AUDA-NEPAD
AFRICAN UNION DEVELOPMENT AGENCY

Regional Health Financing Hubs Design and Operational Manual

2022

ACRONYMS AND ABBREVIATIONS

ALM	African Leadership Meeting
AfCFTA	African Continental Free Trade Area
ASR	Age Standardised Rate
AU	African Union
AUC	African Union Commission
AUDA-NEPAD	African Union Development Agency-NEPAD
AUDF	AUDA-NEPAD Development Fund
AWA	AIDS Watch Africa
COMESA	Common Market for Eastern and Southern Africa
COVID-19	Corona Virus Disease-2019
CSO	Civil Society Organization
EAC	East African Community
ECOWAS	Economic Community of West African States
GDP	Gross Domestic Product
GHE	Global Health Expenditure
GHO	Global health Observatory
HALE	Health Life Expectancy
HSGOC	Heads of State and Government Orientation Committee
ICT	Information & Communication Technology
IHME	Institute of Health Metrics and Evaluation
LE	Life Expectancy
LIC	Lower Income Countries
LMIC	Lower Middle Income Countries
M&E	Monitoring and Evaluation
MOF	Ministry of Finance
MOH	Ministry of Health
MS	Member States
NCDs	Non-communicable Diseases
NGO	Non-Governmental Organisation
PMPA	Pharmaceutical Manufacturing Plan for Africa Business Plan
PPP	Public Private Partnership
PSE	Private Sector Engagement
RECs	Regional Economic Communities
RHFH	Regional Health Financing Hub
RMNCH	Reproductive, Maternal, New-born & Child Health
SADC	Southern African Development Community
SDG	Sustainable Development Goal
TOR	Terms of Reference
TWG	Technical Working Group
UHC	Universal Health Coverage
WHO	World Health Organization
WHO-AFRO	World Health Organization Africa Regional Office

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PURPOSE & STRUCTURE

This document serves the purpose of operationalising the ALM-Investing in Health decisions in the Regional Health Financing Hubs (RHFH). It provides background information and an evidence-informed, step-by-step approach to the conceptualization, design, and operationalization of the RHFH. The methodology utilised in this document is grounded on the ALM-Investing in Health Declaration (Assembly/AU/Decl.4(XXXII)), which was adopted in February 2019.

AUDA-NEPAD leads the conceptualization, design and implementation of the RHFH based on ***Decision Assembly/AU/Dec.810(XXXIV) of 6–7 February 2021*** *on domestic health financing (ALM-Investing in health), which requests the AU Commission to speed up implementation of Item 6(v) of the February 2019 ALM-Investing in Health Declaration, regarding working with partners to create regional platforms to support Member States to increase domestic health financing, by assigning responsibility for coordinating this mandate to AUDA-NEPAD.*

This document is structured into eight main sections as follows:

BACKGROUND: Elaborates the 'WHAT' part of the ALM-Investing in Health declaration and Regional Health Financing Hubs, including key milestones. It also provides the progress made so far since the adoption of the declaration in February 2019.

INTRODUCTION: This section provides evidence on progress, challenges, and needs on domestic health financing to achieve quality assured Universal Health Coverage (UHC) in the continent.

APPROACH: Provides key steps followed in evidence generation, conceptualization, design, and operationalization of the RHFH.

VISION, MISSION, GUIDING PRINCIPLES, GOAL AND OBJECTIVES: This section sets out the short and long-term goals of the RHFH, including the principles to be followed during the design and implementation.

FUNCTIONS: Details the core operational elements required for achieving the objectives of the RHFH.

OPERATIONALIZATION OF THE RHFH: Elaborates the proposed expertise requirements, location, and resource requirements of RHFHs, including the roles and responsibilities of Member States, RECs, AUDA-NEPAD, and AUC in the operationalization process.

GOVERNANCE: Entails the governance framework of RHFH, institutionalization of the ALM-Investing in Health agenda, and Stakeholder Engagement strategies.

MONITORING AND EVALUATION: Describes how the implementation of RHFH will be monitored and evaluated using the results framework.

1. BACKGROUND

The Africa Leadership Meeting (ALM)-Investing in Health, held in February 2019, adopted a declaration after reviewing the progress, challenges, and next steps needed for increased domestic financing to strengthen health systems and achieve quality assured Universal Health Coverage (UHC) on the continent. The declaration is founded on the objectives of (i) Agenda 2063[1] that fosters 'self-reliance and Africa financing its own development' and a shift towards African-led initiatives for funding disease responses, and the (ii) Africa Health Strategy 2016-2030[2] that puts forward 'sustainable and predictable health financing as essential to building viable health systems' as a critical ingredient for achieving UHC and building healthy human capital. The declaration reaffirms enhancing the political commitments to invest in health, including the Abuja Declaration, 2001[3], whereby Heads of State and Government committed to spend at least 15 % of budgets on Health, and Abuja +12 Declaration, 2013[4] that reinvigorates the focus on innovative domestic financing mechanisms.

The key milestones of the ALM-Investing in Health declaration include, among others, political will and commitment; establishment of Regional Health Financing Hubs (RHFH) in each of the African Union regions; strategic partnership and coordination with the private sector and development partners for sustainable and diversified health financing; optimised public financial management system to increase domestic health resource; improved national health financing system, and effective, efficient and equitable health budget allocation and spending.

Table 1. ALM-Investing in Health Declaration Milestones

MILESTONES of ALM-Investing in Health DECLARATION	
Establishment of Regional Health Financing Hubs in each of Africa's regions	RHFHs are the central point to support MS to realise the ALM-Investing in Health agenda.
Political will and commitment	Government should play a stewardship role to keep health financing high on the political agenda and ensure country led and a context-based approach to strengthening the health system to achieve and sustain quality assured UHC. Biennial meeting of Ministers of Health and Finance is essential to review the work of the RHFH and monitor progress.
Strategic partnership with private sector and development partners for sustainable and diversified health financing	Develop health investment strategies that foster harmonization and alignment of development partners and private sector investment to continental, regional and country health priorities
Optimum public financial management system to increase resource for the health sector	Put in place systems to maximise health resource mobilization, including through improved revenue generation and progressive taxation.
Improved national health financing system	Reduce and ultimately eliminate catastrophic health spending using context-based innovative risk-pooling models, such as national health insurance, community-based insurance, subsidies, etc.
Effective health budget allocation	This entails alignment of budget resources and health priorities; and maximizing UHC performance with the money available by

	ensuring equity in service access and utilization across all population groups, with more emphasis on the most vulnerable ones.
Efficient health budget spending	Member States should strive to ensure that the health sector delivers results in an economic and timely way and narrow the gap between health budget allocation and expenditure.

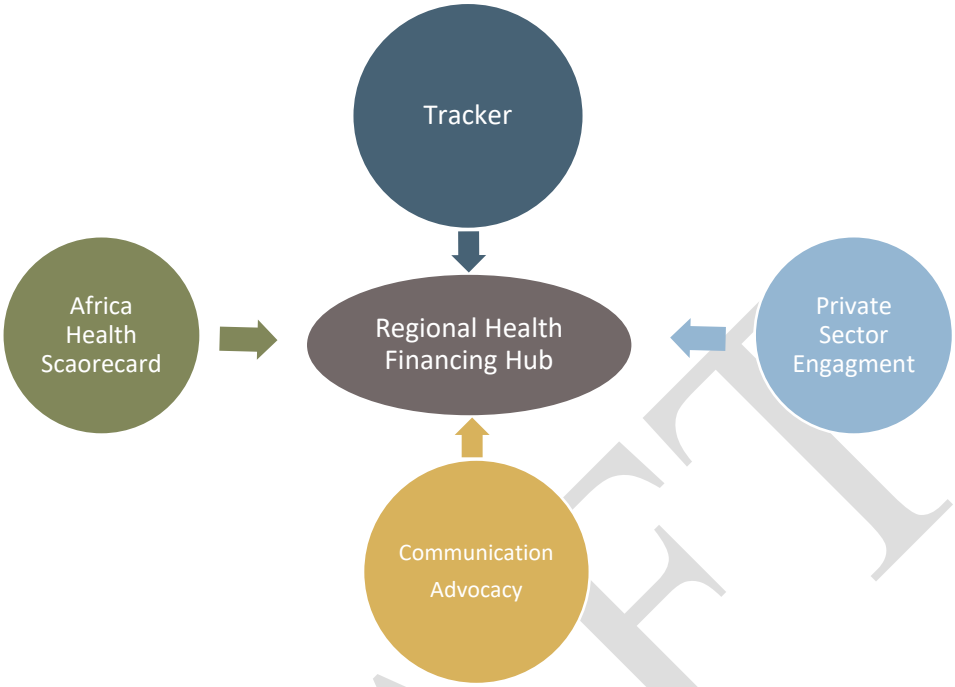
Better coordination is needed between multilateral, bilateral and private sector partners to align efforts in the continent and create regional platforms (Hubs) in each of Africa's five geographic regions to support the Member States through relevant ministries, including finance and health, to catalyse, capture and scale innovative financing mechanisms. In view of this, the 34th AU Assembly Heads of State and Government made the following decision:

Decision Assembly/AU/Dec.810(XXXIV) of 6–7 February 2021 *on domestic health financing (ALM-Investing in health), which requests Commission to speed up implementation of Item 6(v) of the February 2019 ALM-Investing in Health Declaration, regarding working with partners to create regional platforms to support Member States to increase domestic health financing, by assigning responsibility for coordinating this mandate to AUDA-NEPAD.*

The mandate granted to AUDA-NEPAD based on the ***Decision Ext/Assembly/AU/Dec.1-4(XI) of 17–18 November 2018****: i) to coordinate and execute priority regional and continental projects to promote regional integration towards the accelerated realisation of Agenda 2063; ii) to strengthen the capacity of African Union Member States and regional bodies; and iii) to advance knowledge-based advisory support, undertake the full range of resource mobilisation, and serve as the continent's technical interface with all Africa's development stakeholders and development partners,* is in alignment and an added value to this important task to lead the conceptualization, design and operationalization of the RHFH

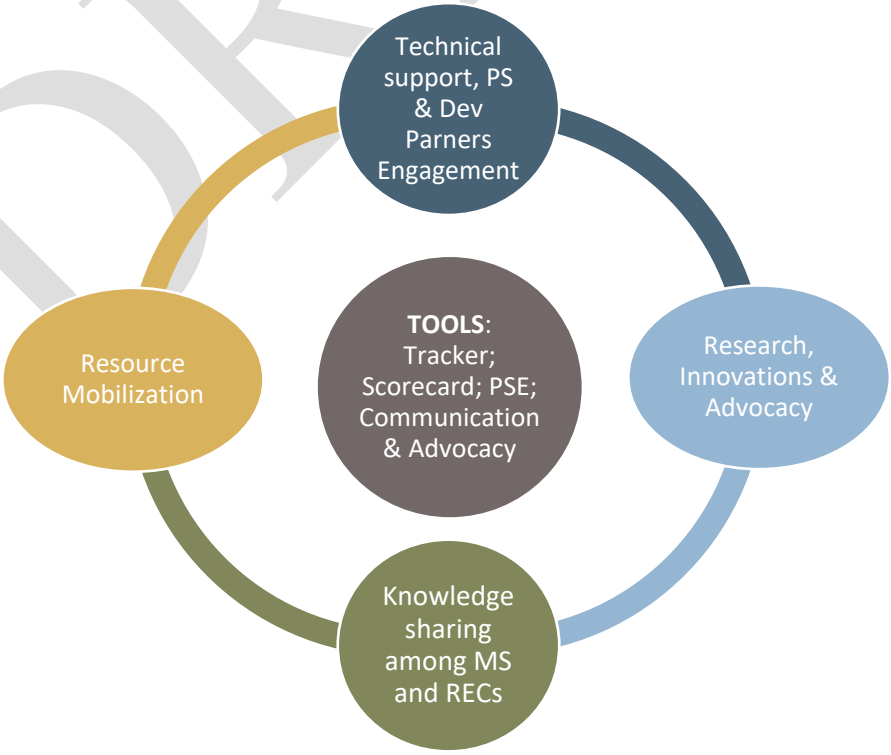
The RHFHs are the effective centre of the ALM's-Investing in Health initiatives. It is through the RHFH that countries will be supported to drive increased coherence of investment through improved alignment of multilateral, bilateral and private sector efforts to the priorities of the continent, and to track progress and diagnose key health financing challenges. The RHFH use diagnostic and strategic tools, such as Africa Health Scorecard, Health Financing Tracker, Private Sector Engagement (PSE), and Communication and Advocacy to optimise innovative financing mechanisms, public financial management systems, health budget allocation, and spending.

Figure 1. ALM-Investing in Health initiative



The RHFH are an ideal platform for: technical support to Member States and engaging the private sector and development partners; advocacy and an opportunity to showcase and implement products of research and innovation; knowledge sharing among Member States and RECs; and resource mobilization.

Figure 2. RHFH Functional Framework



According to the ALM-Investing in Health Declaration, the Africa Scorecard on Domestic Financing for Health is being digitised to allow for the expanded dissemination of performance review data. To complement the Africa Scorecard, a health financing Tracker is under development to guide health financing reforms and track country progress in implementing these enablers.

In May 2020, the ALM-Investing in Health Technical Working Group (TWG), responsible for coordination and oversight as well as four Subcommittees were established. The Subcommittees, such as a Hubs Subcommittee, a Tracker Subcommittee, an Advocacy and Communications Subcommittee, and a Private Sector Engagement Subcommittee were drawn from partners, implementers, RECs and key African agencies to drive these various components of Africa's domestic health financing agenda as set out in the ALM-Investing in Health Declaration. The absence of Member states in Subcommittees and their limited engagement in work done so far requires serious consideration in carving the way forward.

Finally, it is essential to note that ALM-Investing in Health Declaration with its call to work with partners to establish RHFH becomes timelier and more relevant than ever before to address the challenges of domestic health financing.

2. SITUATIONAL ANALYSIS

Africa has made tremendous progress in improving health outcomes in the past two decades. However, it continues to face an increased disease burden and growing demand for quality health care services amidst limited economic resources, low economic growth, and high population growth rates. In order to respond to this crisis, many countries in Africa, with support of development partners, undertook health sector reforms with regard to health financing and health services delivery and organization. However, despite this huge effort, to date, serious challenges remain in health financing and health services delivery such that the achievement of Universal Health Coverage (UHC) appear to be elusive.

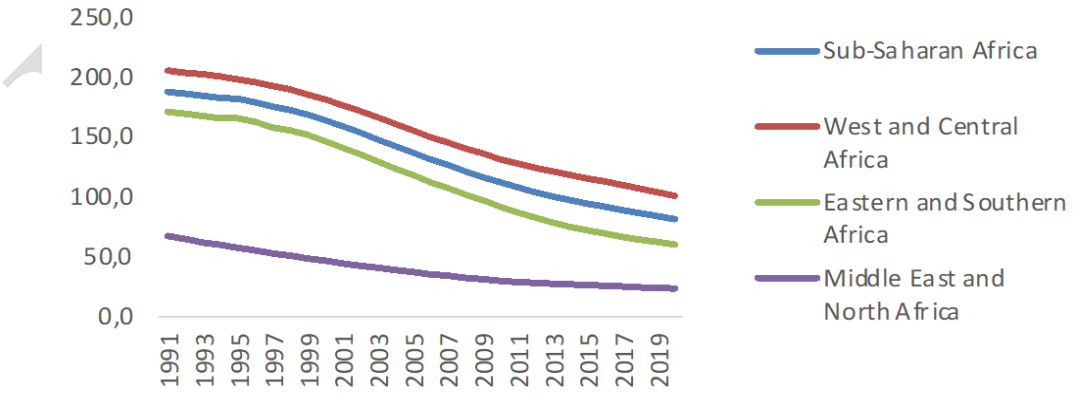
Below is the summary of the progress made and major challenges facing the health sector that require concerted action by all stakeholders to enhance domestic financing to strengthen health systems and achieve UHC.

