**COMESA Health Framework**

**2016**

# Table of Contents

## Acronyms

| | |
|---|---|
| AEC | African Economic Community |
| AIDS | Acquired Immuno-deficiency Syndrome |
| AMU | Arab Maghreb Union |
| ART | Anti-Retroviral Therapy |
| ASDG | African Solemn Declaration on Gender |
| ATI | Africa Trade Insurance Agency |
| ATM | African Traditional Medicine |
| AU | African Union |
| CCC | COMESA Competition Commission |
| CEN-SAD | Community of Sahel and Saharan States |
| CMI | COMESA Monetary Institute |
| COMESA | Common Market for Eastern and Southern Africa |
| CRC | Convention on the Rights of the Child |
| CRPD | Convention on the Rights of People with Disabilities |
| CSOs | Civil Society Organisations |
| ECCAS | Economic Community of Central African States |
| ECOWAS | Economic Community of West African States |
| FBO | Faith-Based Organisation |
| FEMCOM | Federation of National Associations of Women in Business in Common Market for Eastern and Southern Africa |
| GDP | Gross Domestic Product |
| GSAD | Gender and Social Affairs Division |
| HIV | Human Immuno-deficiency Virus |
| HMIS | Health Management Information System |
| HTC | HIV Testing and Counselling |
| ICT | Information Communication Technology |
| IGAD | Inter-Governmental Authority on Development |
| ILO | International Labour Organisation |
| IMF | International Monetary Fund |
| IPPA | International Planned Parenthood Association |
| MPA | Maputo Plan of Action |
| NCD | Non-Communicable Disease |
| PC | Population Council |
| PI | Plan International |
| PMPA | Pharmaceutical Manufacturing Plan for Africa |
| PMTCT | Prevention of Mother-To-Child Transmission |
| PPPs | Public Private Partnerships |
| PTA | Preferential Trade Area |
| RECs | Regional Economic Communities |
| R&D | Research and Development |
| SADC | Southern African Development Community |
| SADCDG | Southern African Development Community Declaration on Gender |
| SGBV | Sexual and Gender-Based Violence |

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|---|---|
| SRH | Sexual Reproductive Health |
| StC | Save the Children |
| STI | Sexually-Transmitted Illness |
| TB | Tuberculosis |
| THPs | Traditional Health Practitioners |
| TRIPs | Trade-Related Aspects of Intellectual Property Rights |
| UN | United Nations |
| UNECA | United Nations Economic Commission for Africa |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| UNCTOC | United Nations Convention against Transnational Organised Crime |
| UNODC | United Nations Office on Drugs and Crime |
| WB | World Bank |
| WHO | World Health Organisation |

## Definition of Terms

**Affirmative Action:** A commitment to creating a state of equality by adopting and implementing deliberate measures that elevate the status of disadvantaged groups or persons.

**Child Labour:** Work being performed by children under the age of 16 that leads to the detriment and endangerment of the child's psychological, physical, social, spiritual and mental development.

**Community:** Refers to a social unit of any size that shares common values.

**Culture:** A whole range of complex and distinctive spiritual, material, intellectual and emotional attributes that characterise a society or social group.

**Cultural practices:** Functional roles and rituals that are culturally determined and assigned to both sexes.

**Empowerment:** The process of gaining access to and ownership of resources and developing one's capacities with a view to participating actively in shaping one's own life and that of one's community in economic, socio-cultural, political and religious terms.

**Feminisation of poverty:** A concept used to describe a state of poverty incidence that disproportionately affects women relative to other segments of the population.

**Gender:** Culturally and socially-constructed differences and relations between males and females. These vary widely among societies and cultures and change over time. Gender roles are learned behaviours in a given society or other social group. They condition which activities, tasks and responsibilities are perceived as appropriate to males and females, respectively. Gender relations are also relations of power which affect who can access and control tangible and intangible resources and make decisions. Gender roles are affected by age, socio-economic class, race/ethnicity, religion, and geographical, economic, political and cultural environments (ILO, ABC of Women's Workers rights and gender equality, 2007).

**Gender-Based Violence (GBV):** An act of aggression intended to cause physical, psychological, economic, social and emotional harm to a person due to their gender in society. Forms of gender-based violence may include rape, defilement, spouse battering, property grabbing, incest and sexual cleansing.

**Gender-disaggregated data:** Presentation of data by male/female classification.

**Gender equality:** A situation where women and men have equal conditions for realising their full Human Rights and potential to contribute to and benefit from socio-economic, cultural and political development of a nation, taking into account their similarities, differences and varying roles that they play (Government of the Republic of Zambia, National Gender Policy, 2000).

**Gender equity:** Fairness of treatment of different needs and interests of women and men taking into account corresponding rights, duties, obligations, benefits and opportunities (ILO, ABC of Women Workers' Rights, 2007).

**Gender analysis:** Understanding the situation of women and men, boys and girls in terms of their constraints, needs, priorities and interests. It also identifies how public policies or programmes and projects affect women and men differently. Gender analysis results in gathering gender-disaggregated data which is very crucial when planning and implementing development projects and programmes.

**Gender blind**: Ignoring or failing to address the gender issues and concerns.

**Gender gap**: Gap in any area between women and men in terms of their levels of participation, access to resources, rights, remunerations or benefits.

**Gender inequalities/gaps/imbalances**: Discrepancies or differences between women and men, or boys and girls in terms of their conditions of how they access or benefit from resources that arise from their different gender roles.

