lower than 68 years for South-East Asian region. Infant mortality and under-five mortality are 59.9 and 90.1(per 1000 live births) which are higher than the figures for South East Asian Region – (37.3 and 46.9 respectively).[8] The parlous health situation in Africa is the consequence of emerging and re-emerging diseases, such as HIV/AIDS, tuberculosis, malaria, Ebola, hepatitis, meningitis, sleeping sickness, SARS and others. HIV/AIDS, in particular, has affected Africa than any other region on earth. Yet another concern is that Africa bears a significant proportion of the global burden of chronic diseases. The World Health Organisation has projected that by 2020 the continent will experience the highest increase in death rates from cardiovascular disease, cancer, respiratory disease and diabetes. [9]This state of affairs has been exacerbated by recurring natural disasters, poor economic performance and military conflicts. All these problems have posed serious health development challenges for Africa.

The appalling situation does not imply dearth of health development initiatives in the past both at the global and regional levels. Rather the success of such initiatives is foreclosed by several problems notably, poverty, dysfunctional health systems, lack of access to health facilities, resource scarcity, corruption, health inequality among others. Besides, the global community has also done more harm than good by posing serious threats to health development in Africa. A case in point is the web of global institutional arrangements, which perpetuates massive poverty in Africa such as the introduction of SAP World Bank/IMF ideological framework based on neo liberal policies, have affected and continued to affect health care delivery in most African countries. Equally, the World Trade Organisation (WTO) Agreements, particularly the General Agreement on Trade and Services (GATS) and Trade Related Aspects of Intellectual Property Rights (TRIPS) since 1995, have further undermined the already precarious health sector in most African countries resulting in the migration of African health professionals to the West and lack of access to essential medicines and vaccines.[10] In this context, this chapter examines how the SDGs can drive the future of health development in Africa by 2030. It also analyses some of the global and regional health interventions and suggests innovative policy guidelines that could provide more effective responses by African countries to the myriad challenges that had consistently undermined previous efforts towards a sustainable health development in the continent.

Previous Global and Regional Efforts towards Sustainable Health Development in Africa

Concerted and widespread efforts to develop appropriate and effective policies for improved health internationally began in the late 1970s and 1980s. Yet they have not yielded the desired results. The Alma Ata Declaration of 1978 represents one of the earliest attempts at improving the health of populations in developing countries including Africa. Alma Ata Declares that the promotion and protection of the health of people is essential to sustained economic and social development.[11] The Declaration specifies primary health care as the key to attaining the target of health for all by the year 2000 'as part of development in the spirit of justice'. The concept of primary health care is based on the basic determinants of health and it further recognised that health is dependent on social and economic development and also contributes to it This approach was a departure from the previous primarily medical approach

to health and touched deeply the social, political and cultural structure of the societies concerned. No doubt, the national governments turned their efforts to its implementation. As observed by Kelley Lee and Hilary Goodman, "Primary health care was not only seen to be desirable ideologically, supported by a political commitment to extend coverage of health services to rural and other underserved populations, but necessary as a cost effective strategy in resource constrained economies."[12]

It cannot be denied that some progress was made with the health services in Africa. For the first time, the needs of the larger rural population were being met and after a while, people began to see the results, particularly, in immunisation programmes, diarrhoea in children, malaria treatment and acute respiratory infection. In Nigeria, for instance, primary health care formed an integral part of the country's social and economic development. It became the first level of contact of the individual and community in the national health system thus bringing health care closer to the people and contributes the first element of a continuing health care process. However, the early advance lost momentum. The Alma Ata vision of primary health care was criticised for being ambitious and expensive. Several forces disrupted the primary health care strategy including continuing economic recession in the 1980s, the rise of neoliberalism, market ideologies and structural adjustment policies and by new epidemiological challenges like the emergence of HIV/AIDS.[13] It was replaced in the 1980s by selective primary health care, which focused on a few cheap and effective interventions requiring little investment in infrastructure – such as oral dehydration therapy for diarrheal disease in children and growth monitoring, breast feeding and immunization programmes.[14] Nevertheless, the Alma Ata declaration was remarkable as it was the first time the health care problems of the poorest countries were seriously taken into consideration, both health needs and development issues were strongly linked. It also marked a paradigm shift, establishing the notion of international responsibility for health, the idea that rich countries should help poorer ones to achieve health goals.