2.1 Africa's progress in improving health outcomes has been remarkable; but the disease burden remains high

The average life expectancy (LE) and healthy life expectancy (HALE) in Africa have shown the largest gains in the world over the past two decades across all income groups, that reached on average 64.5 and 56.0 years in 2019, respectively[5].

These trends in LE and HALE indicate the progress being made against many diseases, underpinned by a dramatic decline in communicable diseases and injuries and suggests an improving trend in overall health and well-being in the continent. The marked gains in LE and HALE at birth in Africa, in lower income countries (LICs) and lower middle income countries (LMICs) in particular, predominantly reflect the significant progress made in the past 20 years in reducing mortality among children under 5 years of age in these settings(**Figure 3**)[6] .

Figure 3. Estimates of Under-five mortality rates (deaths per 1,000 live births)



Source: UNIGME 2021, taken from Hubs discussion slide deck

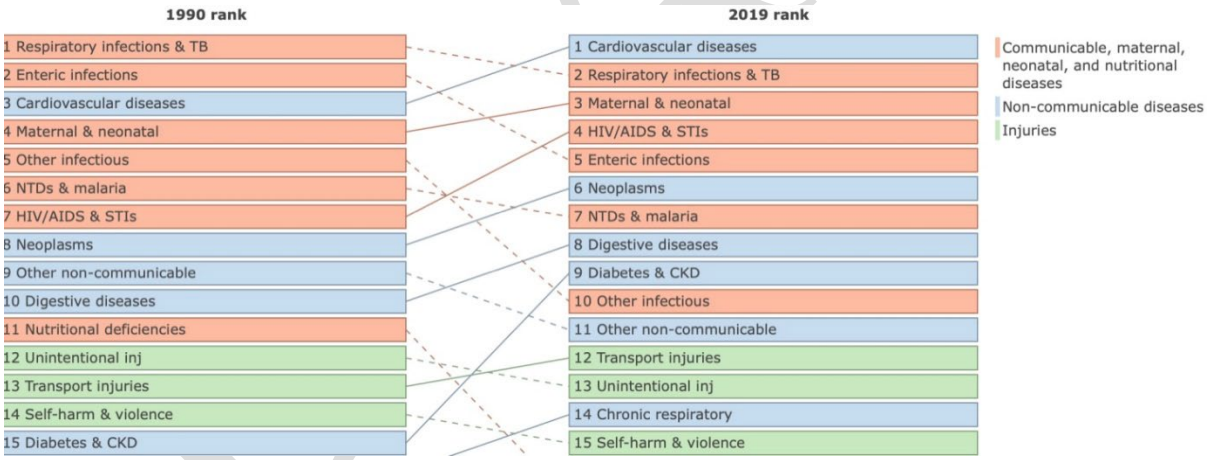
However, there does not appear to be a significant variation in the improvement of healthy life based on a country's level of spending on health. While the overall healthy life is higher in countries spending most, the rate of change between 2010 and 2015 is the same in countries spending least (2.9 years versus 3.1 years respectively)[7]. This indicates that more money for health is not the only solution; a more comprehensive

approach that addresses other critical factors is important, such as alignment of budget resources and health priorities; and efficiency and equity in investment to maximize UHC performance with the money available.

The relative gains in life expectancy and reductions in morbidity/mortality is an encouraging achievement that should be protected. However, it is important to note that the continent is coming from a very low base, with current levels still lower than the rest of the world. In addition, the high burden of NCDs, including the risk factors associated with it prevents well-being from being assured, and this burden will continue to rise to a level where the improvements in healthy life become eroded by losses in wellbeing.

In 2019, cardiovascular diseases were the main cause of mortality in the African continent: more people died from cardiovascular diseases than TB and respiratory infections or maternal and neonatal conditions (**Figure 4**). Four of the top ten causes of mortality are now due to NCDs, such as cardiovascular diseases, cancer, digestive diseases, diabetes, and chronic kidney diseases. The major risk factors that drive the burden of NCDs, such as alcohol abuse, insufficient physical activities, unhealthy diets and substance abuse are high in the continent[8]. This demonstrates the double burden of both communicable and non-communicable diseases coexistence in Africa that calls for increased domestic and external investment targeting both, not prioritising one over the other.

Figure 4. Trends in the top 15 causes of mortality (death rate per 100,000 population) in Africa, 1990 and 2019



Source: IHME database

2.2 The health system is weak and performs poorly

The average index of **Health Systems Outcomes** (measured by six dimensions of health outcomes, such as **service availability, coverage of SDG3 and non-SDG3 interventions, financial risk protection, health security, and service responsiveness**) in Africa is very low. In the WHO Africa region (where data were available), the average index of all dimensions is 0.48 (48%), with variation between 0.31to 0.7 between the lowest and highest performing countries[8]. With some variation between countries, all dimensions of service outcomes underperform, with the best (health security & SDG3 coverage) only able to provide 57% of what is feasible. The worst performing dimensions relative to the others are service availability (36% of what is feasible) and financial risk protection (34% of what is feasible). The adolescent and

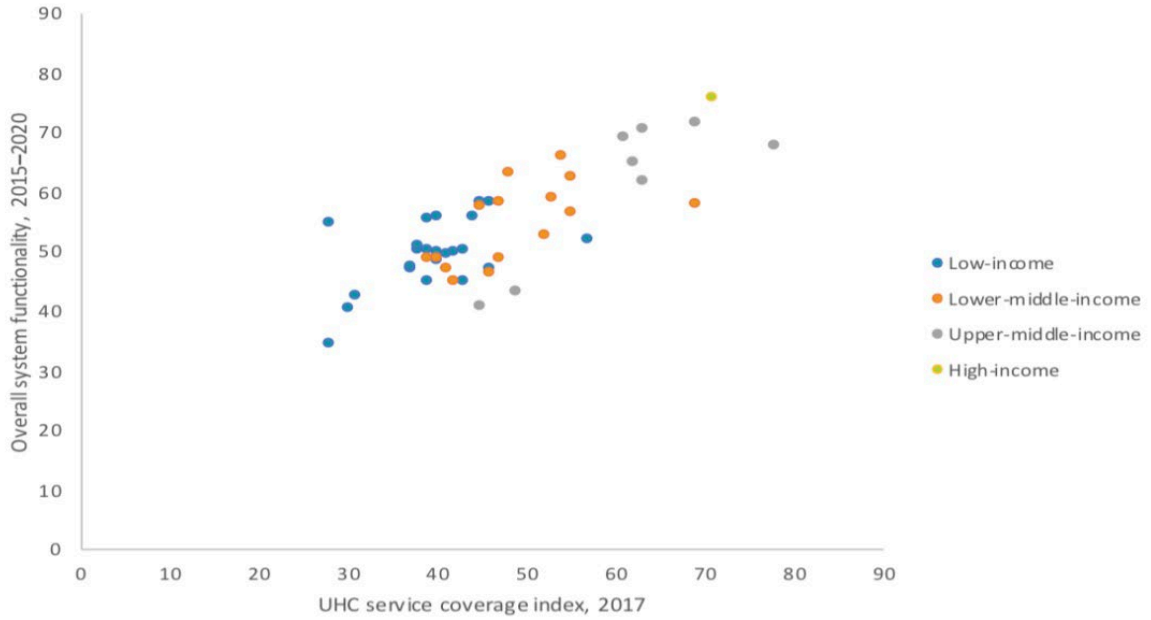
the elderly age cohorts have the lowest range of services available, and the service availability is lowest for NCDs. Improving health outcomes in member states will therefore require relatively more effort and investment in improving these two dimensions.

The 57% SDG3 coverage (it means utilization of essential preventive, promotive, curative, and palliative services) is not homogenous across countries and across the different packages of essential services. The service coverage in countries ranges from 36% to 79%, with the utilization generally increasing with the country's economic ranking. Communicable diseases have the highest rate of utilization (76%) compared to the other essential health services. NCDs have very low utilization contrary to their high burden in the continent. This calls for all Member States to review their strategies and investment priorities.

The average **Health Systems Performance Index** (which is measured by four dimensions of health system performance/output indicators, such as **Access, Quality, Demand for services, and Resilience)** in the WHO Africa region is 0.49, with countries' performance scores ranging from 0.26 and 0.70. This shows that the health systems in the region are only performing at half the potential of their possible levels of functionality(8). Among the four dimensions of health system performance indicators, the system resilience (provision of essential services uninterrupted by shocks to the health system, due to epidemics, disasters, etc.) and access to essential services (making available the hardware needed to deliver services as close to the population as is feasible), are the worst performing (0.32), that calls for more effort and investment in these two dimensions by the Member States.

The average of the four combined indices of **Access, Quality, Demand and Resilience** shows a high correlation with the current status of health outcomes (**Figure 5**). Overall, health system functionality and UHC service coverage index show a positive correlation with gains in economic status. Member States should put concerted effort and resource in tracking progress as well as enhancing health systems performance (service access, quality, demand and system resilience) for specific prioritization and action and make meaningful gains in health outcomes. More investment is needed by Member States on data collection and in fixing data collection inefficiencies and be able to generate essential information to better understand where efforts need to be concentrated, as relative health system functionality varies by country, allowing for specific prioritization and actions.

Figure 5. Correlation of health system functionality index with UHC service coverage index in countries of the WHO African Region, by income group



Source: World Health Statistics, 2021

Investment across the six interlinked health system input/process dimensions, such as **health workforce, health infrastructure, medical products, service delivery, health governance, and health information,** is critical to move towards UHC. According to WHO AFRO recent report[8], countries in the Africa region are spending an average of 60% of their health expenditures on health workforce, health infrastructure, and medical products, with the highest spending being on medical products (39%), followed by the health workforce (14%) and infrastructure (7%). However, further data analysis shows a country with a sound performing health system puts more emphasis on the health workforce (40% versus 14%) and infrastructure (33% versus 7%), which includes equipment, transport and ICT, compared to countries with less performing systems. Health workforce, health infrastructure and medical products are the leading causes of health system inefficiencies, hence require special attention in health financing reforms. This demonstrates the importance of information generation and analysis to inform health investment prioritization in health systems strengthening.

Research and development (R&D) to inform domestic health investment and to strengthen health systems is at an infancy stage in the continent. R&D is critical to creating new or improved technology in health, including medical products that can provide a competitive advantage at the national, regional and continental level. While the rewards can be very high, the process of technological innovation (of which R&D is the first phase) is complex and risky. Hence the RHFH's support to R&D efforts must be carefully organized, managed, monitored and evaluated.

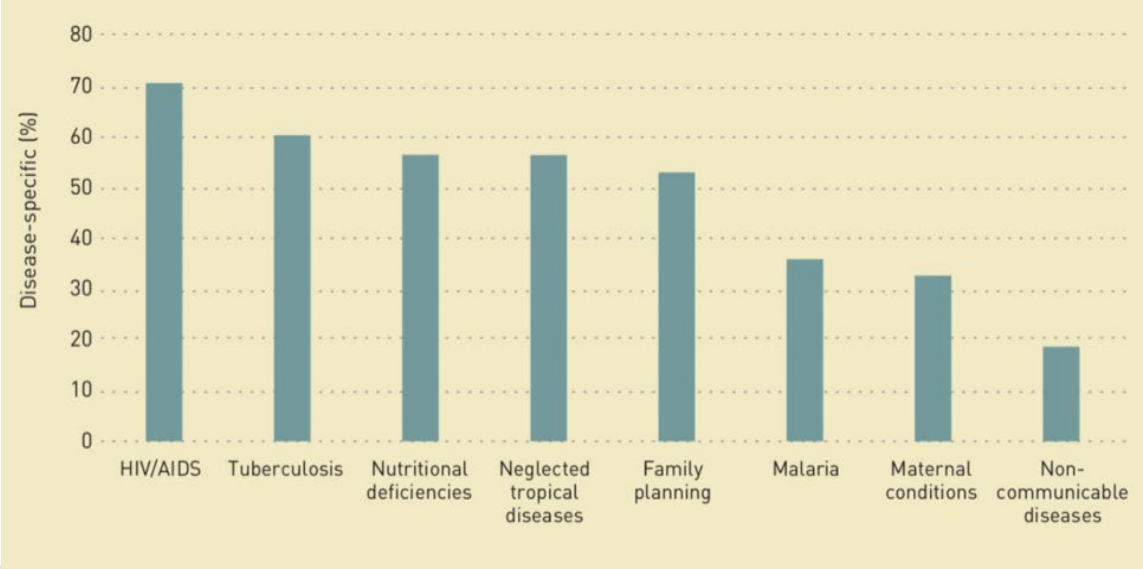
2.3 Limited alignment of health priorities and budget allocation/spending

Analysis of spending patterns by disease or programme across 17 low-income and 23 middle-income countries has found (9) that NCDs have the lowest spending relative to other diseases in low and middle-income countries. External aid for health mainly funds infectious and parasitic disease programmes, while domestic public funds

focused more on NCDs. Of total spending on NCDs, 37% came from domestic public funds in low-income countries, and 15% was attributed to aid. In middle-income countries, 59% came from domestic public funds, and 2% was attributed to external aid. In low-income countries, infectious diseases accounted for half of the overall health spending.

This is a clear indication that despite the rising NCDs and associated risk factors in low- and middle-income countries, the focus of health investments, external aid in particular, rests on communicable diseases. Considering the double burden of NCDs and communicable diseases, countries should proportionally invest in both. Clearly, focusing on NCDs does not have to mean taking resources away from effective communicable and maternal and child health programmes. A major reform of health services is required in most African countries to enable UHC and to integrate current vertical programmes into a primary care model that would provide cost-effective health care for all common health conditions.

Figure 6. Disease-specific spending as a share of spending on selected diseases or programmes in 12 low & middle income countries



Source: WHO, Global spending on health, 2020

'Donor funding has plateaued since the financial crisis in 2008 and compounding the situation is that many African countries are graduating to the Middle-Income Status which implies a further decline in donor funding'[1]. This calls for increased domestic resource mobilization. However, transitioning from external assistance to sustainable domestic public financing needs to be addressed strategically to sustain coverage of previously donor-funded health services, including integrating different groups of staff and vertical services created into the existing general health service delivery system.