**Gender issues**: Concerns that are related to injustice and inequality based on gender roles.

**Gender mainstreaming**: The process of assessing the implications for women and men of any planned action, including legislation, policies or programme in any area and at all levels. It is a strategy for making women's as well as men's concerns and experiences integral dimensions of the design, implementation, monitoring and evaluation of policies and programs in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated (ECOSOC).

**Gender perspective**: The views and ideas of both women and men are taken seriously; differentiation is made between the needs and priorities of women and men; action is taken to address inequalities or imbalance between women and men; and implications of decisions on the situation of women relative to men are considered.

**Gender relations**: Socially determined relations between and among women and men or boys and girls in how power is distributed between them.

**Gender responsive**: Being aware of existing gender gaps, disparities and their causes and taking action to address and overcome gender-based inequalities.

**Gender roles**: Functional responsibilities that may be assigned by society to males and females and are influenced by cultural, political, religious or economic situation.

**Human Rights-Based Approach**: A principle that ensures that due regard is given to safeguarding and protecting fundamental Human Rights entitlements in the planning, implementation, monitoring and evaluation of development policies, plans, strategies and programmes. Operationalisation of the principle should be accompanied by the identification of Human Rights right-holders and duty bearers.

**Human Rights:** Fundamental Freedoms and Human Rights that every person is entitled to in the Constitution of the Republic of Zambia and international human rights conventions and agreements to which Zambia is party.

**Human Trafficking:** Recruitment, transportation, transferring, harbouring or receiving of a person through force, abduction, threat, coercion, fraud or deception for purposes of exploitation.

**Non-Communicable Disease (NCD** is a medical condition or disease that is non-infectious and cannot be transmitted from one person to another. NCDs often last for long periods of time and progress slowly. Certain NCDs, such as autoimmune diseases, heart diseases, stroke, cancers, diabetes, chronic kidney disease, osteoporosis, Alzheimer's disease and cataracts may result in sudden death.

**Poverty:** The inability of an individual, family or community to attain a minimum standard of living.

**Productive:** Ability to produce value-added goods or services.

**Role stereotypes:** Rigidly held and over generalised beliefs that males and females by virtue of their sex possess distinct traits and characteristics.

**Reproductive:** Refers to the biological process by which new individual organisms/off-springs are produced.

**Sex roles:** The functions that females and males perform on the basis of their reproductive, physiological or biological makeup.

**Sex:** The biological differences between females and males that are naturally defined attributes of an organism.

**Socialisation:** A process through which a person learns all things that he/she needs to know to function as a member of a specific society.

**Traditional Practices:** Acts that are performed by people over and over again and which become part and parcel of one's day-to-day life and are usually subjects of the mainstream society.

**Triple Roles of Women**: Refers to the roles that women play as mothers, home carers and workers.

## 1.0. Introduction

1.      The Common Market for Eastern and Southern African (COMESA) comprises independent sovereign States of Burundi, Comoros, Democratic Republic of Congo, Djibouti, Egypt, Eritrea, Ethiopia, Kenya, Libya, Madagascar, Malawi, Mauritius, Rwanda, Seychelles, Sudan, Swaziland, Uganda, Zambia and Zimbabwe. It is home to an estimated population of over 480 million people, or 51 percent of the 936.1 million population of Sub-Saharan Africa, and 43 per cent of the continent's 1.1 billion people. Full cooperation in trade, customs and monetary affairs constitutes key pillars of its regional economic integration agenda.  In 2008, COMESA agreed to an expanded free-trade zone including the East African Community (EAC) and Southern African Development Community (SADC).

2.      The COMESA region is characterised by high burdens of communicable and non-communicable diseases. Several factors drive disease burdens in the COMESA region, and Africa as a whole. Among them are: Inadequate health budgets, which often fall well below the Abuja Declaration threshold of 15 per cent of national budgets resulting in weak and fragile health systems which do not allow pro-active, efficient and effective disease prevention, early diagnosis and treatment of diseases and management of disease outbreaks; limited medical research and development; poor retention of qualified medical personnel;  poor medical equipment; poor transport and telecommunications infrastructure; concentration of national health budgets on diagnosis and treatment of known communicable diseases deficits of trained personnel for treating NCDs; limited access to information; inadequate involvement of communities; rapid urbanisation and its unplanned urban settlements; overcrowding and inhuman housing; poor nutrition; poor access to clean water and sanitation; environmental degradation; gender-based violence, harmful social/cultural practices; and wars and conflict.

3.      Increased movement of goods and people across borders has resulted in heightened risk of communicable disease infections, particularly Sexually-Transmitted Infections (STIs), HIV, Cholera, Malaria, Hepatitis, Tuberculosis (TB) and Yellow Fever. Epidemics require strengthened and coordinated multi-country responses as no single country has the capacity to meaningfully screen and treat, let alone contain, disease epidemics and pandemics.

4.      Negative socio-economic impacts of the disease burden have been manifested in, *inter alia*, reversal of economic gains, loss of qualified manpower, unexpected spikes in budgetary allocations to the health sector and strained health infrastructure and service delivery systems. Disease outbreaks, especially on a pandemic scale, leave communities existentially dislocated in ways that require several years of concerted economic and social reconstruction. In addition, the rapid emergence of erstwhile neglected non-communicable diseases such as hypertension, stroke, cancer, diabetes and chronic respiratory complications, including alcohol, drug and substance abuse-related diseases has limited economic growth in the region.

5.      Concerned with the negative effects of the diseases burden to Regional Economic Integration and Sustained Development, the COMESA Member States through Chapter 14 and Article 110, and Chapter 21 and Article 123 of the Treaty provided for the cooperation of Member States on Health and Social Development

respectively. This concern was reiterated in the COMESA Social Charter and through the Council of Ministers decision in 2013 that a health desk should be established at Secretariat to promote the implementation of Health programmes and focus on wider health issues affecting the region beyond HIV and AIDS, especially, sexual and reproductive health and other communicable diseases; and promote research and leveraging best practices such as the manufacturing of essential drugs.