The Bamako Initiative (BI) was launched in 1987 in an attempt to meet the growing crisis of scarcity of drugs and reduced access to quality health care as well as counters the negative impact of SAP.[15] It was introduced against the background of the problem of financing health services experienced in the 1980s in many countries especially in sub-Saharan Africa. The aim of BI, among other things, was to increase resource availability, primarily through charging for drugs, and to use those resources to improve

access for the least well served. It provided start-up funds for community financing schemes such as the revolving drug funds. In the case of Revolving drug funds an initially provided drug-stock would be sold to patients at a mark-up price that would provide a self-sustaining means of generating incomes for supplying drugs to rural communities.

This scheme was widely adopted from the late 1980s but the exact nature varied from country to country. Most countries in Africa were encouraged to introduce or extend user fees in government health facilities. These policies were strongly supported by major donors of health sector aid, notably the World Bank, USAID and UNICEF. For instance, in 1988, Nigeria adopted the Bamako Initiative, as a strategy for strengthening PHC with five major components. These are; community participation through a variety of local government, district and village level committee; improvement of Maternal and Child Health (MCH) services; the provision of essential drugs, cost recovery and enhanced management, supervision and monitoring systems. In 1995, out of the 589 local government areas in Nigeria, 53 were responding to the Bamako Initiative[16] but by 1997, about 60 out of the 774 local governments in Nigeria covering approximately 10 percent of the population had the Bamako Initiative.[17]

Certainly, most of the countries in Africa that adopted the Bamako Initiative achieved significant results. They have been reorganising their health systems since the adoption of BI in 1987, which promoted community, based methods of increasing accessibility of drugs and health care services to the population through the implementation of user fees. However, The Bamako Initiative was not without its limitations. Although many African countries adopted the approach, only in a handful were initiatives scaled up. Even in those countries like Nigeria where Bamako Initiative has been deemed a success, the application of user fees to poor households and the principles of cost recovery drew strong criticisms. In most African countries where Bamako Initiative has been deemed a success, poor people viewed price as a barrier. Consequently, a large share did not use essential health services despite exemptions and subsidies. It also gave rise to multi drug prescribing, some of which are irrational. The initiative was donor driven with limited coverage.

The inability of the PHC and Bamako Initiative and other international initiatives to improve access and quality of healthcare in sub-Saharan Africa led to the search for alternatives to health policymaking.[18] The interest began to shift from 'Health for All' towards what became known as 'Health Sector Reform'. Andrew Green and Ann Matthias in 1997 reaffirmed

this when they wrote, "If primary health care was the talking point in the early 1980s, health sector reform has replaced it a decade later as the major policy thrust occupying donors."[19] The major precursor of health sector reforms was the World Bank through its several publications particularly the 1993 *World Development Report* 1993 (World Bank 1993).[20] This report demonstrated that investing in health is a prerequisite for sustained development. Another publication '*Better Health in Africa'* set forth a vision of health improvement that was achievable through health sector reform.[21] Through its advocacy of user fees, cost recovery, private health insurance and public and private partnership, the reports called for limiting the role of the state to core public health and an enlarged role for the market and market forces. The promotion of this new economic idea was led by external donors; World Bank and International Monetary Fund, initially in the form of structural adjustment programmes. The adoption of adjustment measures led to an unprecedented decline of the health status of the poor and worsened health inequalities in Africa.[22] In Tanzania for instance, the adoption of a series of adjustment measures from 1981 onwards, including the reduction of government expenditure by introducing cost sharing in the health sector was accompanied by increased maternal mortality, chronic malnutrition and an erosion of capacity to implement HIV/AIDS intervention strategies.[23]

The United Nations System has been actively involved in providing health assistance through several initiatives. The World Health Organisation is the UN designated specialised agency in health expected to play a leading role in coordinating international health activities. The WHO is now joined by other UN agencies including UNDP, UNICEF and UNFPA among others, in providing health assistance. Other regional bodies such as the EU have also increased their interest in Africa's health sector. The past ten years have also witnessed massive growth of global programmes focused on specific diseases such as the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunization (GAVI). These global initiatives have billion dollar budgets and are major source of health financing in Africa. Furthermore, civil society organisations like Oxfam, *Médecins San Frontières* among others have made critical contributions to health development in Africa. There are also many philanthropic organisations currently involved in health in Africa. These organisations include Bill Melinda Gates Foundation, Bill Clinton Foundation among others. Although these initiatives have brought specific benefits, they are also causing a

dangerous degree of fragmentation and overcrowding in Africa's health sector.