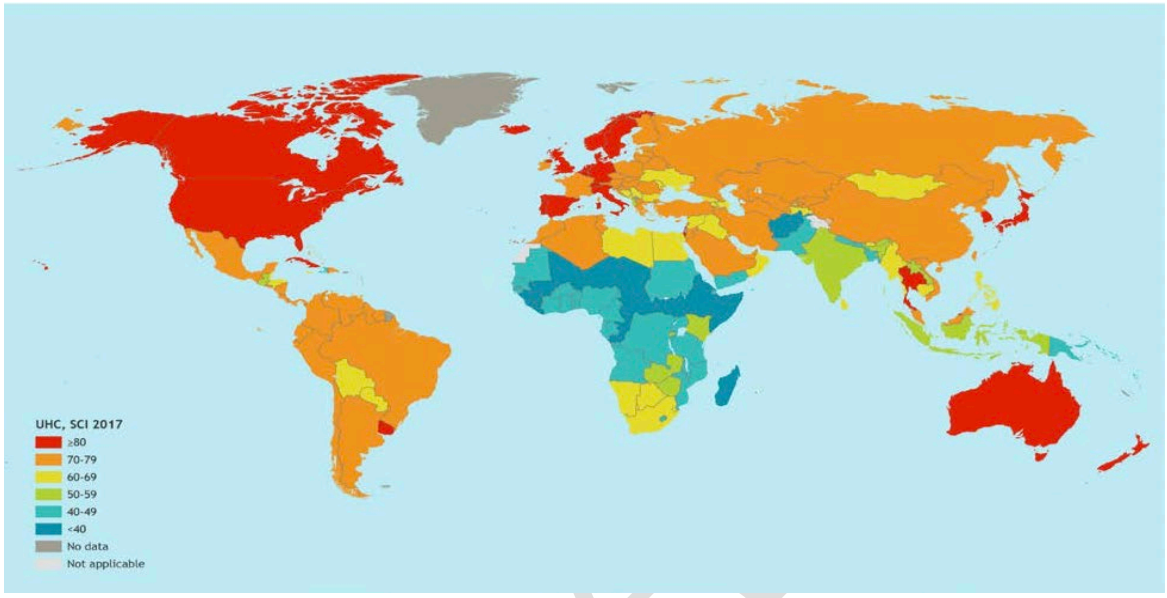
2.4 Limited financial protection to boost equity in service utilisation

Universal health coverage means that all people have access to essential health promotion, prevention, treatment, and palliative care they need, when and where they need them, without financial hardship.

[1] RHFH discussion slide deck

Currently, at least half of the people in the world do not receive the health services they need. About 100 million people are pushed into extreme poverty each year because of out-of-pocket spending on health[5]. The UHC index of essential service coverage varies between Member States, with an average value of 48% (SD 12.22)[2] (**Figure 7**).

Figure 7. Global UHC essential service coverage index, 2017



Source: Primary health care on the road to universal health coverage: 2019 report[10]

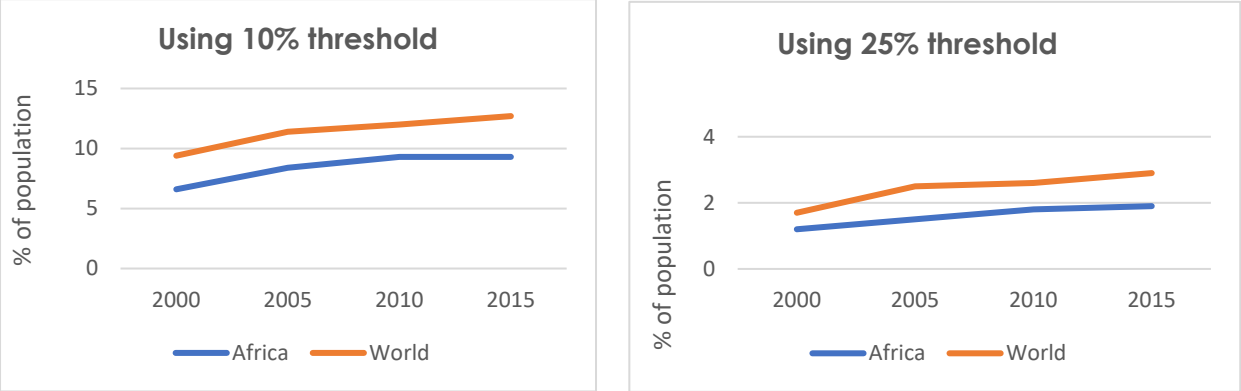
Financial protection is achieved when direct payments made to obtain health services do not expose people to financial hardship and do not threaten living standards. The key to protecting people is to ensure prepayment and pooling of resources for health, rather than relying on people paying for health services out-of-pocket at the time of use.

WHO and the World Bank have been tracking progress in financial protection through household survey data using indicators of **catastrophic health spending** (defined as out-of-pocket health spending exceeding 10% or 25% of total household consumption or income) and indicators of **impoverishing health spending** (these are indicators that capture the impact of out-of-pocket health spending on poverty at the $1.90 a day, at $3.20 a day absolute poverty lines, and at the relative poverty line of 60% of median per capita daily consumption at all income levels).

In 2015, about 110 million people in Africa (9.3% of Africa's population) incurred catastrophic health spending as they dedicated at least 10% of their household budgets to pay for health care out of their own pockets (**Figure 8**). Catastrophic spending shows increasing trend in the continent and globally since 2000 on both thresholds.

[2] Analyzed from 2017 data of GHO database

Figure 8. Trends in catastrophic health spending



Source: Global database on financial protection assembled by WHO and the World Bank, 2019 update

About 16 million people in Africa (1.3% of the population) are still being pushed into extreme poverty (living on $ 1.90 or less a day) because they paid for health care out-of-pocket (**Table 2**).

Indicators of financial protection point to mixed improvements between 2000 and 2015 (**Table 2**). The number of people impoverished by out-of-pocket health spending at the $1.90 and $3.20 per person per day thresholds has decreased at different rates. At the same time, there have been a growing number of people incurring catastrophic health spending and an increase in impoverishment due to out-of-pocket health spending using a relative poverty line.

Table 2. Trends in impoverishment due to out-of-pocket health spending (at the $1.90 a day and $3.20 a day absolute poverty lines and at the relative poverty line of 60% of median per capita daily consumption)

$1.90 a day poverty line	**% of population**			
	2000	**2005**	**2010**	**2015**
World	2.0	1.8	1.5	1.2
Africa	2.8	1.2	1.4	1.3
$3.2 a day poverty line	**% of population**			
	2000	**2005**	**2010**	**2015**
World	1.5	1.8	1.7	1.4
Africa	1.7	1.3	1.5	1.5
Relative poverty line (60% median per capita daily consumption)	**% of population**			
	2000	**2005**	**2010**	**2015**
World	1.8	1.9	2.2	2.5
Africa	1.2	1.5	1.7	1.8

Source: GHO database

Evidence from the analysis of key models of health financing shows[11] that policymakers should pay attention to:

(a) As countries become richer, people may face greater financial hardship due to increased exposure to out-of-pocket payments. This may pose a policy challenge to ensure that additional resources for health care are channelled through compulsory pooled prepayment mechanisms.

(b) Out-of-pocket spending on medicines is a leading cause of catastrophic and impoverishing health spending.

(c) Greater reliance on public spending on health (defined as 'the share of total health spending channelled through social security funds and other

government agencies') tends to be negatively correlated with the incidence of catastrophic and impoverishing health spending.

(d) Health spending channelled through private voluntary insurance has no significant effect on financial protection outcomes, especially for marginalised and poor populations.

(e) Increases in public spending on health or reductions in out-of-pocket spending are not enough to improve financial protection in all contexts. The way in which coverage is designed, implemented and governed plays a key role in determining financial hardship, not just patterns of health spending.

These are important lessons for Member States in Africa to critically consider in the design, implementation and governance of financial reforms. Member States should push the agenda for greater government spending and ensuring social security for vulnerable populations. Some African countries have introduced social health insurance schemes as a way to ensure access to all income groups, especially the poor. These countries have either national or community-based insurance schemes with the intent of providing health insurance for all citizens[12]. However, limited information is available on the effectiveness of their financing strategies[13].

2.5 Investments in health are not growing fast enough

The centrality of public financing is well recognised in hastening progress towards UHC, for low- and middle-income countries (LMICs) in particular, as discussed above. Government spending on health has grown, but primarily due to economic growth. Based on the 2017 health financing data from Africa Scorecard on Domestic Financing for Health (the latest data currently available), few Governments in Africa have increased the priority they assign to health care in their budget (**Table 3**).

Table 3. Performance against the three benchmarks of the Africa Scorecard on Domestic Health Financing

Government spending on health	Target	Median (Range), 2017	# (%) of the 51 AU MS meeting target	MS that met target
Per capita (US$)	86.30	17 (2-573)	10 (19.6%)	Algeria, Botswana, Cabo Verde Eswatini, Gabon, Mauritius, Namibia, South Africa, Seychelles & Tunisia
Per capita (US$ PPP)[3]	-	143(37-1,441)	-	-
As a % of GDP	5%	1.7%(0.5%-5.6%)	3 (5.9%)	Eswatini, Lesotho, Namibia
As a % of the government budget	15%	6.5%(2.6%-17.8%)	2 (3.6%)	Eswatini & Madagascar

Source: GHE database and Africa Scorecard online dashboard, accessed on July 27, 2021

Progress in government spending on health depends on strengthened revenue collection efficiency, effectiveness and priority given to health. Tax capacity must be strengthened to allow expanded space for financing health and social sectors. As national income and domestic revenues increase, the allocation of public,

[3] Global Health Expenditure Database

compulsory funds to health should be better prioritised within existing multi-year and annual fiscal frameworks.

A large proportion of health spending in Sub-Saharan Africa remains out of pocket, almost 40% of total health expenditure. However, since 2000 it has shown a decline in trend as a share of total health expenditure, and this needs to be protected. Health expenditure per person grew significantly in Africa in recent years but remains low. According to the latest Africa Scorecard data, 29 Member States increased per capita spending on health between 2015-2017. However, in half of the 51 countries, where data are available, the per capita spending in 2017 was 17 US$ compared to the continental target of US$86.30.

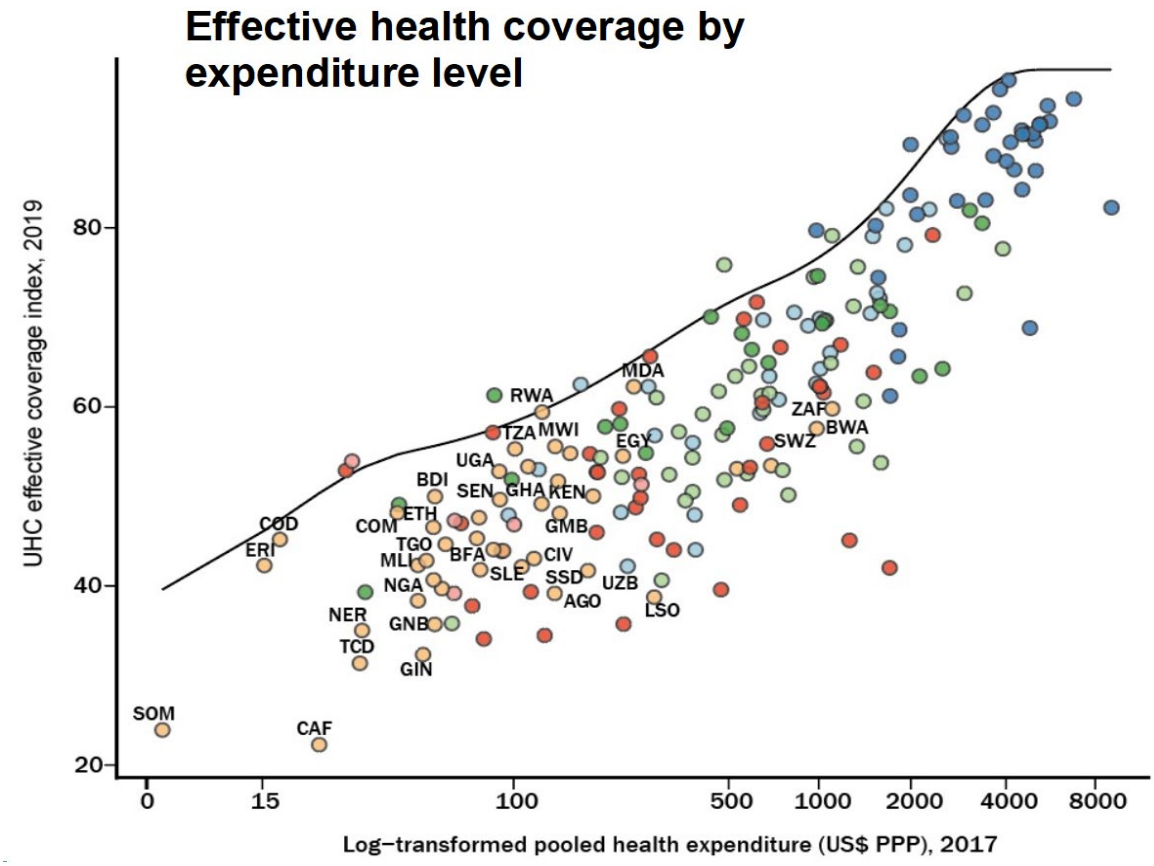
2.6 Health System inefficiencies

Evidence shows in general, UHC's effective coverage[4] performance ('on the basis of pooled health spending per capita, representing UHC effective coverage index levels achieved in 2019 relative to country-level government health spending, prepaid private expenditures, and development assistance for health') was positively correlated with pooled per capita health spending (r=0·79)[14]. However, at each level of pooled expenditures per capita, countries achieve very different levels of effective health coverage as a result of inefficiencies in the system and a lack of economic evidence as the basis for decision making (**Figure 9**). Health workforce, health infrastructure and medical products are attributed as the leading causes of health system inefficiencies. For example, a study[15] done in SADC Member States demonstrated that 'public procurement prices for tracer drugs vary significantly across countries' due to inefficiencies in procurement systems. For most products, one country is paying five times as much as another for the same products. This shows how increased health spending is necessary but insufficient on its own to improve UHC effective coverage.

Common sources of inefficiency include[5], but are not limited to: Ghost workers, absenteeism, counterfeit medicines, under-use of generics, wrong hospital size, inappropriate length of stay, corruption and fraud, excessive procedures, medical error, poor quality care, wrong staff mix. Addressing public financial management shortcomings and exploring efficiency models of service delivery is a priority if the effectiveness of public spending on health and overall sector results are to improve. The failure to fully execute budgets constitutes a significant fiscal loss for the sector, with unused budgetary space ranging from US$10 to 100 million across African countries(16).