6.      The development of the COMESA Health Framework is based on the Treaty, the COMESA Social Charter, and the Council of Ministers Decision on the establishment of a Health Desk at Secretariat to strengthen cooperation of Member States on Health. The Framework seeks to provide strategic direction to COMESA Member States in addressing health priorities and key challenges to reduce the persistent disease burden, strengthening health sectors, and use it to report on progress.

7.      The Framework begins by presenting a brief background on the regional, continental and international policy frameworks that have informed its development; situation analysis on the disease burden and factors that contribute to the disease burden; guiding principles; vision, mission, goals, strategic objectives and priority measures; accountability framework; roles and responsibilities.

## 2.0 Background

8.      The development of the COMESA Health Framework 2016 – 2030 (CHF) involved mainly the review of secondary data from various regional, continental and international policy frameworks that Member States have committed to. In addition, the process involved consultations with stakeholders including experts from Member States, African Union Commission, WHO Regional Office, UNAIDS, UNFPA, UNESCO, and UN-Women.

9.      At regional level, the policy frameworks that informed include the COMESA Treaty, COMESA Social Charter, the COMESA Gender Policy and the Eastern and Southern Africa Commitment on Comprehensive Sexuality Education. At Continental level, the CHF has been informed by the Maputo Protocol, Agenda 2063, the Catalytic Framework to End AIDS, TB and eliminate Malaria by 2030, the SRHR Continental Policy Framework on Sexual and Reproductive Health and Rights (SRHR) and its Maputo Plan of Action 2016-2030, the Pharmaceutical Manufacturing Plan for Africa, the African Regional Nutrition Strategy 2015 – 2025 and the AU Decade on Traditional Medicines. At International level, the CHF is informed by the Agenda 2030 for Sustainable Development, the Global Strategy for Women's, Children's and Adolescent Health 2016-2030, and the 2016 High-Level Resolutions on Gender, Women, Girls and HIV and AIDS and other policy frameworks.

10.     All these policy frameworks call on strengthening coordination of interventions for health in order to deliver universal, equitable, inclusive, evidence-based, innovative, well-resourced, technically sound, quality, life-saving and accountable services. Specifically, the frameworks call for Member States and Cooperating Partners to: increase health financing; scale-up immunization for disease prevention; address communicable and non-communicable diseases; prioritize child health, and sexual and reproductive health of women and adolescents; address harmful practices such as gender-based violence, child marriage, and other practices; ensure manufacturing of

essential medicines and commodities for sustained supply and universal access; strengthen health systems including Human Resource Capacity, Retention, Equipment, Technology, Information and Documentation, medical supplies, ensuring community/primary health care; and Research and Innovation; scale up Social Protection; ensure access to portable water and sanitation; end hunger and malnutrition.

11. The COMESA Health Framework responds to the priorities in of the above regional, continental and international policy frameworks mentioned in order to strengthen cooperation of Member States in addressing the prevailing challenges as well as enhance preparedness for any epidemics.

## 3.0 Situation Analysis

## 3.1 Disease Burden

12.     The Health Sector in Africa and COMESA Region in particular continues to be strained at all levels due to continued disease burden. Alongside Asia and Latin America, Africa bears a disproportionate share of the world's burden of chronic diseases. HIV, Tuberculosis and Malaria comprise the most debilitating disease burdens in the region. However, according to the African Union (AU), "Non-communicable diseases are also becoming increasingly prominent across the rest of the continent given the demographic changes that are taking place and they are predicted to overtake infectious diseases as the leading causes of death in Africa by 2030" (Pharmaceutical Manufacturing Plan for Africa Business Plan, 2012).

13.     Similarly, the World Health Organisation (WHO) has indicated that Africa increasingly faces high morbidity and mortality from non-communicable chronic diseases such as cardiovascular diseases, cancer, respiratory disease and diabetes. According to WHO, a Non-Communicable Disease (NCD) kill 38 million people each year. Almost three quarters of NCD deaths - 28 million - occur in low- and middle-income countries. Cardiovascular diseases account for most NCD deaths and affects 17.5 million people annually, followed by cancers (8.2 million), respiratory diseases (4 million), and diabetes (1.5 million). Tobacco use, physical inactivity, the harmful use of alcohol and unhealthy diets such as consumption of fatty and refined foods all increase the risk of dying from a NCD. Other factors that cause NCDs include ageing, rapid unplanned urban settlements and illegal substances.

14.     In addition, the African region is plagued by other diseases such as Pneumonia, Diarrhoea, Cholera, Measles, Onchocerciasis, Trypanosomiasis, Schistosomiasis, Dracunculiasis, Filariasis, Meningitis and Ebola, including periodic outbreaks of Human Avian Influenza. Aside from these, the African region has seen an upsurge in cases of severe injuries and health conditions arising from, *inter alia*, road and industrial accidents, demographic and environmental degradation, crowding, adoption of unhealthy diets, lack of exercise, gender-based violence, harmful social/cultural practices, and habitual consumption of alcohol and illicit substances.

15.     Apart from human diseases, it has also been established that animal and plant diseases are likely to rapidly spread across borders in the absence of coordinated and robust phytosanitary inspection mechanisms. This threat is compounded by porous borders, inadequate skills and poor screening infrastructure in the region which make it almost impossible to effectively control the spread of human and animal diseases across borders. Poor mechanisms for controlling domestic and wild animal movements across borders in the region also compromise the region's capacity to respond to and fight animal-related disease burdens. It further makes it difficult to ascertain the source of, let alone contain, certain Bovine disease outbreaks. Evidence further suggests that there are inadequate institutional mechanisms for collaboration in support of rapid responses to disease outbreaks.