African countries have also benefitted from the US global health initiatives – US President's Emergency Fund for AIDS Relief (PEPFAR), and the US President's Malaria Initiative. Presidential Emergency Plan for HIV/AIDS Relief is a five-year bilateral commitment by the United States Government to support HIV/AIDS prevention, care and treatment programmes in developing countries (Sessions). The majority of the PEPFAR resources are dedicated to focus-country programmes and twelve African countries are part of the beneficiaries. In all 15-focus countries, PEPFAR supports a comprehensive programme in HIV/AIDS prevention, care and treatment, as well as limited activities in health system strengthening as it relates to HIV/AIDS monitoring and evaluation and policy reform. An assessment of the progress of PEPFAR on HIV/AIDS indicates that it has achieved encouraging results and has also made significant contributions to HIV response in Africa. However, despite the providing millions of Africans with access to antiretroviral treatment for the first time, for example US HIV prevention policy in Africa under George W. Bush administration advocated abstinence rather than use of condoms and needle exchange reflecting the administration moral stance rather than the advice of health workers in Africa.[24] A study by Oomman *et al*. in 2007 suggests that PEPFAR funding policy, rather than the specific needs of Mozambique, Uganda and Zambia, have taken precedent.[25] Jeremy Youde has also demonstrated that funding for HIV/AIDS does not necessarily go to the states with highest prevalence but reflects other strategic priorities.[26]

In May 2009, President Barrack Obama announced the Global Health Initiative (GHI), a multi-year comprehensive effort to reduce the burden of disease and promote healthy communities and families around the world. The President's Malaria Initiative (PMI) is a core component of the GHI. PMI was launched in June 2005 as a five year, $1.2 billion initiative to rapidly scale up malaria prevention and treatment interventions and reduce related mortality by 50 percent in 15 high burden countries in sub-Saharan Africa.[27] With the passage of the Lantos-Hyde Act, funding for PMI was extended to 2014 and as part of the GHI; PMI goal was adjusted to reduce malaria related mortality by 70 percent in the original 15 countries by the end of 2015. While the US assistance has been beneficial in these areas, its performance in terms of overall health impact has been limited. This is attributable to poor aid

harmonisation, limited support for general budget support, and vertical disease approach among others.

At the regional level, the African Union since its inception had initiated several health initiatives. In April 2001, the AU Heads of state adopted the Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases, pledging to make fighting against HIV/AIDS their highest priority in respect to national development plans.[28] They also pledged to set a target of allocating at least 15 percent of their annual budget to the improvement of the health sector. They called for international resources and collaborations between the WHO, UNAIDS, other UN and regional organisations and monitor the implementation of the outcome of the summit. In 2006, the AU adopted the Abuja Call for Accelerated Action towards universal Access to HIV/AIDS, Tuberculosis and Malaria services by 2010. Sadly, African countries have failed to fulfil Abuja pledge to commit 15 percent of their national budgets to health spending. According to a WHO report, only four countries (Rwanda, Botswana, Zambia and Togo) were compliant with the Abuja pledge (WHO 2011).[29] Another 22 countries spent between 10 percent and 15 percent of their budgets on health, but 25 countries spent less than 10 percent of their budget on health, and five spent less than 5 percent. Today, a number of countries now allocate a lower portion of their budgets to health care than before Abuja Declaration.

Similarly, at the turn of the century, prominent African leaders called for an African renaissance, which materialised as the New Partnership for African Development NEPAD, a vision and a strategic framework. NEPAD is a comprehensive and integrated development plan for the continent that makes peace security, democracy, good economic and corporate governance preconditions for sustainable development in the continent. Thus, in line with NEPAD priorities, which included among others, policy reforms and increased investment in health, the African Health Strategy (AHS) 2007 – 2015, was developed.[30] The goal of the strategy was to enrich and complement Member States strategies by adding value in terms of health systems strengthening from the unique continental perspective. The AHS 2007 – 2015 explored challenges and opportunities related to efforts, which can decrease the continent's burden of disease, strengthen its health systems and enhance human capital by improving health. The AHS, 2007 – 2015, was recently revised as African Health Strategy 2016 – 2030 (African Union 2016).[31] The AHS 2016 – 2030 is similar to some extent to its predecessor in that it also seeks to provide strategic direction to Africa's efforts in creating better

performing health sectors. It recognizes existing continental commitments and addresses key challenges to reducing the continent's burden of disease, while also drawing on lessons learned from implementing AHS 2007 – 2015 and existing opportunities. However, the challenges to progress on health include resource limitations and non-implementation of health initiatives in member states of the African Union. Other regional integration organisations in Africa including ECOWAS, East African Community and COMESA (Common Market of Eastern and Southern Africa) have integrated health into their regional agendas.