[4] Effective coverage was based on intervention coverage or access to quality care approximated by outcome-based measures such as mortality-to-incidence/prevalence ratios.
[5] Hubs discussion slide deck

Figure 9. UHC effective coverage index relative to log-transformed pooled health spending per capita

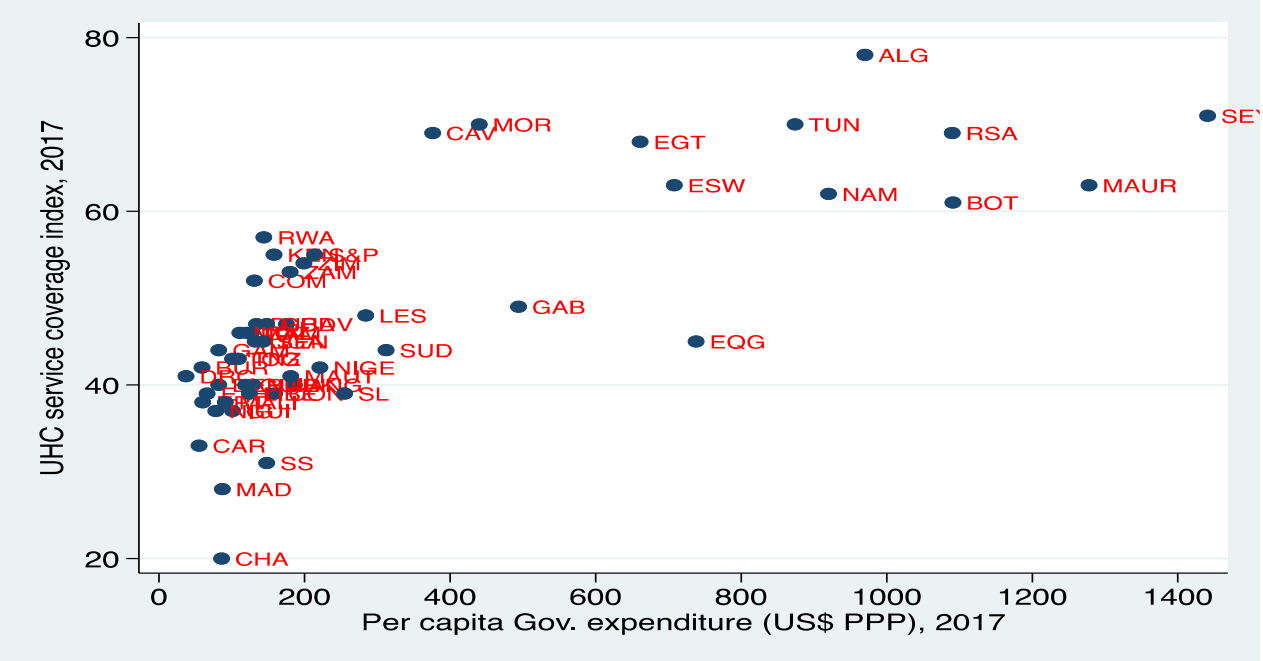


N.B. Colour markings: Orange dot indicates countries in SSA; Dark green represents North Africa & Middle East; Other colours represent countries in Europe & Central Asia, Latin America & Caribbean, South Asia, and Southeast Asia & Oceania, respectively.
Source: GBD 2019 Health Coverage Collaborators, taken from Hubs discussion slide deck

The use of government/public funds is critical to financial protection, particularly to the poor and marginalised and achieving UHC. Analysis of the 2017 data obtained from Global Health Expenditure (GHE) and Global Health Observatory (GHO) Databases showed that the UHC coverage index was also positively correlated with Government per capita health spending (r=0.75, p<0.001) (**Figure 10**). The analysis further estimated that the difference in health spending per capita for countries in Africa with similar health outcomes could be as high as 2.5 times. This indicates the potential system inefficiencies if other sources of funding (such as prepaid private expenditures, development assistance) are not optimised, and other health outcomes determinants are not seriously addressed. Improving system efficiencies and dealing with other determinants of health outcomes is an area where countries can start taking immediate steps to ensure the spending of available funds is optimised.

Figure 10. UHC effective coverage index relative to Government health spending per capita

(N=51 MS*)



* Data is not available for Libya, Saharawi Republic, and Somalia

2.7 Weak coordination, alignment and engagement of donors and private sector

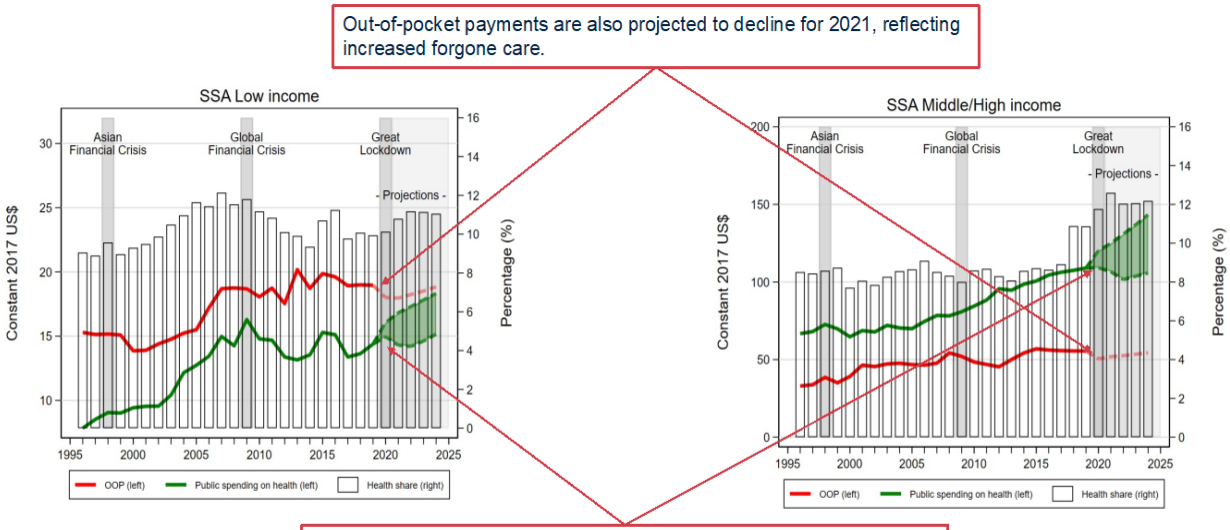
Health systems are seriously characterised by the proliferation of uncoordinated donor-funded projects and private sector efforts. Evidence is mounting that donors may weaken rather than improve health systems without effective coordination arrangements, undermining attempts to reform those systems[17][18]. Improved donors coordination is essential to avoid duplication and verticalization of health service delivery, and to facilitate alignment with government priorities. Private sector engagement in health can take various forms; however, understanding of these models is limited(19). Successful engagement of the private sector requires recognition of their diversity and tailoring of strategies to different types of private sector. It is vital that the evidence base guiding policymakers in their decisions regarding which public-private partnership (PPP) models to utilize in and how best to implement them to enhance their role in health investment, is strengthened.

2.8 Impact of COVID-19

COVID-19 has accentuated existing health systems' fragilities and exacerbated risks to mobilize, sustain and efficiently invest domestic resources for the health sector. The World Bank projects a decline in public health expenditure and Out-of-Pocket

payments through 2021[6]. The decline in Out-of-pocket spending reflects increased forgone care due to financial hardships brought by COVID-19.

Figure 11. Projection of public health expenditure and Out-of-Pocket payments 2021



Source: World Bank Presentation (AU MoHF meeting Nov. 2020)

Addressing and containing COVID-19 is key for any economic recovery, however, significant uncertainty remains around GDP estimates and the impact due to COVID-19. Government revenues and net borrowing are the key drivers of domestic health spending.

[6] RHFH discussion slide deck

3. APPROACH

The approach in the conceptualization, design and operationalization of RHFH follows a participatory process that is evidence-informed, led from a country perspective, owned by Member States and led by Government.

The design and operationalization of the RHFH is spearheaded by AUDA-NEPAD. The oversight and technical input by Hubs Subcommittee members and the active involvement of Members States, RECs, and Partners was critical in ensuring ownership and drawing the comparative advantages of each stakeholder in the different stages of the design and implementation process.

Consultations with Members States, Subcommittees, AUC, the Champions Office, RECs and Partners have been successfully held, which have led to the production of this draft document. AUDA-NEPAD proactively focused its efforts in involving the Member States in the design and operationalization of the RHFH and paves the way for their stewardship role in the ALM-Investing in Health Initiative.

Evidence generation and analysis for the design of the RHFH was built on extensive Desk Reviews and Consultations with Member States, Subcommittees, ALM-Investing in Health Champions office and stakeholders.

A comprehensive desk review was undertaken to elaborate the successes, opportunities, challenges and next steps on sustainable domestic health financing in the continent, and the need for RHFH formation. Documents reviews include, among others: Continental commitments and strategies on development, health, and sustainable health sector financing; Regional Hub slide deck; Publicly available databases on health (e.g. IHME, GHO) and health sector financing (e.g. Global Health Expenditure Database, Africa Scorecard); Continental state of health reports and studies; Global health and health systems financing reports and statistics; and peer-reviewed journals on innovative finance, private sector engagement, and donor coordination.

The reference team at AUDA-NEPAD conducted retreats and a series of feedback meetings to articulate the RHFH objectives, functions, operational modalities, and governance. The team also held meetings with AUC and ALM Champions Office to clarify roles and responsibilities and reporting lines.

Consultation with RECs and Members States is critical during the design and piloting stage. This was ensured through stepwise engagement strategies, that include virtual and face to face meetings and workshops. The AUDA-NEPAD team has taken significant steps to organize technical meetings/workshops with RECs, including Member States to review the draft RHFH design and operational manual and articulate the way forward to piloting and operationalization of the RHFHs in selected RECs.

4. VISION, MISSION AND GUIDING PRINCIPLES OF RHFH

The vision, mission, guiding principles, and values of the Regional Health Financing Hubs (RHFH) are derived from the ALM-Declaration and aligned to continental commitments, such as agenda 2063, health sector strategy 2016-2030, and Abuja declarations.

Vision: Universal Health Coverage is a reality in Africa

Mission: Coordinate, support, and steer momentum towards sustainable, sufficient, equitable and efficient investments in the health sector.

Guiding Principles and Values:

The guiding principles and values of the RHFH recognize that the achievement of UHC can only be possible with country leadership and political commitment, and the support of multi-lateral and bilateral partners, other strategic partners and private sector as outlined in the ALM-Investing in Health Declaration (Annex 1). As such, the guiding principles, and values of the RHFH are as follows:

1. **Country-Led:** Technical and policy support provided to Member States to increase domestic investments in health and improve health financing is based on country context and that Member States own and lead the process.
2. **Responsiveness to demand:** Efficiently and effectively respond to demand from Member States for technical and policy support for undertaking health financing reforms, while proactively engaging passive Member States on the need for health financing reforms to increase domestic investments in health.
3. **Innovation**: In collaboration with Member States and partners explores, evaluate, and implement innovative solutions for health financing challenges.
4. **Coordination, harmonization, and alignment:** Positioned as a coordination (interlocutor between countries and partners), and support mechanism (acts as catalyst, strategic partner, convener, supportive coach) to reduce resource duplication and overlaps, and foster alignment to continental, regional and national commitments, and priorities.
5. **Transparency and accountability:** Work in a transparent manner that allows learning and contributes to accountability by establishing clear operational framework among key players, such as MS, RECs, AUC, AUDA-NEPAD, committees, development partners and private sector.
6. **Ideologically and politically neutral:** Provide technical and policy support without any institutional ideology, policy, or political position.
7. **Learning, adaptation and flexibility:** Treat each country context as unique and adapts tools and approaches to suit the situation while maintaining regional coherence; facilitate learning between countries and country engagement with relevant stakeholders and identify and bridge gaps with existing local capacity.

5. GOAL AND OBJECTIVES

The goal and objectives of the RHFH is guided by the key milestones of the ALM-Investing in Health Declaration.

5.1 Goal

Achieve diversified and sustainable domestic health financing by 2030

This goal is ambitious but achievable. Progress must be urgently fast-tracked, and the ALM-Investing in health initiative is the means to do so.

5.2 Objectives

The specific objectives of the RHFH are to support Member States to:

1. Increase domestic health resource mobilization
2. Improve the national health financing system to reduce and ultimately eliminate catastrophic health spending
3. Enhance efficiency, equity and effectiveness of budget allocation and spending
4. Strengthen cross-sectoral collaboration, harmonization and alignment of development partners and private sector investment to continental, regional and country health priorities

6. FUNCTIONS

To achieve the above objectives, the key functions of the RHFH will include:

1. **Drive the exploration and adoption of viable domestic financing mechanisms:** RHFH will lead and support health financing reform processes through context-relevant existing and innovative financing mechanisms in line with the ALM-Investing in health Declaration:
    a. *Develop Innovative and feasible domestic financing mechanisms:* Support Member States to raise additional revenues by looking beyond conventional traditional mechanisms of budget outlays from established donors, non-governmental organizations, private sector, government etc. such as: advance market commitments, product development partnership, investment funds, and challenges to fill gaps in research and development; volume guarantees, third-party financing and corporate investments to facilitate market entry, increase production capacity of medical products; and small-scale enterprise and trade finance, credit guarantees, social impact bonds, corporate and third-party investment bonds etc.[20]
    b. *Strengthen taxation systems*: Support Member States to strengthen their capacities and capabilities in tax collection through equitable, efficient, and progressive taxation and revenue collection mechanisms.
    c. *Enhance national health financing systems:* explore options to reduce fragmentation of resource pooling mechanisms; strengthen national health insurance (where appropriate) and other risk pooling mechanisms to reduce catastrophic health spending; and improve allocative efficiency and effectiveness of spending
    d. *Reorient resource allocation and spending*: target key health systems dimensions, diseases and conditions across the lifecycle that have the greatest impact on mortality, morbidity, and human capital development with the mix of interventions that will deliver the most significant impact. And ensure that the health sector delivers, or is likely to deliver, results in an economic and timely way.
2. **Strategic regional policy advisory services:** RHFH will provide evidence-based and dynamic policy guidance to Member States at the nexus of MOH and MOF and help identify catalytic short and long-term financing reforms and support strategic planning.
3. **Enhance development partner and private sector engagement coordination:** RHFH will leverage and foster private capital injection and partner cooperation, learning and support to unlock political assets for reforms, and coordinate for continental-regional-national health priorities alignment and harmonization.
4. **Facilitate utilization of diagnostic and tracking tools:** RHFH will provide technical support to facilitate the application of tools such as the Health Financing Tracker, Africa Scorecard, as well as Private Sector Engagement for identifying health financing issues and needs that require reforms.
5. **Provide technical assistance and capacity-building services to Member States:** RHFH in collaboration with AUDA-NEPAD will identify capacity and competence needs and provide backstopping to Member States.
6. **Facilitate knowledge sharing:** RHFH will coordinate creation of technical and policy reform platforms at country level (composed of officials from MOH and

MOF and other key stakeholders), creation of a repository of knowledge sharing platform between MS and RECs and build informal networks for communication between MS and RECs.

7. **Resource Mobilization:** Mobilize resources for the implementation of priority projects.
8. **Support research, innovation, and entrepreneurship:** Support research, innovation and entrepreneurship in health financing and health systems strengthening. RHFH should play a proactive role in improving data collection and analysis, and in fixing data collection inefficiencies in Members States to generate essential data to understand the priority areas of interventions better.

7. OPERATIONALIZATION OF THE RHFH

The RHFH will operate independently as part of the AU system, embedded within RECs structures. The Hubs principal beneficiaries will be the Member States who will have direct access to efficient technical and policy support in their quest for increasing domestic investments in health. To ensure that Member States are well supported, the following will be put in place in the Hubs structure.

Location: RHFH will be positioned in the RECs with governance embedded in the organizational framework of each REC . In so doing, this will ensure that there is ownership and accountability of the ALM-Investing in health Declaration by the RECs.

RHFH will be established in the RECs of the five regions of the AU. As there are multiple RECs in one region, with overlapping REC Membership, one Member State being a member of multiple RECs, including some Member States working with RECs in different AU regions, the choice to join any particular REC will be left to each of the concerned Member State. Of particular note is that COMESA's mandate is on commerce and economics and has no health unit, therefore, other areas of focus can be explored such as private sector engagement, infrastructure development for medical products manufacturing, among other functions.

Expertise required: Much as each REC is unique and thus this could determine its expertise needs, however, for the hubs to be effective and efficient, they need to have experts with competencies that match with the key functions of the Hub indicated above. As such, in view of the above RHFH key functions, the Hubs need to have experts with extensive skills and experience in the following areas: 1) Health economics/health financing policy reforms (including modelling of innovative domestic health financing mechanisms, and evidence gathering methods/tools such as National Health Accounts, public health expenditure reviews, WHO health financing progress matrix etc. whose information will be used to fill most of the indicators of the Africa Score Card and Health Financing Tracker, public finance management; 2) Private sector engagement; 3) Public health, including health systems strengthening, monitoring, evaluation, and research methods; and 4) Advocacy and communication.