16.     The detailed situation analysis is attached in the **annex** of the framework.

# VISION, STRATEGIC OBJECTIVES AND INTERVENTIONS ON THE HEALTH CHALLENGES

## 4.0. Vision

17. A COMESA region free from the threat of preventable communicable and non-communicable diseases and death in line with the Abuja +12 2030 Target Catalytic Framework to End HIV/AIDS, TB and Malaria by 2030.

## 5.0. Strategic Objectives

18. The COMESA Health Framework seeks to ensure that the region is free from the threat of preventable communicable and non-communicable diseases and death in tandem with the Abuja +12 2030 Target Catalytic Framework to End HIV/AIDS, TB and Malaria by 2030, the Ending the AIDS Epidemic 90-90-90 Strategy and the UN Sustainable Development Goal No. 3. Specifically, the Framework is meant to:

19. Strengthen national and regional health systems and infrastructure;
Ensure that national and regional health policies are developed from a Human Rights Approach;
   i. Ensure access to health services by all;
   ii. Reduce the disease burden in the region and death from preventable diseases;
   iii. Establish mechanisms for health information-sharing;
   iv. Establish capacity for health Research and Development (R&D) and production of medicines and supplies;
   v. Establish mechanisms for health information sharing; and
   vi. Build capacity for coordination, monitoring and evaluation of national and regional health policies and programmes.

## 6.0. Strategic Interventions

## 6.1. Communicable and Non-Communicable Diseases

20. Experience shows that disproportionate amounts of health resources in the region are directed towards diagnosis and treatment of known communicable diseases at the expense of non-communicable diseases. Given the rapid increase in non-communicable diseases, Member States should:

i. Revisit their prioritisation of health budgets with a view to ensuring that non-communicable diseases are given due attention in national health budgets;
ii. Pro-actively train specialist health personnel for handling non-communicable diseases;
iii. Prioritise health research areas in non-communicable diseases; and
iv. Promote healthy lifestyles through, inter alia, provision of affordable public recreational infrastructure.

**6.2. Drivers of the Disease Burden and Measures to Address the Challenges**

21.     Disease burdens in the COMESA region, and Africa as a whole, are primarily driven by several factors among which is generalised poverty. However, the following are the common drivers of most known disease burdens in the COMESA region and Africa as a whole.

**6.2.1. Fragile Health Systems and Infrastructure**

22.     Poor and fragile health systems and related infrastructure are among major factors that hinder effective delivery of health services not only in the COMESA region but in Africa as a whole. This has largely been caused by prolonged neglect and, in some cases, poor prioritisation of health in national budget frameworks. Member States should, therefore:

i.     Heavily invest in construction of health-related infrastructure; and
ii.    Build mechanisms for sustainable maintenance of health infrastructure.

**6.2.2. Inadequate Health Budgets**

23.     Most national economies in the region lack requisite resource capacity to adequately invest in health and depend on external resource in-flows to fund their core health programmes. This challenge is compounded by inadequate prioritisation of health in the allocation of budgetary resources.  Member States should, therefore, ensure that:

i.     They allocate a minimum of 15 per cent of their national budgets to the health sector in tandem with the Abuja Declaration;
ii.    Prioritise Public Private Partnerships in resource mobilisation for health; and
iii.   Strengthen mechanisms for improved accountability and transparency in health resource management.

**6.2.3. Environmental Degradation**

24.     Human pressure on the environment and the rapid rate of urbanisation, unplanned urban settlements, including effects of global warming, have negatively impacted not only on the capacity of Member States to adequately provide health care services but also on the ability of communities to access medical care. Breached urban environments and urban crowding have combined to exacerbate the vulnerability of urban dwellers to disease and pre-mature death. In order to address these and other challenges, Member States should:

i.     Pro-actively promote proper human settlements, especially in urban areas;
ii.    Tie urban development to adequate Social and Environmental Impact Assessments (SEIAs);
iii.   Address environmental degradation caused by pollution, deforestation, underground and open cast mining and uncontrolled agricultural land clearing; and
iv.    Sensitise communities to the inter-relationship among disease burdens, poverty, pollution, deforestation and environmental degradation.

### 6.2.4. Poor Nutrition

25. There is broad consensus that poor nutrition is one of the major drivers of disease burdens not only in the COMESA region but in Africa as a whole. COMESA States should, therefore, take steps to:

    i. Comprehensively review their national agricultural policies with a view to aligning them to CAADP;
   ii. Prioritise rural agriculture and infrastructure in national development planning;
  iii. Mainstream nutrition in national development and social protection policies and programmes; and
  iv. Progressively make access to food, clean water and sanitation by all justiciable.

### 6.2.5. Violations of Sexual Reproductive Health Rights

26. Violations of sexual reproductive health-related Human Rights are ever-increasing challenges in the region. In addition, gender-based injustices, such as Sexual and Gender-Based Violence (SGBV, discrimination, social exclusion and exclusion from key decision-making structures, are routinely reported in the region. These injustices severely compromise programmes that are targeted at ensuring equitable, inclusive and sustainable human development and equitable access to health. Member States should, therefore, ensure that:

    i. Sexual reproductive health and rights are pro-actively promoted as part of basic Human Rights;
   ii. Sexual reproductive health and rights information are integrated in reproductive health service delivery systems;
  iii. Sexual reproductive health and rights are mainstreamed in pre-and in-service training curricula of all health training institutions;
  iv. Communities are adequately ventilated with sexual reproductive health and rights information and messages;
   v. All sexual reproductive health and rights-related sub-regional, regional and international conventions and agreements are domesticated;
  vi. Mechanisms for simultaneous provision of female and male sexual reproductive health and rights information are provided in all health facilities;
 vii. Institutional capacities for monitoring and evaluation of sexual reproductive health and rights policies, strategies and programmes are strengthened; and
viii. A life-cycle approach to the provision of integrated sexual reproductive health and rights services as way of meeting gender and age-appropriate needs is adopted.