From Millennium Development Goals to Sustainable Development Goals

The Millennium Development Goals (MDGs) were another set of development commitments, which African countries adopted in 2000, along with the rest of the world.[32] Significantly, health featured in the MDG's, reflecting a new consensus that although many suffered ill health because of poverty many were also poor because they were sick.[33] Three of the eight MDGs were directly related to health. These include Goal 4: Reduce child mortality, Goal 5; Improve maternal health and Goal 6: Combat HIV/AIDS, malaria and other diseases. Other MDGs indirectly relate to health. For 15 years, African health priorities were organised around these health goals of the UN MDGs. During this period, child and maternal health became a measure of a nation's overall development. At the same time, it was acknowledged that combating the spread of tuberculosis and malaria was critical to human progress, as these diseases disproportionately impact the development potentials of many countries.

Despite the cynicism, the darkness and the miserable politics on many of the issues, the world has made a tremendous progress with the MDGs.[34] Africa, in particular, saw some progress for each of the health related MDGs. For instance, WHO African Region[35] reported that under-five mortality rate in Africa fell by 54 percent from 177 deaths per 1000 live births in 1990 to 81 in 2015. Neonatal mortality rate also declined by 38 percent from 45 deaths per 1000 live births in 1990 to 28 in 2015. Maternal mortality varied between 53 and 1100 per 100000 live births, with four countries achieving the target of reducing maternal mortality ratio by three quarters. Moreover, 37 of 47 countries in the African region showed outstanding progress in the attainment of the target of lowering the HIV/AIDS incidence, with a 40 per cent reduction in the incidence of HIV in the region between 2001 and 2014. About 10

countries reached the target of lowering malaria mortality. Between 2000 and 2013, the estimated number of cases per 1000 persons at risk of malaria declined by 34 percent and malaria mortality rates declined by 54 percent in the African region. There was also increased life expectancy. The tremendous progress is the consequence of increased funding for health in Africa since 2000. In other words, the health MDGs generated a considerable amount of finance, efforts and new institutions for meeting the goals. A case in point is HIV/AIDS that generated an unprecedented level of funding from national and international bodies.

Sadly, the increased funding for HIV/AIDS led to a distortion of many health systems in Africa, where the health system is organised around HIV/AIDS programme because of the funds available from new funding mechanisms like the Global Fund to Fight AIDS, Tuberculosis and Malaria. Besides, the identification of three specific health goals and the funding that attended them fostered health silos where vertical-specific disease interventions were prioritized over horizontal interventions that fund the health system more broadly.[36] It has been observed that providing visibility to some high-profile health problems at the expense of others exacerbates inequalities in global health. The MDGs also created result-based culture that is guided by investing in what can be easily measured, for instance, the number of children that have received a polio vaccination, rather than the complexity of health systems that cannot be easily quantified.

The consequence of all these is that health systems (hospitals and clinics, clinical professionals, equipment and supplies among others) have been neglected. The outcome of such neglect was starkly revealed during the Ebola crisis in West Africa. Health systems neglect poses a serious problem when addressing the issue of non-communicable diseases or universal health coverage, which requires more integrated, multi-sectoral approaches. For instance, tackling the problem of NCDs calls for an approach that combines preventive actions with continuous, well-coordinated medical services for those with chronic conditions or at high risk of developing them.[37] Thus, while external funding for health grew significantly since the millennium, it is clear that a narrow focus on goals targets and performance missed what is core to the health of any population – a functioning health system.

Nonetheless, there is a consensus among policy makers and civil society that progress against disease is notable. The MDGs have played an important part in securing that progress, a justification for the fight to continue beyond 2015. Hence, the need for the SDGs to complete the unfinished works

of the MDGs as well as fill the identified gaps. One of the major strengths of the SDGs is that it is more encompassing than the MDGs they replace. Unlike the health MDG'S, the SDGs include new targets on non-communicable diseases, mental health, substance abuse, health impact from hazardous chemicals, water and soil pollution, health financing and health workforce issues and universal health coverage. See Table 1.