To facilitate smooth implementation, staffing at the RHFH could be secured, first through recruitment of consultants, and second by, a mix of secondments by Member States with necessary salary top-ups among others. A recruitment process would be needed and must be prioritized to expedite placement. An assessment of available skills and expertise may be required within the RECs.

To further facilitate technical and policy support to Member States, the RHFH will form regional communities of practice/expert groups on domestic resource mobilization, including innovative financing mechanisms/health financing reforms. Expert groups will be composed of Member States representatives from Ministry of Finance (Macroeconomics/Budget/Taxation), Ministry of Health (Health Planning/Health Services Delivery), development partners, academia, civil society groups and private sector—which would act as a technical committee for supporting evidence gathering/generation, analysis and making policy recommendations (the same should be replicated in each Member State).

Financing: The design and effective implementation of the key functions of the RHFH requires financial resources at RHFH and AUDA-NEPAD levels. At the Hubs level, the following costs need to be considered. The actual cost of resource requirements will be done once all major components of the design are agreed upon by stakeholders.

- Personnel costs: salary, miscellaneous
- Operational costs: travel, communication
- Program costs: data collection, analysis, reporting, research, policy guidelines development, monitoring and evaluation, dissemination, workshops, technical assistance, etc.

During the pilot phase, while working on modalities for the RHFH costs to be included in the RECs regular budget, a performance-based funding model will be applied to ensure that financing helps achieve desired results in the RHFH. Performance will be evaluated by comparing verified results to agreed targets from the results framework and by considering contextual factors, such as the review of progress of planned activities and proposed corrective measures by the RHFH.

At the AUDA-NEPAD level, the following costs should at least be accounted:

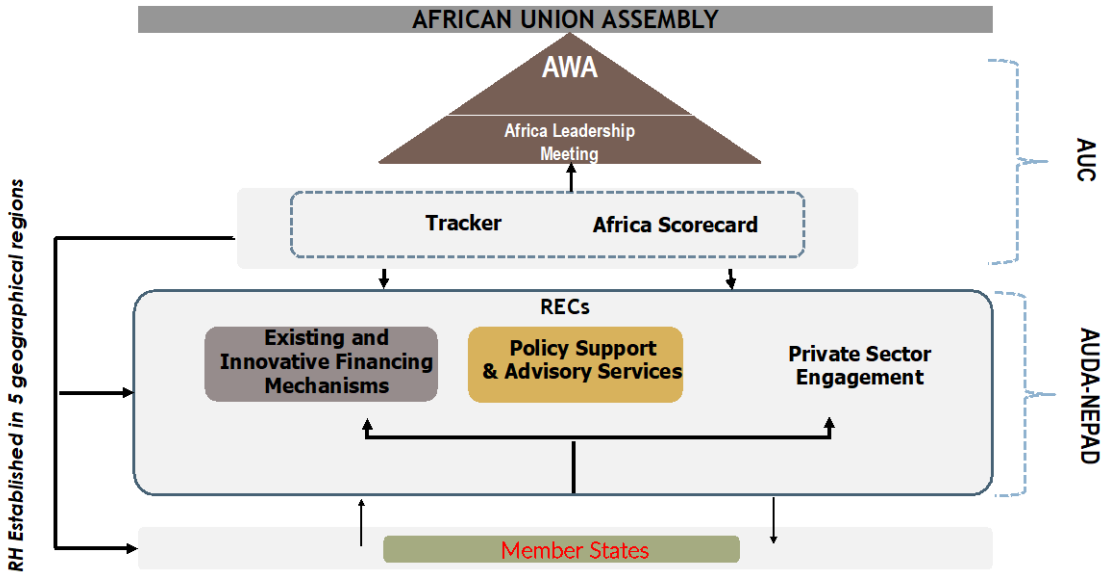
- Personnel: salary, miscellaneous
- Operational: travel, communication, workshops, technical assistance services (TA)

Operational Framework: The operation of the RHFH will have three main pillars: 1) Existing and Innovative Financing Mechanism; 2) Policy and advisory support services; and 3) Private sector engagement (PSE). Such pillars will be in line with the key functions of the RHFH. Policy and advisory support services will be carried out based on the analysis of evidence obtained from Member States using diagnostic and reporting tools such as the Health Financing Tracker, and Africa Score Card, among others. The existing and innovative financing mechanisms include, but not limited to innovations on financing reforms, equity and financial risk protection, efficiency in government health spending and effectiveness of investment in the right priorities, and improved leadership and governance. Private sector engagement interventions will be implemented based on the guidance contained in the PSE strategic framework.

Member States (with the leadership of Ministry of Finance and Ministry of Health) will own and lead the implementation of the ALM-Investing in Health Declaration at national level. First, AUDA-NEPAD in collaboration with RECS, will facilitate and provide a platform for the implementation of the Tracker and Score Card (Tracker and Score Card being developed by the AUC), and the Private Sector Engagement Framework (being developed by AUDA-NEPAD) that will be used by Member States for diagnosis of the health financing and system issues and challenges, and for reporting progress. Second, Member States will own and lead the process of health financing situation assessments using the tools/frameworks (such as the Tracker, Score Card and Private Sector Engagement), including evaluation of the potential and feasible options for financing health with technical support from the RHFH and AUDA-NEPAD. To do this, in Member States where a **Health Financing Unit/Reform Unit** does not exist or is weak, the Ministry of Health and Ministry of Finance will need to establish/strengthen such a Unit. This unit should be composed of four core staff members: 1) Public Financial

Management Reform Specialist; 2) Health Economist and Health Financing Reforms Specialist; 3) Private Sector Engagement (Finance & Investment) Specialist, and 4) Public Health Expert.

Figure 12. RHFH Operational Framework



Furthermore, to coordinate partners and private sector investments, RHFH will form a **Partner Advisory Committee** composed of the RECs, development partners and private sector representatives working in each REC. The same forum should be created at the country level composed of senior policy officials from Ministry of Finance, Ministry of Health, development partners, private sector, Non-governmental Organizations and Civil Society which would act as a vehicle for alignment and harmonization of development partners to country priorities and attracting private sector investments in health.

Roles and responsibilities: The ALM-Investing in Health Declaration is comprehensive and covers several areas that call for action from different AU institutions and Member States. As such, different institutions have to play different, but complementary roles and responsibilities to ensure effective and efficient design and implementation of RHFH that would lead to the attainment of the ALM-Investing in Health agenda. The roles of the institutions are as follows:

AUC

The ALM – Investing in Health Declaration initially gave the mandate of working with partners to create RHFH to AUC. However, as noted above, since February 2021, this mandate has been assigned to AUDA-NEPAD. Thus, according to the Declaration (Annex 1), the following functions remain under the mandate of the Commission:

i. Coordinate the development of Health Financing Tracker and Africa Scorecard (item 8)
ii. Update presentation of data in the Africa Scorecard on Domestic Financing for Health (item 8)
iii. Organize biennial meetings of Ministers of Health and Finance to review the work of the platforms and monitor progress (item 6(vi))

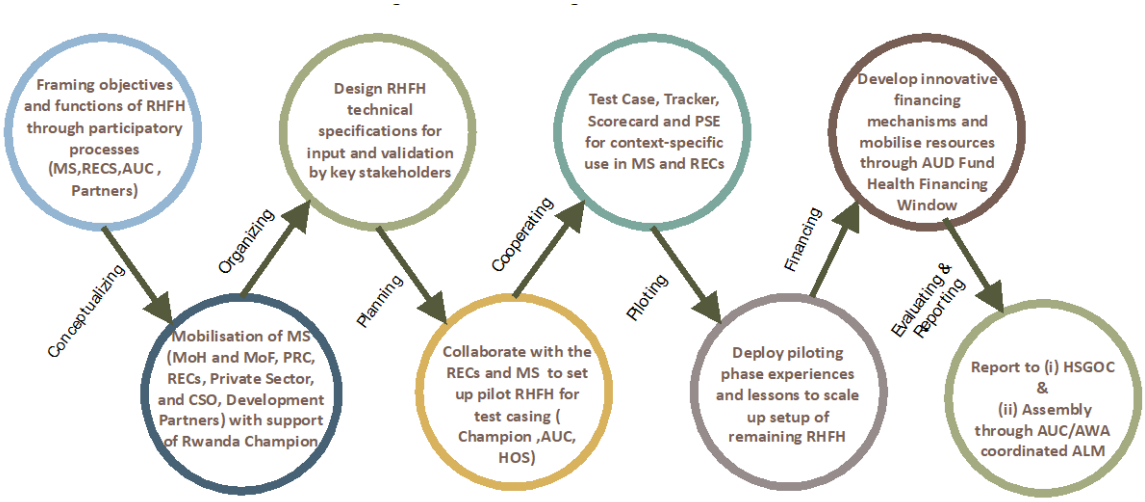
iv. Monitor implementation of the commitments of the ALM (item 6(vii))
v. Organise ALM/AWA summits to report on implementation of ALM declaration (item 7)

AUDA-NEPAD

AUDA-NEPAD will support RHFH and Member States to undertake the following roles as per ALM-Investing in Health Declaration (Annex 1):

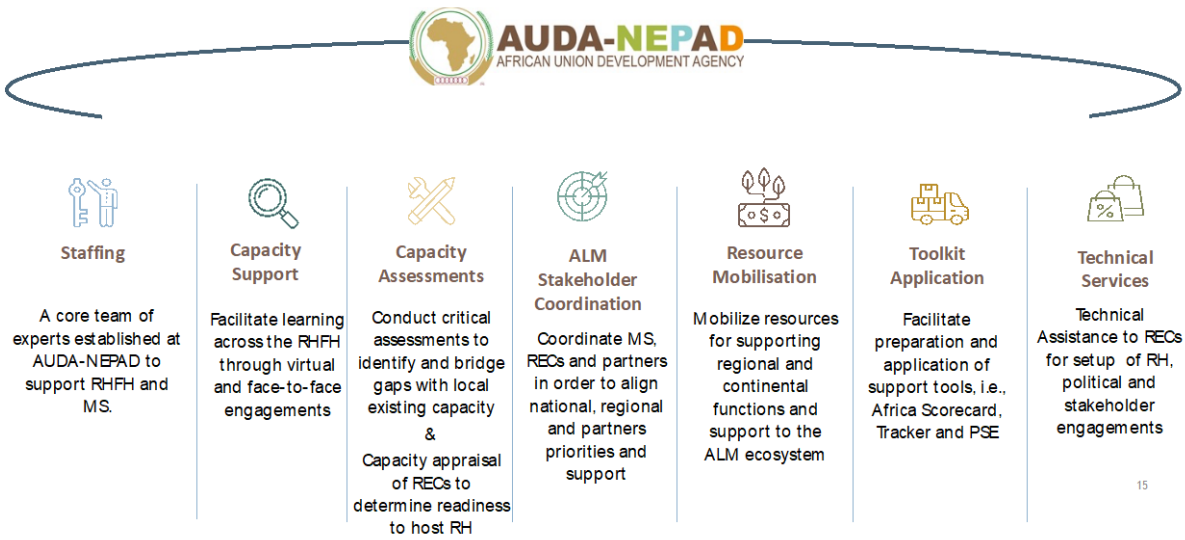
i. Lead the creation of the RHFH across the five AU regions (**item 6(v**)): 'AUDA-NEPAD will lead the conceptualization, design and operationalization of the Regional hub through a consultative process with RECs, Member States, AUC, the Champions Office and Partners.'
ii. Mobilize sufficient and sustainable financing (as per **item 6 (ii) and item 3**-increase domestic health resources mobilization and progressive taxation**):** AUDA-NEPAD will mobilize resources through existing and innovative financing mechanisms to support continental, regional and national projects and also build the capacity of RHFH and Member States in domestic resource mobilization mechanisms.
iii. Mobilise the private sector and development partners to support and invest in expanding access to quality health care services and achieving UHC (**item 4**): One of the AUDA-NEPAD core mandates is to serve as the continent's technical interface with all Africa's development partners. Thus, AUDA-NEPAD will support the RHFH and Member States to have a coordinated and coherent investment from private sector and development partners aligned to their policies, strategies and priorities.
iv. Fully implement the Pharmaceutical Manufacturing Plan for Africa (PMPA) and regulatory harmonization (**item 5**): The strong track record of AUDA-NEPAD in co-ordination and timely execution of priority regional and similar continental projects, such as private sector engagement in health is an added value for this important role.
v. Build the capacity of the RHFH which in turn would assist strengthening the capacity of Member States in research and innovation in health financing and health systems strengthening.

Figure 13. AUDA-NEPAD strategic actions on ALM-investing in health and RHFH



To undertake these roles effectively and efficiently, AUDA-NEPAD shall coordinate and execute the strategic functions presented in (**Figure 13)** and health financing support (**Figure 14**) in order to establish the RHFH and thereafter support the implementation of the Hubs' key functions that would lead to strengthening existing and innovative domestic financing mechanisms at Regional and National levels, that would ultimately lead to increased domestic investments in health

Figure 14. AUDA-NEPAD health financing support to ALM-investing in health initiative



RECs

Different RECs are at various levels of supporting Member States to undertake health financing reforms using various strategies/structures in order to achieve UHC. For example, the EAC developed a consultative structure aimed at discussing and guiding the regional initiatives in sustainable health financing composed of experts from the ministries of health and finance, including the Private Sector and Civil Society Stakeholders—**EAC Expert Working Group** (EWG) of Sustainable Financing in 2016. This

Expert Working Group supported the undertaking of sustainable financing analysis for UHC for the EAC region whose report formed the basis for a high level dialogue on sustainable financing which brought together Ministers of Finance and Health to deliberate and agree on the most viable financing options to ensure sustainable financing for health and HIV/AIDS in the EAC region in June 2016.

Similarly, the SADC region has developed the Terms of Reference for Health Equity and Inclusive Development Thematic Group (HEIDTG) with the aim of identifying issues of common interest and address them jointly in a coordinated manner within the region; map the interventions and resources available across the region to fill the gap and maximize effectiveness; and provide a platform for sharing experience, information and reviewing progress made in addressing social and human development issues in the region, among others.

As the RHFH will be embedded in RECs, there will be great need to ensure that in the RECs where some structures already exist such as those in EAC and SADC noted above, these structures are aligned with the objectives and functions of the RHFH and in RECs where the structures that support health financing do not exist, following the guidance contained in this document, such structures be created to implement the functions of the RHFH so as to achieve the RHFH objectives and vision. As such, in order to effectively design the regional hubs and later efficiently lead the implementation of the Regional Hubs functions, the RECs will play the following roles:

1) Collaborate with AUDA-NEPAD in the conceptualization, design and operationalization of the RHFH
2) Organize and provide leadership to Member States in participating in the conceptualization, design and operationalization of the RHFH
3) Collaborate with subcommittees: Tracker, score card, and private sector engagement to ensure that the diagnostic and reporting tools are finalized and ready for piloting

Member States (MS)
Member States and Governments will commit and play a stewardship role in implementing the ALM-Investing in Health Declaration as they have already committed themselves to undertake the following as per ALM- Investing in Health Declaration (Annex 1): 1) increase domestic investments in health and improve health financing systems in a context-appropriate manner such that each country pursues its own path to achieving and sustaining UHC (item 6 (i)); 2) mobilize sufficient and sustainable financing to strengthen health systems and achieve UHC (item 6 (ii)); and 3) foster collaboration between public and private sectors to create synergies and deliver health for all (item 6 (iii)).