### 6.2.6. Poor Adolescent Sexual and Reproductive Health

27. Young people face multiple sexual and reproductive health-related challenges which compromise their development and prevent them from realising their full social and economic potential. Sexual and reproductive health-related challenges such as various forms of sexual and gender-based violence further compromise the ability of affected adolescents to acquire skills that are vital for prevention of inter-generational poverty. It is, therefore, important that Member States take necessary measures to ensure that:

i. Adolescent sexual reproductive health is pro-actively promoted as part of basic Human Rights;
ii. Adolescent sexual reproductive health is mainstreamed in pre-and in-service training curricula of all health training institutions, including primary and secondary schools;
iii. Adolescents are recognised as a special population group that need to be targeted with tailor-made sexual reproductive health services;
iv. Adolescent-friendly sexual reproductive health corners are established in all heath facilities, schools and colleges;
v. All schools and colleges establish sexual reproductive health peer groups.
vi. Adopt multi-sectoral approaches in addressing negative social and cultural norms and practices, including harmful traditional practices such as early marriages and Female Genital Mutilation (FGM);
vii. Adopt and enforce policies, legislation and other measures, including actions on age-appropriate reproductive health education, as a means of addressing teenage pregnancy, forced marriage, elopement, patriarchy and other vices such as Female Genital Mutilation and child trafficking;
viii. Stiffen legislation and punishment for rape, defilement, elopement and abduction.
ix. Review and harmonise child-related legislation and policies with a view to, inter alia, expunging them of contradictions and inconsistencies;
x. Enforce compulsory and comprehensive early and primary education; and
xi. Promote the role of CSOs in adolescent sexual reproductive health.

### 6.2.7. Poor Maternal Health Care

28.     Due to their combined reproductive and productive roles, women experience special challenges relative to their male counterparts. Consequently, Member States shall:

i. Ensure full domestication and implementation of internationally-agreed conventions on maternity protection (such as the ILO Recommendation 183 and Recommendation 191) and support for workers with family responsibilities;
ii. Engender national and cross-border trade policies with a view to taking into account maternal health-related needs of women;
iii. Establish mechanisms for the promotion of male involvement in maternal health care (e.g. paternal leave, antenatal and post-natal care);
iv. Improve availability of maternal health-related infrastructure in rural and hard-to-reach areas and along intra-regional transport corridors;
v. Increase access to maternal and reproductive health-related information among customs and immigration officials in the region.

### 6.2.8. Gender Inequalities

29.     Disease burdens affect all irrespective of sex and gender. However, women and girls often bear the heaviest brunt of disease burdens due to gender-related inequalities and socially-assigned responsibilities. In order to address this challenge, Member States have the obligation to ensure that they:

i. Ensure that communities recognise and compensate the care role that females play in family settings;
ii. Invest in infrastructure systems and mechanisms that reduce the burden of care work in family settings;
iii. Promote male involvement in care of the sick in family settings;
iv. Develop special assistance, empowerment and impact mitigation programmes for women and girls suffering from effects of disease burdens;
v. Mainstream gender in disaster management and mitigation policies and programmes; and
vi. Build and strengthen capacities of national and regional gender machineries for addressing challenges faced by women and girls affected by disease burdens.

### 6.2.9. Child Marriage

30. Child marriage is an abuse of Human Rights and severely compromises the health of affected children. Member States should, therefore:

i. Resolutely fight the scourge through targeted policies and pieces of legislation;
ii. Review and strengthen laws that deal with child marriage;
iii. Stiffen punishment against offenders;
iv. Harmonise child-related policies and laws;
v. Address cultural and traditional practices that contribute to child marriage with the full involvement of traditional leaders;
vi. Appoint selected traditional leaders and famous sportswomen and men, including musicians, as anti-child marriage ambassadors; and
vii. Effectively use Roundtables of Spouses of COMESA Heads of State and Government to address the challenge of child marriage.

### 6.2.10. Alcohol, Drugs and Substance abuse

31. Over the last couple of decades, many Member States have been facing rising cases of abuse of alcohol, drugs and substances. The scourge has negatively impacted regional economies and, therefore, it is important that Member States take necessary measures to:

i. Acknowledge the negative impact of alcohol, drug and substance abuse on human development;
ii. Develop strong national alcohol, drug and substance abuse policies and laws;
iii. Stiffen penalties against alcohol, drug and substance abuse;
iv. Address root causes of alcohol, drug and substance abuse;
v. Establish empowerment programmes for abusers of alcohol, drugs and substances;
vi. Closely support and work with organisations involved in counselling and rehabilitation of alcohol, drug and substance abuse abusers;
vii. Domesticate international alcohol, drug and substance abuse-related conventions and agreements;
viii. Closely collaborate and work with international alcohol and drug control organisations such as the United Nations Office on Drugs and Crime (UNODC)

and the United Nations Convention against Transnational Organised Crime (UNCTOC), including relevant CSOs;

ix.   Strictly regulate production of alcohol, drugs and substances; and

x.   Strictly enforce liquor licensing laws.