Table 1: Health Targets in SDG 3

3.1	By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births
3.2	By 2030, end preventable deaths of newborns and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-five mortality to at least as low as 25 per 1000 live birth
3.3	By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases
3.4	By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
3.5	Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
3.6	By 2020, halve the number of global deaths and injuries from road traffic accidents
3.7	By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
3.8	Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
3.9	By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
3.a	Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
3.b	Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in

	accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all
3.c	Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least-developed countries and small island developing States
3.d	Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

Health, Agenda 2030 and the future of Africa's Development: Challenges and Prospects

There is a consensus that the SDG's are windows of opportunities to fast track the development trajectory of Africa. This is because many challenges that the new goals seek to address have a particular reference to Africa. This is particularly true in the area of health. While the single health goal (SDG3) captures the key aspects of achieving good health, many other development goals, including those that relate to poverty reduction, hunger relief and nutrition, safer cities, lower inequality, sustainable consumption, affordable and clean energy, the management of toxic chemicals, clean water and sanitation, efforts to combat climate change and the conservation of aquatic and terrestrial ecosystem, also have a big effect on health. See Table 2. Health is a contributor to, and a beneficiary of all these goals. Nevertheless, these are just goals. Beyond declaration, Africa needs to translate these goals into actions, to drive its development in the next 15 years. The fundamental question is, what will it take to achieve the SDGs related to health in Africa? This is an arduous task in view of the health challenges facing Africa today.

However, a good starting point will be for African countries to align the health SDGs with long-term national development goals. The health of people is not solely a health sector responsibility; it is also impacted by issues such as transport, agriculture, housing, trade and foreign policy. Thus, to address the multi-sectoral nature of health determinants requires the political will to engage the whole of government in health. African countries should adopt a method that emphasises health in all policies – an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies avoids harmful health impacts in order to improve population health and health equity and address the social

determinants of health. The civil servants and the legislators have a major role to play in this. They need to work closely to ensure speedy implementation.
It is on record that the failure to tackle extreme poverty is at the heart of the poor state of health in Africa. Renewed focus, therefore, is needed on the determinants of poor health with action taken to tackle the root causes of poverty at both the global and local levels. Trade liberalisation has contributed to poverty in Africa. Khor maintains that the neo-liberal economic recipes – financial, trade and investment have had cataclysmic effects on the South.[38] In Africa, the policies of neo-liberalism are closely associated with economic regression, increased debt, the loss of social services, drastic inequality, declining terms of trade and financial crisis. Agricultural subsidy by the developed countries, which is in excess of 350 million dollars per year, provides an apt example of how neo-liberalism contributes to poverty in Africa. Agricultural subsidy has dampened commodity prices in the world market and adversely affects the competitive advantage of African farmers thereby further impoverishing them.[39] Achieving the health SDGs is highly dependent on poverty reduction and would require the introduction of mechanisms to achieve fair and stable prices for African exports, and removing western agricultural subsidies that put African producers at a disadvantage.

Table 2: Sustainable Development Goals Health-Related Targets

1.3	Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable
2.2	By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under five years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons
4.2	By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education
4.a	Build and upgrade education facilities that are child, disability and gender sensitive and provide safe, non-violent, inclusive and effective learning environments for all
5.2	Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation

5.3	Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation
5.6	Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences
6.1	By 2030, achieve universal and equitable access to safe and affordable drinking-water to all
6.2	By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations
6.3	By 2030, improve water quality by reducing pollution, eliminating dumping and minimizing release of hazardous chemicals and materials, halving the proportion of untreated wastewater and substantially increasing recycling and safe reuse globally
10.4	Adopt policies, especially fiscal, wage and social protection policies, and progressively achieve greater equality
11.5	By 2030, significantly reduce the number of deaths and the number of people affected and substantially decrease the direct economic losses relative to global gross domestic product caused by disasters, including water-related disasters, with a focus on protecting the poor and people in vulnerable situations
16.1	Significantly reduce all forms of violence and related death rates everywhere
16.2	End abuse, exploitation, trafficking and all forms of violence against and torture of children
16.6	Develop effective, accountable and transparent institutions at all levels
16.9	By 2030, provide legal identity for all, including birth registration
17.18	By 2020, enhance capacity-building support to developing countries, including for least-developed countries and small island developing States, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts

Besides, urgent action must also be taken to counter the commercial determinants of health.[40] Today in Africa, the big transnational corporations influence health through the sale of harmful and health promoting commodities. The consequences of their activities are enormous in terms of

both non-communicable diseases and communicable diseases. The WHO Director General has noted that "efforts to prevent non-communicable diseases go against the business interest of powerful economic operators"[41]. The rise of non-communicable diseases in Africa is a manifestation of a global economic system that currently prioritises 'wealth creation over health creation'. Hence, adequate steps should be taken globally to counter the power of transnational corporations and the effects of their activities on health.

Moreover, the neo-liberal policies that underpin World Bank/IMF Structural Adjustment Programmes SAPs and later Poverty Reduction Support Papers PRSPs, particularly the focus on reduced government role in the provision of health care should be reconsidered. While we are not averse to private sector participation in health sector, leaving the provision of health care to the market will only thrive in countries with strong institutions with capacity to monitor and regulate provisions as well as address the dangers of an often-predatory corporate health sector. The truth is that this cannot be achieved in most African countries largely due to their weak institutional capacities. In a related vein, the World Trade Organisation TRIPS Agreement that all the products are subject to intellectual property rights unless explicitly exempted and also requires member states to grant 20 years monopoly patent, should also be reviewed. It would be recalled that most African countries before the passage of the WTO TRIPS Agreement, have exempted agriculture, medicines and other essential products and processes from their national patent laws. The implication of the new Agreement is that a majority of the Africa's population is priced out of important and producible new medicines.[42] The inability of AIDS patients to have access to patented drugs due to their high prices provides an apt example.

Another key issue worthy of attention is how to motivate the global pharmaceutical industry to devote more research and development budget to neglected tropical diseases of the poor such as sleeping sickness, elephantiasis, trachoma, onchocerciasis among others. While these diseases are rarely fatal, they cause disability and impose a heavy burden on families and communities. Future African health diplomacy in the next fifteen years should concentrate on mitigating the problem of neglected tropical diseases concentrated among the poor by supplementing the patent regime with a complementary source of incentives and rewards for developing new medicines. The proposal for a Health Impact Fund – a global agency financed mainly by governments – that would give pharmaceutical innovators the option to register any new product is instructive. Moreover, there is need for advancement in the level of local

production of medicines and other health commodities. This is particularly imperative in order to address the challenge of health inequities and build capacity to meet the supply shortages that cannot be sourced reliably and sustainably from outside Africa. The renewed commitment of African leaders to the manufacturing of essential health technologies and generic essential medicines is a welcome development. One major move was the adoption of African Union Commission's (AUC) Business Plan for implementing the Pharmaceutical Manufacturing Plan for Africa (PMPA).[43] At the 2013 Abuja Summit, African leaders called for a strengthening of south-south cooperation, including collaboration with BRICS countries aimed at scaling up investment in Africa's pharmaceutical manufacturing capacity, especially for generic essential medicines. The AUC has also forged strategic partnerships with United Nations Industrial Development Organisation (UNIDO), UNAIDS and the World Health Organisation to better coordinate inter agency efforts to support African governments in their resolve to achieve a reliable and sustainable manufacturing of medicines and other health technologies.

It is true that external assistance for health is needed to supplement public and private sector financing for health in Africa. Nevertheless, African states can only maximise their gains from external assistance for health if they take leadership in coordinating health activities in their countries within the context of a comprehensive national health plan. Current arrangements indicate that there is a disjuncture between the issues that external actors and African recipients prioritise. While attention to priority diseases has initiated much needed increases in external assistance for health, these priorities are not necessarily in line with the recipient country government's overall plan for the health sector. Experience to date in Rwanda lends credence to this view. In Rwanda, for instance, donors earmarked $46 million for HIV/AIDS in 2005, when the country had a 3 percent prevalence rate, and only $18.3 million for malaria, which was the biggest cause of mortality.[44] The Rwandan Ministry of Health has managed to direct donors to align their contributions with national policies through a donor mapping study and a systematic costing of the health sector strategic plan. Each year all donors meet with government to evaluate progress made and plan for future activities. As a result, Rwanda has become the only African country with near universal health coverage. The recent Rwandan example is a right step in the right direction. The Rwandan Ministry of Health has managed to direct donors to align their contributions with national policies through a donor mapping study and a systematic costing of the health sector strategic plan. Each year all donors meet with government to

evaluate progress made and plan for future activities. As a result, Rwanda has become the only African country with near universal health coverage. Immunisation rates at 95 percent are among the highest in sub-Saharan Africa.