In addition to this commitment, it should be noted that Member States are currently at various stages and levels of designing or implementing health financing reforms aimed at mobilizing additional revenues, reducing inefficiencies and inequities to achieve UHC. To ensure ownership of these reforms, in most of the Member States such health financing reforms are being designed or implemented through the creation of structures or reviving of existing structures composed of diverse stakeholders in the health sector (often led by the Ministry of Health), including other public institutions such as Ministry of Local Government (rarely do they include the Ministry of Finance – only involved during annual budget allocations), Development

Partners, and Non-Governmental Organizations/Faith-Based Organizations (in rare circumstances, the private for-profit sector).

Of particular note is that these structures are created or revived to address a particular health financing issue. For example, when there is a need to develop a health financing strategy/policy (e.g. Zambia, Kenya, Malawi, Uganda, Ethiopia etc); design and implementation of national/public health insurance scheme (e.g. Ghana, Nigeria, Zambia, Malawi, Rwanda, South Africa etc); community health financing schemes (e.g. Rwanda, Ghana, Mali, Senegal, Uganda etc); design and implementation of performance-based financing/incentive schemes (Rwanda, Burundi, Lesotho, Malawi, Zambia, Nigeria etc); and design and implementation of national health accounts/public expenditure reviews (e.g. Morocco, Ghana, Namibia, Senegal, Rwanda, Sierra Leone, The Gambia, Ethiopia, Zambia, Zimbabwe, Togo etc). Please refer to Annex 2 that contains examples of the structures present in some Member States in EAC and SADC.

Furthermore, almost all MS are at various stages of undertaking reforms in order to strengthen their public financial management systems (headed by the Ministry of Finance) so as to raise additional domestic general revenues; improve efficiency; equity, and transparency in revenue raising; and efficiency, equity and effectiveness in allocation and spending of these public revenues by different public ministries, departments and agencies.

Thus, in order to effectively implement ALM-Investing in Health commitments, Member States in addition to creating/strengthening a Health Financing Unit/Reform Unit under the leadership of the Ministries of Finance and Health as indicated earlier, there will also be a need to create (in Member States where structure are absent) or revive/strengthen (where systems are weak), any or a combination of any of the following technical, policy and coordination structures (depending on country needs) with the following functions:

1. The Ministry of Finance and Ministry of Health in MS will form a separate **Technical/Policy Committee**: As the Ministries of Health and Finance rarely meet outside annual budget allocations, this high-level committee will be responsible for the dialogue on public financial management and health financing. These two arms of the government will need to foster mutual understanding and find amicable and practical ways for problem-solving e.g. presenting health as not a cost but an investment in human capital – presenting evidence that clearly shows the causal link between health investments and macroeconomic performance, hence encourage MOF to identify other sectors/areas of low priority or where efficiency gains could be made to reallocate the funds to the health sector. Furthermore, Ministries of health could use this forum to present evidence on the need for fiscal space for health i.e. resource needs versus available resources and lobby for increased resources from Ministry of Finance among others.
2. The **Multi-Stakeholder Technical Committee:** This committee will be responsible for leading and coordinating MS domestic health financing reform activities, including policy analysis using data generated from Tracker, Africa Scorecard, WHO Health Financing Progressive Matrix, National Health Accounts, and special studies, with the support of the RHFH and AUDA-NEPAD. The technical team will be composed of senior technical officials from the Ministry of Finance

(Macroeconomics/Budget/Taxation), Health (Health Planning/Health Services Delivery), development partners, academia, civil society groups and private sector among others.

3. **Multi-stakeholder Policy Committee:** This Committee will be responsible for guiding the technical working group and lead the development and adoption of policies by working closely with other arms of government (national parliamentary committees on health/economy etc.). The Policy Committee will be composed of heads of institutions, such as Principal/Permanent Secretaries and Director Generals, drawn from Ministry of Finance, Ministry of Health, development partners, academia/research institutions, private sector, and civil society.
4. **Partners Advisory Committee** that would lead to harmonized effort by development partners and private sector aligned to ALM-investing in Health agenda. It will offer advice and support to ensure the following: 1) active participation of partners in strategic conversations with governments; 2) support in generating demand for Hub-led strategic advice; and 3) alignment of financial and technical support activities among all stakeholders.

8. GOVERNANCE OF THE ALM-INVESTING IN HEALTH INITIATIVE

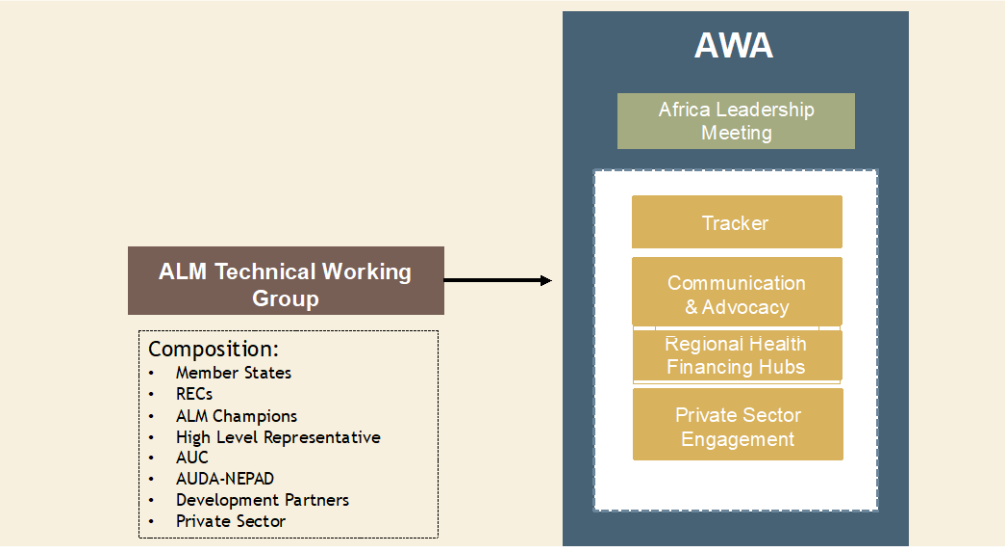
8.1 Technical Working Group and Subcommittees

To implement the ALM-Investing in Health Declaration, a Technical Working Group (TWG) was formed that is reporting to the AUC with four subcommittees: 1) Hubs Subcommittee, 2) Tracker Subcommittee, 3) Advocacy and Communications Subcommittee, and 4) Private Sector Engagement Subcommittee. The subcommittee members were drawn from partners, implementers, RECs, and key African Agencies to drive these various components of Africa's domestic health financing agenda as set out in the ALM Declaration.

The Subcommittees were not intended to add a layer of bureaucracy but serve as a versatile and value-adding group representing various stakeholders of the ALM–Investing in Health initiative. It was designed to be a group of senior technical experts with the requisite capacity and capabilities to accelerate the implementation of the ALM-Investing in Health Initiative.

Based on one of the key outcomes of the recent ALM-TWG meeting, which was held in Kigali in October, 2021 a recommendation was made to form an inclusive ALM-TWG to coordinate and provide overall technical guidance/oversight of the implementation of ALM-Investing in Health declaration (**Figure 15**). More specifically the TWG will facilitate active participation of all stakeholders in strategic decision making. The TWG will report to ALM/AWA and will replace the existing ALM-Subcommittees. This approach is believed to enhance the participation of all stakeholders, in particular Member States and RECs, improve accountability, and reduce fragmented technical guidance and oversight.

Figure 15. RHFH Governance Framework



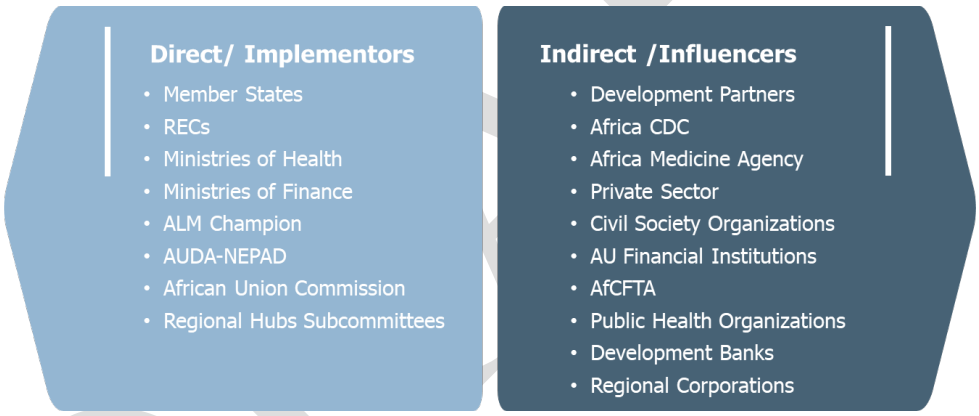
8.2 Members States and Stakeholder Engagement

An outcomes-driven Member States and Stakeholder Engagement strategy is fundamental for the effective and sustainable design and operationalization of the RHFH. it is essential to ensure that Member States are actively engaged as custodians to contribute to the design, piloting, and implementation of RHFH. Through the undertaking of consultative engagements with Member States and Key Stakeholders in the design phase, this will ensure the endorsement and rationalisation of the RHFH in line with the needs of the Member States and RECs.

In framing the stakeholder engagement, it is important to define and identify stakeholders within the context of the Regional Health Financing Hubs initiative: The Regional Hub Stakeholders are ***all parties that hold a vested interest and could affect or be affected by the initiative. Stakeholders can be further segmented into 2 categories***

a. Direct/Implementors
b. Indirect/Influencers

Figure 16. Key Stakeholders of ALM-Investing in Health initiative



8.2.1 Objectives

The Stakeholder Engagement strategy aims to address 5 central objectives:

i. Provide an exposition of the RHFH Objectives and Functions at the national, regional, and continental levels.
ii. Foster political buy-in of Member States and RECs through political advocacy driven by the AU champion on Domestic Financing and Head of HSGOC - H.E President Kagame and H.E President of Ghana, champion on AU Finance institution.
iii. Support the design and development process through harnessing feedback received from the consultative platforms. Consequently, this will ensure that the form and functions of the RHFH are in alignment with the needs of Members States.
iv. Secure commitment for the sustained utilisation and support of the RHFH as a platform to strengthen national health systems through enhanced domestic financing.

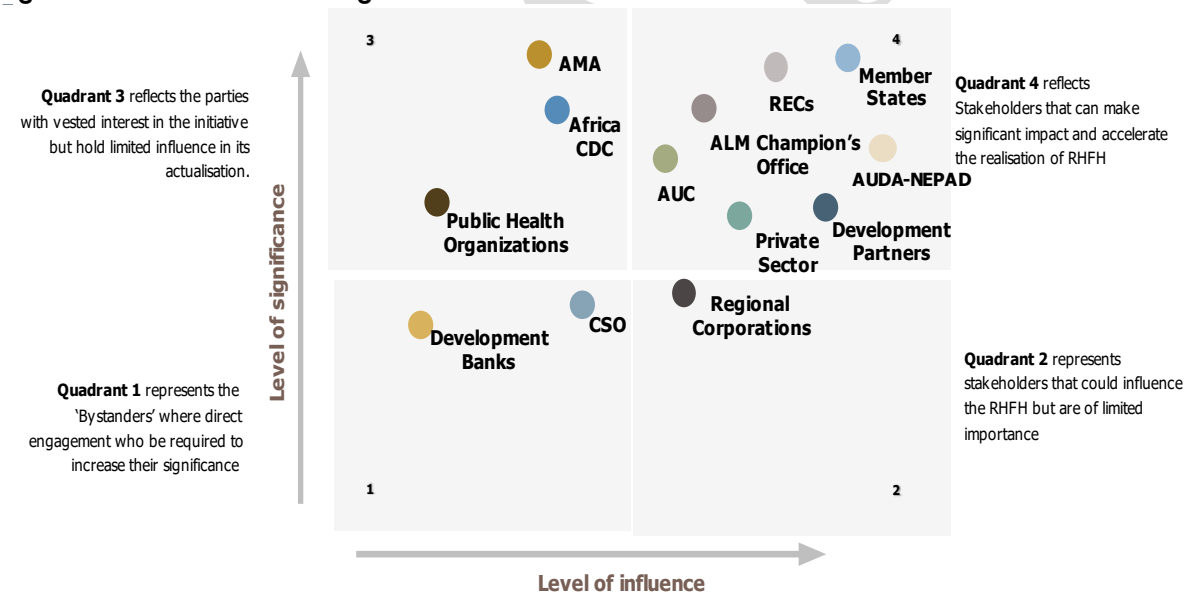
v. Drive the effective use of RHFH by fostering widespread understanding of the Hubs value proposition and key functions while showcasing the key strategic elements of the Diagnostic Tools

8.2.2 Strategies

In order to effectively secure active engagement of Stakeholders the following strategies shall be utilised. The proposed strategies will supplement the overall ALM Advocacy activities led by the ALM Champion's Office and Advocacy & Communications Subcommittee. Through a stepwise and targeted approach commencing with the two pilot Hubs (EAC and SADC), the following engagement strategies shall be utilised to achieve the objectives of the Engagement Plan.

- Stakeholder mapping and analysis: Identify stakeholders and analyse the degree to which they may become a help or hindrance to RHFH by considering a number of criteria, including the relative power of the stakeholder to the objectives of the Hubs; the degree of interest that the stakeholder is likely to demonstrate actively; and the likelihood of the stakeholder to support the Hubs function. This analysis is critical in identifying tailored strategies for engaging each stakeholder. A preliminary stakeholder mapping is depicted below:

Figure 17. RHFH Stakeholder Segmentation



- High-Level Dialogues on RHFH (Ministries of Health and Finance, PRC, RECs, Private Sector, Civil Society, Development partners, and Other Government Ministries/sectors, such as trade and industry, Key AU continental and regional organs, etc.)
- Establishment of an interactive Technical Working Groups comprising of representatives from each Member State within the region
- Sensitisation Webinars on key components of the RHFH and the Diagnostic tools
- Political Advocacy Campaigns support by the AU Champion on Domestic Financing and Head of HSGOC - H.E President Kagame

- Targeted Seminars/Webinars within the RECs to promote participation in the testing of Tracker and Scorecard
- Develop Landing Pages on AUDA-NEPAD website highlighting the Agency's key touchpoints, milestones, and progress dashboards within the respective REC's in relation to the establishment and utilisation of the RHFH
- Establish social media presence to report on the Agency's Key engagements with Member States and RECs.

In order to ensure that the engagements are impactful, AUDA-NEPAD shall develop 'Key Messages' that will encompass the mission and purpose of the RHFH. This key message should be in line with the overall objectives of the ALM-Investing in Health Initiative while showcasing the intrinsic value of the RHFH. The impact and efficacy of the engagement strategy is dependent on ensuring that the 'key messages reach the target stakeholders' and advocacy campaigns are presented through the appropriate channels.

To guide the activities of the Stakeholder Engagement, AUDA-NEPAD shall develop a Stakeholder Contact Plan for 2021 mapping out the following:

- Which stakeholders shall the Agency engage with?
- Through which strategy will the engagement be most effective?
- What key messages and material regarding the RHFH will be disseminated by the Agency?
- When shall the engagement take place?

The details of the expanded contact plan will guide the stakeholder engagement activities which will, in turn, support the conceptualisation, design, and operationalisation of the RHFH.