### 6.2.11. Harmful Cultural and Traditional Practices

32.   Some cultural and traditional practices, such as certain aspects of initiation ceremonies, Female Genital Mutilation (FGM) and sexual cleansing, tend to compromise the health of affected young people. Cognisant of this, and while acknowledging the centrality of culture and traditions in community life in the region, Member States should:

i.   Review existing policies and legislation relating to culture and tradition with a view to removing contradictions between culture and tradition on one hand, and demands of modern life on the other;

ii.   Pro-actively sensitise communities to health-related dangers of certain cultural and traditional practices;

iii.   Appoint selected traditional leaders as champions in the fight against negative cultural and traditional practices;

iv.   Closely involve traditional leaders in the promotion of positive aspects of cultural and traditional practices; and

v.   Promote the participation of women in community and national key decision-making structures.

### 7.0. Other Health Challenges
### 7.1. Poor Transport and Telecommunications Infrastructure

33.   Elaborate and efficient transport and telecommunications are vital cogs in any health system as they facilitate, *inter alia*, expeditious and sustainable distribution of drugs, medical equipment, supplies and personnel, including referrals between and among various levels of the health care system. COMESA Member States should, therefore:

i.   Fast-track implementation of prioritised cooperation areas in transport and communications under Articles 84-98 of the COMESA Treaty;

ii.   Prioritise investments in new transport and telecommunications infrastructure, especially in rural and hard-to-reach areas;

iii.   Invest health-related Information and Communication and Technologies (ICTs); and

iv.   Promote e-medicine as a way of broadening access to health care by all, especially by populations in rural and hard-to-reach areas.

### 7.2. Disability

34.   It is a universally-agreed principle that all persons, by dint of being human, have an inalienable right to the full enjoyment of basic Human Rights; and this applies to

people with all forms of disabilities. Cognisant of this, all Member States have the obligation to ensure that they:

i. Undertake targeted studies to establish the actual extent of disabilities and a gap analysis of special needs of people with disabilities;
ii. Sensitise communities to the fact that disability is not equal to inability to contribute to societal socio-economic development;
iii. Review all disability-related policies, laws and regulations with a view to, inter alia, aligning them to special needs of people with disabilities;
iv. Enact legislation for ensuring that all planned public buildings have user-friendly facilities for people with disabilities;
v. Mainstream disability in national development planning frameworks;
vi. Domesticate all disability-related international conventions and agreements, especially the International Convention on the Rights of People with Disabilities (ICRPD);
vii. Develop and offer fiscal and monetary incentives to local manufacturers and importers of orthopaedic equipment and materials;
viii. Adequately fund and equip disability-related training and rehabilitation facilities;
ix. Train and increase the cadre of specialised personnel for addressing challenges of people with disabilities;
x. Strengthen and work with national associations of people with disabilities and other relevant stakeholders in developing and implementing programmes for demystifying disability;
xi. Reserve quotas for qualified persons with disabilities in public sector employment, training and economic empowerment programmes;
xii. Involve people with disabilities in key decision-making structures;
xiii. Provide user-friendly facilities for people with disabilities in all health facilities; and
xiv. Include special provisions for people with disabilities in national social protection policies and programmes.

## 7.3. Mental Illness

35. Mental illness is like any other disease and should, therefore, be demystified and allowed adequate access to national health resources. In light of this, Member States should:
i. Take all necessary measures and steps to demystify mental illness;
ii. Domesticate all international mental illness-related conventions and agreements;
iii. Train and increase the cadre of specialised health personnel for addressing challenges of persons with mental illness;
iv. Develop and implement special programmes for re-integration of former mental patients into society;
v. Increase the number of mental health facilities; and
vi. Increase funding for mental health training institutions.

## 7.4. Palliative Care

36. Increasing cases of life-long diseases that require long-term care are straining carrying capacities of health infrastructure and facilities in the region. Palliative care has

proved to be a sustainable mode for addressing challenges related to long-term care and relieving formal health facilities of the pressure brought about by the unprecedented demand for hospital bed space. Member States should, therefore, take necessary steps to:

    i.   Mainstream palliative care in national health service delivery systems;
   ii.   Mainstream palliative care in national budgeting frameworks;
  iii.   Scale up training of specialised health personnel in pain diagnosis and management;
  iv.   Adequately fund palliative care training;
   v.   Acknowledge the role that non-State palliative care institutions (such as CSOs) play in the provision of long-term palliative care services;
  vi.   Prioritise palliative care services for the elderly; and Provide budgetary resources to non-State palliative care-providers.

## 7.5. African Traditional Medicine

37.    The positive role that traditional medicine and traditional healers play in ensuring access to health by all was consensually endorsed in the 1978 Alma Ata Declaration. Member States should, therefore, take necessary steps to: Officially recognise and mainstream African Traditional Medicine and traditional healers in national health systems, policies and laws;

    i.   Enact African Traditional Medicine legislation;
   ii.   Promote clinical trials for African Traditional Medicine;
  iii.   Patent proven African Traditional Medicine;
  iv.   Implement the African Regional Strategy on Promoting the Role of Traditional Medicine in Health Systems;
   v.   Closely work with national associations that promote African Traditional Medicine; and
  vi.   Fully implement Resolutions of the Alma Ata Declaration.