However, the provision of external assistance should not detract from African governments' commitment to finance health care for their citizens. This is because a population health is, first and foremost, a national responsibility. African countries owe their citizens a comprehensive package of essential health goods and services under its obligations to respect, protect and fulfil the human rights to health. Future external assistance should abide by John Rawl's 'law of Peoples'.[45] He opined that 'the basis of the duty of assistance is not a liberal principle of distributive justice' but in the axiom that each society with non-ideal conditions be raised to, and assisted towards, conditions that make a well ordered society'. For current and future external assistance for health in Africa to be consistent with the law of peoples, interventions must foster local capacity so that progress is sustainable over the long time.

Indeed, the attainment of universal health coverage UHC by 2030 in Africa is largely dependent on health sector reforms being explicit about reducing inequality in access to health services and ensuring that public health systems mitigate the impact of economic and social inequalities. This implies that equity must be built into the system from the outset to ensure that people living in poverty benefit as much as those who are better off. Experience has shown that prioritizing for-profit private healthcare delivery is extremely unlikely to deliver better health outcomes for poor people thereby frustrating the attainment of UHC by 2030. Private health systems have been shown to be highly regressive, serving the rich far more than the poor. Several studies have also demonstrated higher levels of exclusion of poor people from treatment and care while the wealthy receive the best available medical care. The poor are excluded from most privately funded health insurance schemes. Many poor people are forced to rely on low quality health care administered by unqualified staff and make out of pocket payments for treatments or 'simply do without' and this has had significant access implications particularly in African countries. Notwithstanding their numerous challenges, the publicly financed and delivered health care services offer higher performing, more equitable health systems. For instance, a research conducted in Asia found that no low or middle-income country in the region has achieved universal or near universal access to health care without relying predominantly on tax funded public sector delivery. A case in point is Nepal where significant

improvements in access to health care were achieved after user fees were removed for primary health care services in public services in 2008.[46] Without any shadow of doubt, the universal public services are critical in the fight against inequality. They mitigate the impact of skewed income distribution and redistributive wealth by putting virtual income into the pockets of the poor. Thus, in the face of the growing inequality in African countries, urgent and dedicated action is needed to strengthen public health systems. In addition, there must be a broad strong policy support for a broad primary health care approach including increased access for the poor people.

Poor population health status in Africa is also mirrored by crisis in human resources for health. With 24 percent of the world's disease burden, Africa has only 3 percent of the world's health professionals, with massive shortages of physicians, nurses, technicians, health managers and administrators and planners.[47] In addition to emigrating to better paying employment in the developed world, health professionals are being drawn from rural to urban areas, from the public to the private sector and from lower income to higher income countries within Africa. This has a crippling effect on health. There is need therefore to develop policies that could provide incentive for health workers to remain in their countries.

Conclusion

This chapter has shown that health is critical to the attainment of the SDGs in Africa. We strongly believe that fundamental solutions to Africa's health problems lie with African people themselves. The main duty of the global community is to provide the enabling conditions that will allow Africa to develop and flourish. Central to transformation of the health sector is the development of a more progressive and effective response from African states that would nurture a different set of values and visions from those that dominate now. It is the time to resuscitate those values that inspired many of the struggles for independence across Africa such as equity, social inclusion and human rights. These values are essential today to drive the future of Africa's health development. This implies a political dispensation of good governance and leadership accountability. The crisis of governance that characterises the continent must be seriously combated. Corruption must be tackled head-on through both institutional and legal frameworks. In the final analysis, the solution to the myriad health challenges in Africa lay in what the German pathologist and politician Rudoff Virchow described as 'political

medicine' – education, freedom and prosperity.[48] No doubt, improvement in medicine is welcome as it would eventually prolong human life, but improvement of social conditions could achieve this result rapidly and more successfully. Without democracy (popular participation) and reduced social inequality, efforts to resolve Africa's health crisis would be meaningless.

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