Table 4. Contact plan overview

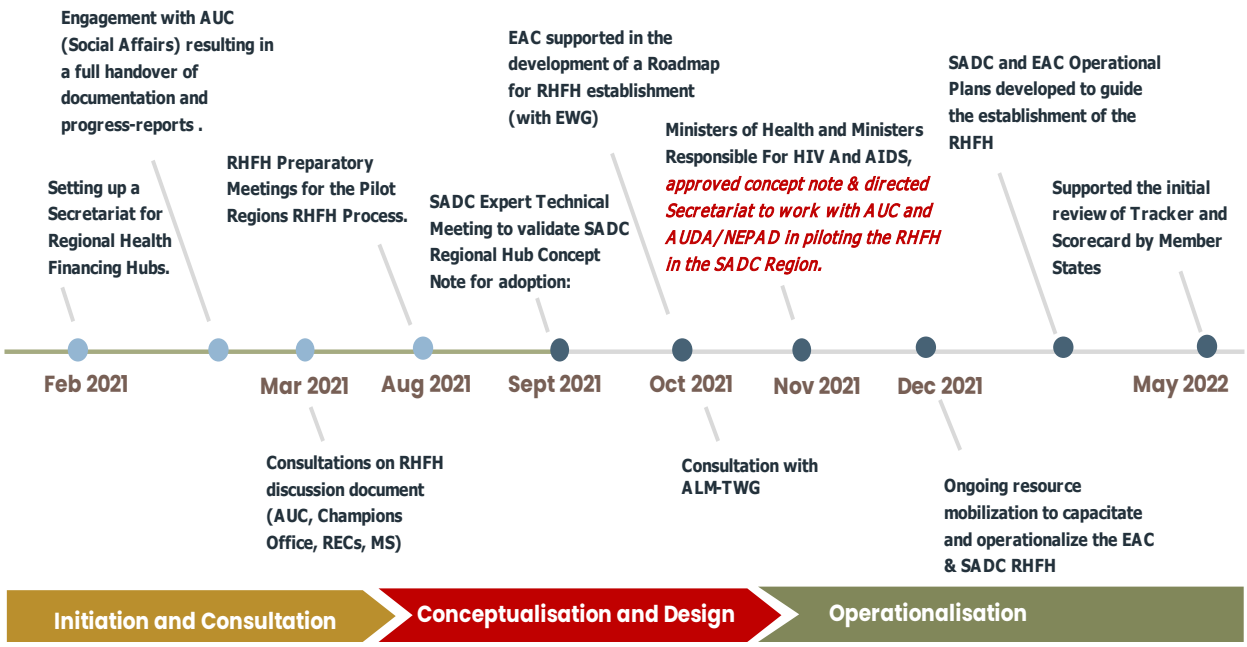
	Target Stakeholder	Engagement Strategy	Targeted Outcome of Engagement
1.	Member States (Segmented by Regions)	**Direct**: Members States (MS) round table discussions and validation workshops; Ongoing non-formal meetings with MS in the design phase **Indirect:** Media briefings, ALM Social Media Toolkit, AUDA-NEPAD RHFH landing Page and progress dashboard	Foster commitment and buy-in for the RHFH design and operationalisation
2.	RECs	**Direct**: Ongoing Consultative meeting with RECs to determine piloting modalities, readiness, capacities, and technical support required; High-level engagements with RECs Executive Secretaries and Key Stakeholders **Indirect:** Media briefings, ALM Social Media Toolkit, AUDA-	Foster overall commitment to hosting the RHFH and build technical capacity within the RECs to ensure Hub's sustainability and effectiveness

		NEPAD RHFH landing Page and progress dashboard	
3.	ALM-Investing in Health Subcommittees	**Direct**: Ongoing Consultative meetings with ALM Subcommittees to coordinate Hubs workstreams and harness tools-Tracker and PSE	Accelerate the establishment of RHFH through effective coordination and alignment of the Regional Hub works streams
4.	Development Partners	**Direct**: Donor round table discussions and sensitisation workshops; One-on-one meetings with development partners supporting the ALM **Indirect:** Media briefings, ALM Social Media Toolkit, AUDA-NEPAD RHFH landing Page and progress dashboard	Effective coordination of partner engagements aligned to ALM-Investing in Health agenda/priorities
5	Private Sector	**Direct**: Private Sector round table discussions, sensitisation workshops & validation workshops, Partner Forums **Indirect:** Media briefings, ALM Social Media Toolkit, AUDA-NEPAD RHFH landing Page and progress dashboard	Improve the public-private partnership (PPP) to foster private sector investment to strengthen Health Systems

9. PROGRESS ON RHFH DESIGN AND WAY FORWARD

9.1 Progress on RHFH Design

Figure 18. RHFH Milestones and Progress



Since February 2021, when AUDA-NEPAD was tasked to work with partners to create RHFH, the progress made is summarised in Figure 18 and detailed below:

1. **Engagement with AUC (Social Affairs):** AUDA-NEPAD has actively engaged with AUC (Social Affairs) resulting in a full handover of documentation and progress-reports to AUDA-NEPAD, as well as introductions of the working team at AUC to AUDA-NEPAD;
2. **Consultations on RHFH discussion document:** At the initial stage, AUDA-NEPAD organized several consultation virtual meetings with AUC, the Champions Office, RECs and Partners to conceptualize the design and operationalization of the RHFHs. The consultation meetings have resulted into: (a) Hub's concept defined collectively by all parties with participation of Member States in the SADC and EAC pilot regions (b) Development of draft implementation plan; and (c) Holding of inception meeting of AUDA-NEPAD reference team to define the key functions and operational framework of the RHFH. This RHFH design and operational manual was the result of these discussions. This document conveys further discussions with all partners, RECs and Member States.
3. **Linking with other Subcommittees:** AUDA-NEPAD has been fully briefed on all ALM components (Tracker, Private Sector Engagement, and Development Partner Coordination) through engagement with the various Subcommittees.
4. **Setting up a Secretariat for Regional Hubs:** AUDA-NEPAD has successfully staffed the RHFH workstream at the agency.
5. **Special Consultations with RECs and Member States:**
   East African Community (EAC): As of December 2021, the EAC sectoral council has already made a decision to host a RHFH pilot. A follow-up meeting was held in August 2021 with EAC Secretariat, in which it was

agreed to hold a follow up RHFH technical meeting. The meeting was successfully held in Nairobi from 12-17 September 2021 and involved Partner States, EAC Secretariat, AUDA-NEPAD and AUC. The meeting objectives were to:

i) Draw insights from the Partner States on existing sustainable health financing systems and understand progress made in the implementation of the Hub piloting decision;
ii) Validate key design elements of the RHFH and determine the most effective approach in accelerating the pilot in East Africa.
iii) Examine the key milestones in the East Africa Regional Hub process to steer the operationalisation efforts; and provide a platform to understand progress of the design, development, and application of the Regional Hub diagnostic tools.

The meeting was a success and the key meeting outcomes include roadmap to operationalize the EAC Regional Health Financing Hub.

Following the development of this Roadmap, the EAC held its 8th EWG in which they:

i) Adopted the proposed work plan and budget to operationalise the ALM initiative in the EAC region.
ii) Recommended to the EAC Secretariat to update the work plan for the Hub to include all planned interventions (including those funded by other partners; and
iii) Urged the Partner States to submit key priority areas to the EAC Secretariat by 30th April 2022, that would inform technical support to be provided, under the Hub.

The EAC continues to work to operationalize its roadmap through the EWG and technical support is provided by AUDA-NEPAD as guided by the EAC Secretariat.

SADC: AUDA-NEPAD has successfully engaged with SADC on the Hub conceptualization and design process. Working jointly with SADC and its Member States, AUDA-NEPAD supported the development of a Hub's Concept Note based on the Draft RHFH Design and Operational Manual to gain approval from Senior government officials. Following a decision made between SADC and AUDA-NEPAD expert team in early August, a preparatory meeting was held with SADC and its Member States, and AUC between 29 August - 3 September 2021 in Johannesburg. The objectives of the meeting were to:

i) Draw insights from Member States on the existing health financing structures, programmes, and capacities to feed into the design and operationalisation process;
ii) Validate key design elements of the RHFH and determine the most effective approach in accelerating the pilot in SADC;
iii) Review the progress, and impending next steps in finalising the diagnostic and strategic tools (Africa Scorecard, Health Financing Tracker, and PSE); and Draft a roadmap for piloting the Southern Africa Regional Financing Hub.

A virtual follow-up meeting was held with SADC with the participation of all Member States, AUC and AUDA-NEPAD from September 20-21, 2021 with the following objectives:

i) Present an overview of Declaration of the Africa Leadership Meeting – Investing In Health
ii) Prepare for scoping for the establishment of Southern Africa RHFH
iii) Review proposed Regional Hub design and operational strategy
iv) Review and clear the Concept Note on RHFH Piloting In SADC for approval by SADC Council of Ministers; Review the progress, and impending next steps in diagnostic and strategic tools (Africa Scorecard, Health Financing Tracker, and PSE)
v) Draw insights and guidance from Member States, and the SADC Sustainable Health Financing Framework to feed into the design process; and review the roadmap in preparation for the Ministers meeting in November 2021.

The key outcome of this meeting was the approved Concept Note by all Member States. Following the approval of the Concept Note, the SADC Council of Ministers demonstrated their commitment to actively support the domestic health financing agenda by serving as a pilot region for the Regional Hubs. This was illustrated through **"Decision 27: Establishment of the Regional Health Financing Hub in the SADC Region**" of the Joint Meeting of SADC Ministers of Health and Ministers Responsible for HIV And AIDS, which:

(i) Approved the concept note of the operationalisation of the SADC Regional Health Financing Hub attached as SADC/MOHHIV/1/2021/15.7.

(ii) Directed Secretariat to work with the AUC and AUDA/NEPAD in piloting the Regional Health Financing Hub in the SADC Region and submit a report in their next meeting in November 2022.

(iii) Directed the Secretariat to mobilise resources for the establishment of the Regional Health Financing Hub.

6. **Hubs Subcommittee Meeting:** On the 18th of October a Hubs Subcommittee meeting was held to discuss on the progress made related to the conceptualization and design of RHFH, including key outcomes of the consultation processes with EAC and SADC, and the way forward to engagement of other RECs.
7. **Consultation with ALM-TWG:** This meeting was held in Kigali between 20-22 October 2021 with the participation of RECs and Member States representative, AUC, delegation of the AU high representative, delegation of the ALM-Investing in Health Champions Office, and AUDA-NEPAD. The meeting's objectives were to: present progress that has been made in the design of regional financing hubs; present progress made on diagnostic and monitoring tools of the ALM Initiative; and seek guidance on the proposed design and roadmap for regional financing hubs and diagnostic tools. The key outcomes of the workshop among others include the formation of a taskforce to guide the review and piloting of the Tracker in selected Members Sates and a consensus to form an inclusive ALM-TWG (**refer to figure 15**) to coordinate

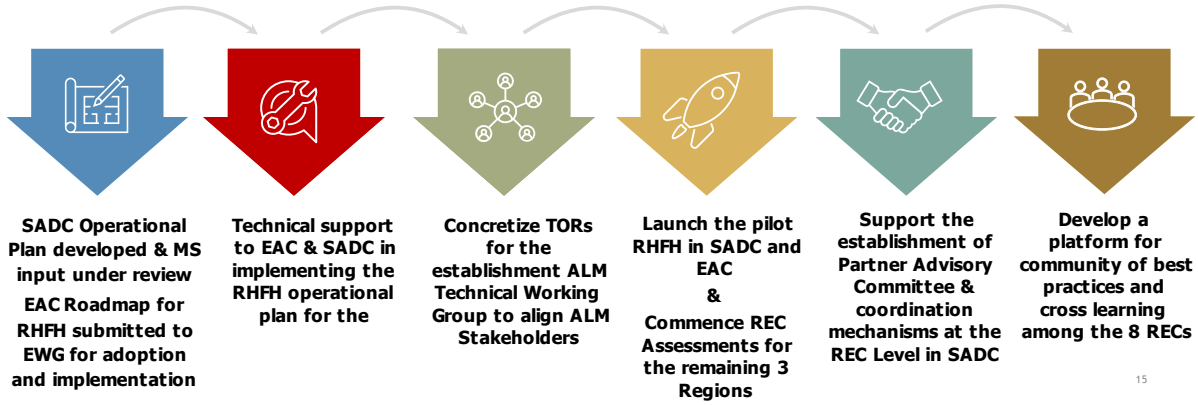
and provide overall technical guidance/oversight of the implementation of ALM-Investing in Health declaration. This TWG will report to ALM/AWA and will replace the existing ALM-Subcommittees once the ToR is developed and the working group is formally established.

8. **Develop an operational plan for piloting in SADC and EAC:** April 2022, AUDA-NEPAD organized a meeting with SADC Secretariat and its Member States to review the implementation plan that will be used for the pilot implementation in the SADC region. Member States inputs were incorporated, and the operational plan finalised. This will guide the steps required to fully operationalise the RHFH in the region
9. **Review of Tracker and Scorecard:** AUDA-NEPAD in collaboration with AUC, successfully organized a meeting between May 23-26, 2022 to review the Tracker and Scorecard in preparation for piloting of the tracker in selected countries. The following Member States attended the meeting: Morocco, Tunisia, Niger, Senegal, Gabon, Tanzania, Malawi, Mozambique and RECs: ECCAS, ECOWAS, and SADC. The meeting presented member States with an opportunity to provide feedback on the preliminary observations made in the application and effectiveness of the Health Financing Tracker. As well as, guide the refinement of Tracker indicators in line with the needs and observations from the Member States.

9.2 Way forward

The next steps (between January 2022 and launch of pilot Hubs) can be summarized in **Figure 19** as follows:

Figure 19. RHFH Milestones and Progress



1. **Conduct assessments of RECs readiness and capacity to host the Regional Hubs for the remaining RECs:** AUDA-NEPAD will assess the RECs capacity and capabilities (in the three remaining regions not included in the RHFH pilot)vis-a-vis the objectives and functions of RHFHs. Such an assessment will determine whether the current capacities are adequate to implement the RHFH activities and develop contingency plan to fill in gaps, if any.
2. **Technical Support to SADC and EAC in the implementation of their RHFH Operational Plans:** AUDA-NEPAD will continue providing technical support to SADC and EAC in the implementation of the RHFH operational plans. Further,

AUDA-NEPAD in collaboration with UNAIDS will support SADC to review the SADC Framework of Action for Sustainable Financing of Health to be aligned to the ALM-Investing in health agenda.