## 7.6. Wars and Conflicts

38.    Wars and conflicts are known for creating conditions for increased exposure to infections and disease. Women, young persons (especially girls) and people with disabilities are particularly affected by effects of war and conflicts. In order to address this challenge, COMESA Member States should:

    i.   Establish mechanisms for prevention of wars and conflicts;
   ii.   Build national and regional capacities for handling war and conflict-related disease outbreaks;
  iii.   Establish an integrated regional fund for managing war and conflict-related health challenges;
  iv.   Build mechanisms for managing gender and disability-related impacts of war and conflicts;
   v.   Establish a regional rapid reaction force for responding to war and conflict-related health challenges; and
  vi.   Closely and meaningfully involve women in war and conflict resolution structures.

## 7.7. Health Research and Development

39.     One of the reasons behind Africa's heavy disease burden is lack of or inadequate capacity to undertake medical Research and Development (R&D). In order to fill this gap, it is important that Member States take necessary steps to:

   i.   Build consensus around priority health research areas with respect to communicable and non-communicable diseases;
  ii.   Mainstreaming of health research and development in national and regional health policies and programmes;
 iii.   Adequately and sustainably funding health research and development institutions;
  iv.   Provision of attractive remuneration and working conditions for personnel involved in health research and development;
   v.   Establishment of annual national and regional health research and development fora for show-casing products of innovative health research and development;
  vi.   Creating national and regional awards for excellence in health research and development; and
 vii.   Establishment of national and regional centres of excellence for health research and development.

## 7.8. Production of Essential Medicines and Commodities

40.     While it is acknowledged that it is unrealistic for the region to be self-reliant in the production of medicines and medical supplies, it is, however, important that the region strives to establish some ability to produce basic medicines and medical supplies. In this regard, Member States should take necessary steps to ensure that they:

   i.   Expeditiously implement provisions of the Pharmaceutical Manufacturing Plan for Africa (PMPA);
  ii.   Fully implement provisions of the COMESA Industrialisation Policy: 2015-2030 and prioritised areas under Articles 99-105 in the COMESA Treaty;
 iii.   Create enabling policy and legal environments for the promotion of both local and foreign investments in the production of medicines, medical supplies and equipment;
  iv.   Offer attractive fiscal and monetary incentives to local producers of medicines and medical supplies;
   v.   Improve national and regional capacities for drug and supply logistics;
  vi.   Take advantage of health-related provisions under the Trade-Related Aspects of Intellectual Property Rights (TRIPs) to establish capacity for production of medicines and medical supplies; and
 vii.   Pro-actively promote PPPs in drug and medical supplies production and logistics.

## 7.9. Public Private Partnerships

41.     Public Private Partnerships (PPPs) in health come with critical skills and other resources that fill resource gaps in the health sector. In order to enhance PPPs for health, Member States shall:

i.    Create enabling policy and legal environments for the promotion of domestic and international PPPs in health; and

ii.   Build institutional capacity for the development of bankable PPP health projects.

## 7.10. Community Involvement

42.   There is broad consensus that community participation in the development and implementation of health policies and programmes has several dividends which include, *inter alia*, people-level ownership of programmes and interventions, responsibility, accountability, transparency, security of programme assets and sustainability. It also results in building community-based champions in support of on-going health programmes. In order to increase community involvement in health, Member States should:

i.    Adopt bottom-up approaches to health policy and programme planning;

ii.   Sensitise communities to the positive relationship between good health and sustainable human development; and

iii.  Scale up training of community-based primary health care providers.

## 7.11. Coordination of Civil Society Organisations

43.   Experience amply demonstrates the positive and complementary role that Civil Society Organisations (CSOs) play in health service delivery. Mindful of this, Member States should:

i.    Acknowledge and mainstream CSOs in national health planning and service delivery systems; and

ii.   Provide direct budgetary support to CSOs that are actively involved in the delivery of health care.

## 7.12. Social Protection

44.   Social protection is necessary along the entire continuum of life as it ensures access to basic essentials of life, including health care. In this regard, Member States should:

i.    Develop dedicated and inclusive national social protection policies with clearly-defined social protection floors;

ii.   Ensure the progressive realisation of the right to food, clean water, sanitation and shelter by all and make it justiciable in national constitutions;

iii.  Mainstream social protection in all national development policies and programmes;

iv.   Domesticate all international social protection-related conventions and agreements; and

v.    Implement the COMESA Social Charter.

## 7.13. Governance

45.    Good health is an indispensable resource and is central to sustainable, inclusive and equitable human development. Good health is a fundamental and inalienable human right and, therefore, all States are obligated to ensure it is enjoyed by all citizens. Bad health, on its part, prevents business persons from doing business, keeps workers from workplaces and causes children to miss school lessons. In emphasising the importance of good health, the 1978 Declaration of Alma-Ata notes that:

> …health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector (Declaration of Alma-Ata, September 1978).

46.    The Declaration goes on to call upon all governments, regardless of politics and conflicts, to work together in ensuring the attainment of good health for all as a foundation for socially and economically-productive life. In light of this, COMESA Member States are obligated to:

  i.    Establish and manage sustainable national governance systems for health;
  ii.   Build mechanisms for guaranteeing access to good health by all; and
  iii.  Ensure domestication of all internationally-agreed conventions that urge Member States to guarantee access to health care for all.

## 7.14. Coordination

47.    Given the diversity and complex nature of national health systems of Member States, there is a likelihood that, in the absence of a regional coordination mechanism, it may not be feasible to meaningfully track the extent to which access to health care is guaranteed for all. COMESA should, therefore:

  i.    Establish an in-house capacity at its Secretariat that will allow it to not only pro-actively track disease burdens but also facilitate diagnosis and treatment of both communicable and non-communicable diseases;
  ii.   Train a dedicated cadre of health specialists as part of its epidemic preparedness and response strategy; and
  iii.  Support Member States in strengthening their capacities for communicable and non-communicable disease surveillance, diagnosis and treatment.