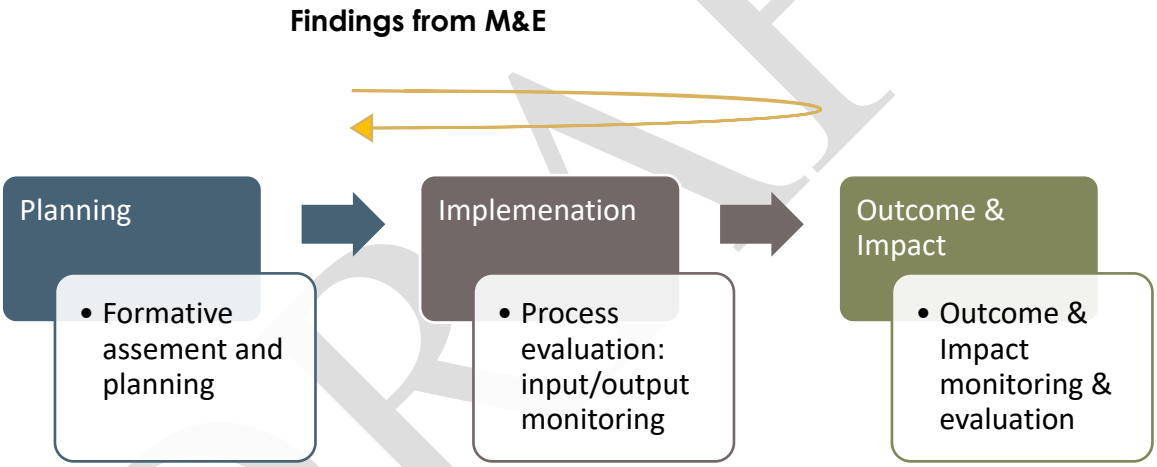
3. **Concretize ToRs for the establishment of ALM Technical Working Group to align ALM Stakeholders** and coordinate their inputs into the overall ALM activities by defining the roles and responsibilities of different stakeholders to enhance collaborative implementation; the Technical Working Group aims to encourage diverse solutions from a vast pool of technical experts across development partners, private sectors and other stakeholders to ensure that no health financing dimension is left uncovered.
4. **Launch the pilot in SADC and EAC:** AUDA-NEPAD will support SADC and EAC in launching the pilots.
5. **Develop a platform for a community of best practices and cross-learning among the 8 RECs.** Cross-learning among the RECs as they work toward operationalising the RHFH structures in the respective regions is a fundamental pillar of the RHFH process, as such in it's key that these platforms of best practice are established in the early stages of the RHFH formation

10. MONITORING & EVALUATION

Monitoring and Evaluation is the process by which data are collected and analyzed to provide information to the various levels of decision makers and stakeholders for use in the RHFH program planning and management. It is an enabler for evidence informed strategic decisions regarding RHFH operations. Monitoring and evaluation of the RHFH functions is one of the essential ingredients in the Hubs planning and management to promote accountability and transparency and to provide incentives for RECs and Members States to use funds efficiently and effectively.

Monitoring of the Hubs functions involves the collection of routine data that measure progress toward achieving Hub's objectives. It is a process evaluation because it focuses on the implementation process; it is a process for checking that activities are being implemented as planned, and mainly looks at inputs, process, and outputs. **Evaluation** measures how well the Hub's activities/functions have met the expected objectives and/or the extent to which changes in outcomes can be attributed to the functions/interventions.

Figure 20. Link between program planning, implementation and M&E



10.1 Results Framework

The foundational element of the results framework is tracking result areas of the **Regional Hub's Functions**:

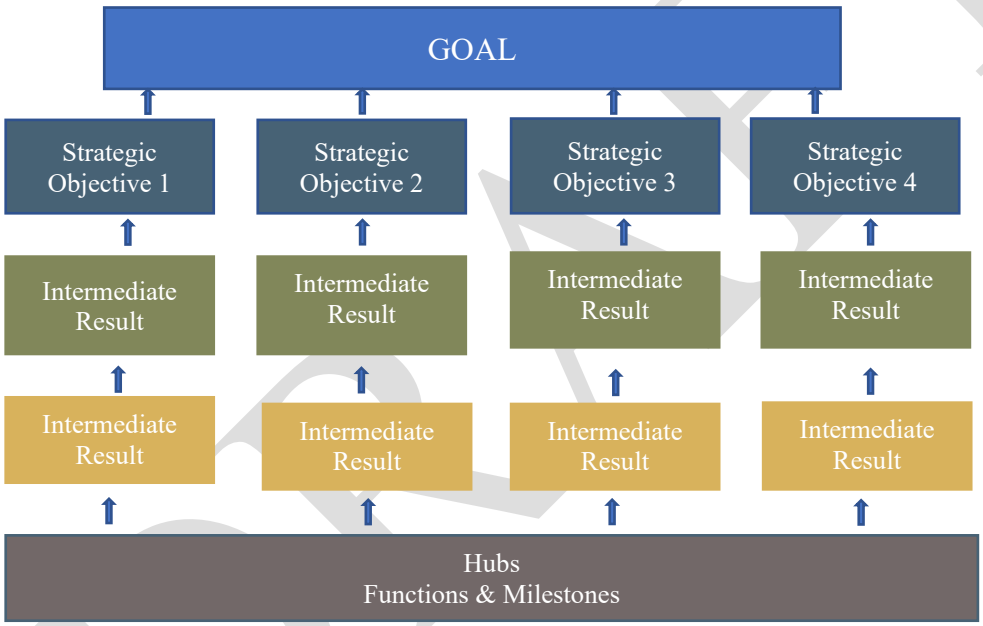
- **Function 1:** Drive the exploration of viable domestic financing mechanisms
- **Function 2:** Provide strategic regional policy advisory services
- **Function 3:** Leverage development partner and private sector engagement
- **Function 4:** Enhance utilization of diagnostic and tracking tools
- **Function 5:** Provide technical assistance services to Member States
- **Function 6:** Facilitate knowledge sharing among MS and RECs
- **Function 7:** Resource mobilization
- **Function 8:** Support research, innovation, and entrepreneurship

The key functions of the RHFH support the achievements of the **Goal** and higher-level **Strategic Objectives** of the ALM-Investing in Health initiatives related to domestic

health financing reform (Increased domestic health resource mobilization, improved national health financing system, and effective, efficient, and equitable health budget allocation and spending), development partners and private sector investment alignment and harmonization, and Government leadership (political will and commitment). The outcomes of these Strategic Objectives and the interventions/outputs to achieve the expected results will be tracked using indicators and tools that will be developed by Tracker, Africa Scorecard, and Private Sector Engagement (PSE) Subcommittees. The analysis of the outcome of the strategic objectives will guide the need for recalibration of the functions of the RHFH.

(Figure 21) below summarizes the conceptual result framework and how the RHFH are positioned to support the achievements of the **Goal** and **Strategic Objectives** of the ALM-Investing in Health initiative. The final result framework for the ALM-Investing in Health initiative will be constructed once the key result areas and indicators of each Strategic Objectives are identified by Tracker and PSE Subcommittees.

Figure 21. Conceptual Results framework for ALM-Investing in Health Initiative



10.2 Hub's Milestones

Table 6 outlines the proposed key millstones of the Hub's function that will be reviewed and incorporated on the ALM-Investing in Health initiative Result Matrix once the Tracker and PSE indicators are defined and activities are clearly articulated. This will also enable defining indicators baseline and target values for each year, data source and the agent(s) responsible for collecting or providing the data, designated time intervals at which the data will be collected and reported, and assumptions and risks associated with the millstones and indictors.

Table 5. Milestones/outputs of RHFH functions and proposed indicators

Outputs/Milestones	Indicators
Function 1: Drive the search for viable domestic financing mechanisms	
Viable domestic financing mechanisms are identified to support health financing reform in MS	- Types of feasible domestic financing mechanisms identified - # of countries supported, disaggregated by type of financing mechanisms (taxation/revenue collection systems, health financing systems, and health spending) - Types of innovative financing mechanisms adopted and implemented by MS, disaggregated by MS
Function2: Provide strategic regional policy advisory services	
Evidence based policy guidance are provided to MS	- Types of policy guidance provided - # of countries benefited from policy guidance - Regional policy guidelines developed for adoption by MS - Policy frameworks developed and adopted at national level
Function 3: Leverage development partner and private sector engagement	
Increased coherence of partners and private sector engagement to regional and MS priorities	- Establishment of partners coordination forum at regional and MS level - Alignment of partners and private sector investment in health to the regional and MS priorities - Review and adoption of policy and regulatory frameworks for private sector engagement at regional and national levels
Function 4: Enhance utilization of diagnostic and tracking tools	
Tracker and Scorecard data are used for strategic decision making in health financing reform	- Tracker indicators are integrated in the national reporting system and regularly reported - Africa Scorecard are digitized and updated annually - # of countries provided with technical support for the application of tools (desegrated by MS and type of technical support)
Function 5: Provide technical assistance services to Member States	
Member State's technical capacity needs are identified and supported	- # of MS covered with capacity needs assessment - # of countries provided with backstopping services (disaggregated by type of technical support and MS) - # of training provided for MS (disaggregated by type of training and MS)
Function 6: Facilitate knowledge sharing among MS and RECs	
Knowledge sharing platforms in place in Hubs and MS	- Online knowledge sharing platforms developed and functional - Online resources published and circulated - Establishment of technical and policy reform platforms at country and RECs level - # of exchange visits conducted between RECs and MS - Hosting of workshops for officials on a defined sustainable domestic health financing topic
Function 7: Resource mobilization	

Outputs/Milestones	Indicators
Increased financial resources for priority regional and national initiatives	- Amount of funds mobilized by source of funding per year - # of regional and national priority projects successfully funded per year
Function 8: Research, innovation and entrepreneurship	
Improved data collection and availability of evidence for decision making	- # of MS supported in data collection and analysis, research, innovation and entrepreneurship - # of individuals trained in data collection and analysis, and entrepreneurship disaggregated by MS and type of training

10.3 Reporting and Feedback Framework

RHFH are expected to monitor progress and supervise the implementation of program activities, and resolve problems in program implementation by undertaking the following:

- Produce quarterly and annual reports using guidelines and templates provided by AUDA-NEPAD
- Annual review meetings with AUDA-NEPAD and Stakeholders to discuss implementation progress
- Participate in joint supportive supervisory visits and feedback sessions by AUDA-NEPAD and partners

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ANNEXES

Annex 1: ALM-Investing in Health Declaration

Assembly/AU/Decl.4(XXXII)

32nd Ordinary Session of the Assembly, 10- 11 February 2019, Addis Ababa, Ethiopia

DECLARATION OF THE AFRICA LEADERSHIP MEETING – INVESTING IN HEALTH "ADDIS ABABA COMMITMENTS TOWARDS SHARED RESPONSIBILITY AND GLOBAL SOLIDARITY FOR INCREASED HEALTH FINANCING"

WE, the Heads of State and Government of the African Union, meeting at the 32nd Ordinary Session of the Assembly of the Union in Addis Ababa, Ethiopia, from 10 to 11 February 2019, reviewed the progress, challenges and next steps needed for increased financing to strengthen health systems and achieve Universal Health Coverage (UHC);

Taking Note of the key outcomes of the Africa Leadership Meeting – Investing in Health, we recommitted to increased domestic investments and urged the private sector and global health financing mechanisms to increase investments to address Africa's health priorities;

Recalling Agenda 2063' Africa's blueprint for socio-economic transformation that calls for increased domestic investments to strengthen health systems as a foundation for solid inclusive growth, prosperity, peace and structural transformation, the 'Africa Health Strategy (2016-2030)' that seeks to strengthen health systems and achieve universal health coverage, the 'Catalytic Framework to end AIDS, TB and Malaria in Africa by 2030', the 'Maputo Plan of Action (2016-2030) for Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa', all endorsed by the Assembly in 2016, and the Declaration on 'Universal Access to Immunization as a Cornerstone for Health and Development in Africa', adopted by African Ministers of Health in 2016;

Recognizing the broader health and development agenda of 'Agenda 2030' and the continued efforts to advocate for, and prioritise health as central to sustainable development;

Also Recognizing that Sustainable Development Goal 3, on the achievement of universal health coverage, can only be achieved with country leadership and the support of multi-lateral and bi-lateral partners, other strategic partners and the private sector;

Noting that the Africa Scorecard on Domestic Financing for Health of 2018 demonstrates that 36 of 55 AU Member States (65.5%) have increased the percentage of GDP invested in health over the previous financial year;

Noting with Concern that, despite this increased investment in health, the level of investment means that only 2 (3.6%) of 55 AU Member States meet the target of dedicating at least 5% of the government budget to health and for this level of investment to exceed $86.30 USD per capita;

Also Noting with Concern that very few developed countries meet the commitment to allocate 0.7% of Gross National Product (GNP) to Official Development Assistance;

Bearing in Mind that the achievements of the last eighteen (18) years towards achieving Universal Health Coverage depended largely on the political will and commitment by Africa's top leadership as well as strategic partnerships at all levels;
Expressing Concern on increased public health threats on the continent that require more concerted efforts to strengthen health systems and significant increase in investments to meet continental targets to end priority diseases by 2030;

Affirming that sustainable and diversified health financing is a shared responsibility which cannot be achieved without global solidarity and collective effort and cognizant of the importance of health and education in developing the human capital needed to drive economic growth, stability, peace and security;

Taking Note of the upcoming Replenishments of the Global Fund to Fight AIDS, TB and Malaria, Gavi, the Vaccine Alliance and the African Development Bank (AfDB) and of the importance of the recent Global Financing Facility (GFF) Replenishment meeting and requests African Union Member States to actively support those Replenishments;

DO HEREBY SOLEMNLY:

1. **COMMEND** the continued global, continental, regional and national efforts to keep health financing high on the political agenda;

2. **ALSO COMMEND** the support of international development partners and Global Health Financing Mechanisms to increase investments in health in the context of competing development priorities;

3. **REAFFIRM** our commitment to increase domestic health resources mobilisation and progressive taxation;

4. **CALL UPON** the private sector to support and invest in expanding access to quality health care services and achieving UHC;

5. **ALSO CALL UPON** Member States and partners to fully implement the Pharmaceutical Manufacturing Plan for Africa Business Plan and Regulatory Harmonisation for increased access to affordable and quality-assured medicines, vaccines and new health technologies, including generics, as well as negotiating for affordable prices for vaccines and medicines for priority diseases;

6. **To this end, WE UNDERTAKE** to:

i) **increase** domestic investments in health and improve health financing systems in a context-appropriate manner so that each country can pursue its own path to achieving and sustaining Universal Health Coverage and that the people of the African continent can receive qualitative, accessible

and affordable prevention, diagnosis, treatment and care services they need without suffering financial hardships;

ii) **mobilise** sufficient and sustainable financing to strengthen health systems and achieve Universal Health Coverage;

iii) **foster** cooperation between public and private sectors to create synergies and deliver health for all;

iv) **request** the Commission and partners to ensure that strategies are in place for diversified, balanced and sustainable financing for health through the development of strategic health investment plans and strategies, including from the private sector;

v) **also request** the Commission to work with partners to create regional platforms to support relevant ministries, including finance and health, to catalyse, capture and scale innovations, best practices and gaps and requests multilateral, bilateral and private sector partners to support the platforms and to use them to align their efforts to those of Member States to increase domestic financing, including through improved taxation and health insurance efforts;

vi) **further request** the Commission to organise a biennial meeting of Ministers of Health and Finance to review the work of the platforms and to monitor progress;

vii) **request** the Commission to work with partners to improve the monitoring of health financing through greater annual implementation of National Health Accounts and wider dissemination; and

viii) **redouble** efforts to promote national health insurance systems, including greater coordination with and access to resources of the Global Fund to Fight AIDS, TB and Malaria, Gavi, the Vaccine Alliance and the AfDB;

7. **REQUEST** the Commission to monitor the implementation of the recommendations of the Africa Leadership Meeting-Investing in Health and report to the Assembly regularly;

8. **ALSO REQUEST** the Commission and partners to support the implementation of the commitments on health financing and to develop an accountability framework to monitor implementation of this Declaration;

9. **EXPRESS** our gratitude to H.E. President Paul Kagame of the Republic of Rwanda for hosting the Africa Leadership Meeting-Investing in Health;

10. **APPOINT** His Excellency President Paul Kagame as Leader for Domestic Health Financing.

Annex 2: Draft ALM-Investing in Health Technical Working Group ToR