## 7.15. Institutional Arrangements

48.    Implementation of this Health Framework at both reginal and national levels will require dedicated and robust institutional mechanisms. Dedicated and robust regional and national implementation mechanisms will, *inter alia*, ensure that resources are mobilised and efficiently utilised, policies and programmes are coordinated and impacts

and outcomes of interventions are monitored and evaluated. Mindful of this, COMESA shall:

i. Establish a dedicated Health Desk in its Gender and Social Affairs Division (GSAD);
ii. Utilise the proposed Health Desk to operationalise Chapter 14, Article 110, of the COMESA Treaty which, *inter alia*, seeks to enhance cooperation in health matters; and
iii. Develop mechanisms for linking this Health Framework to regional health frameworks, international health-related conventions and agreements.

## 7.16. Monitoring and Evaluation

49. Tracking of the status of implementation of this Health Framework, including its people-level impacts and outcomes, will require a robust, sustainable and well-resourced Monitoring and Evaluation (M&E) framework. Consequently, COMESA should:

i. Establish a strong health-related M&E capacity at its Secretariat;
ii. Build a cadre of health-related M&E specialists with capacity to, *inter alia*, build a comprehensive database on health and demographic dynamics in the region; and
iii. Support Member States to build robust and sustainable institutional capacities for health-related M&E.

## Annex: Situation Analysis on Health in the Region

### 1. Disease Burden

50. The Health Sector in Africa and COMESA Region in particular continues to be strained at all levels due to continued disease burden. Alongside Asia and Latin America, Africa bears a disproportionate share of the world's burden of chronic diseases. HIV, Tuberculosis and Malaria comprise the most debilitating disease burdens in the region. However, according to the African Union (AU), "Non-communicable diseases are also becoming increasingly prominent across the rest of the continent given the demographic changes that are taking place and they are predicted to overtake infectious diseases as the leading causes of death in Africa by 2030" (Pharmaceutical Manufacturing Plan for Africa Business Plan, 2012).

51. Similarly, the World Health Organisation (WHO) has indicated that Africa increasingly faces high morbidity and mortality from non-communicable chronic diseases such as cardiovascular diseases, cancer, respiratory disease and diabetes. According to WHO, a Non-Communicable Disease (NCD) kill 38 million people each year. Almost three quarters of NCD deaths - 28 million - occur in low- and middle-income countries. Cardiovascular diseases account for most NCD deaths and affects 17.5 million people annually, followed by cancers (8.2 million), respiratory diseases (4 million), and diabetes (1.5 million). Tobacco use, physical inactivity, the harmful use of alcohol and unhealthy diets such as consumption of fatty and refined foods all increase the risk of dying from a NCD. Other factors that cause NCDs include ageing, rapid unplanned urban settlements and illegal substances.

52. In addition, the African region is plagued by other diseases such as Pneumonia, Diarrhoea, Cholera, Measles, Onchocerciasis, Trypanosomiasis, Schistosomiasis, Dracunculiasis, Filariasis, Meningitis and Ebola, including periodic outbreaks of Human Avian Influenza. Aside from these, the African region has seen an upsurge in cases of severe injuries and health conditions arising from, *inter ali*a, road and industrial accidents, demographic and environmental degradation, crowding, adoption of unhealthy diets, lack of exercise, gender-based violence, harmful social/cultural practices, and habitual consumption of alcohol and illicit substances.

53. Apart from human diseases, it has also been established that animal and plant diseases are likely to rapidly spread across borders in the absence of coordinated and robust phytosanitary inspection mechanisms. This threat is compounded by porous borders, inadequate skills and poor screening infrastructure in the region which make it almost impossible to effectively control the spread of human and animal diseases across borders. Poor mechanisms for controlling domestic and wild animal movements across borders in the region also compromise the region's capacity to respond to and fight animal-related disease burdens. It further makes it difficult to ascertain the source of, let alone contain, certain Bovine disease outbreaks. Evidence further suggests that there are inadequate institutional mechanisms for collaboration in support of rapid responses to disease outbreaks.

## 2. Sexual Reproductive Health Rights

54.    According to the Maputo Plan of Action on Sexual and Reproductive Health Rights (SRHRs), sexual and reproductive health is:

> …a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction and infirmity. It requires a positive and respectful approach to sexuality and sexual relationships as well as the possibility of having pleasurable and sexual experience free of coercion, discrimination and violence (Maputo Plan of Action on Sexual and Reproductive Health Rights).

55.    Due to several factors, such as cultural and traditional practices that promote subservience of women to men, lack of control over productive resources (land, credit, etc.), exclusion from key decision-making structures, poor educational attainment and similar others, women suffer several sexual reproductive health-related challenges. Lack of or inadequate control over productive resources further subjects women to various forms of Sexual and Gender-Based Violence (SGBV). Pregnant women in rural and hard-to-reach areas particularly face challenges in accessing ante-natal clinical services, while their lack of participation in key decision-making structures subjects them to livelihood decisions that do not reflect their needs. Poor educational attainment by the majority of women in the region, on its part, leads to lack of health information and inability to adopt health-seeking behaviours.

## 3. Adolescent Sexual Reproductive Health

56.    Adolescents, or young people who fall in the 10-19 age range, are at a particularly high risk of acquiring sexual reproductive health-related diseases, especially Sexually-Transmitted Infections (STIs). This is largely on account of their undeveloped cognitive capacity and lack of experience which lend them to social manipulation and influence. In the era of HIV, vulnerability and social manipulation account for a disproportionately high percentage of infections in the 15-19 age-group. These factors also fuel early marriage and teenage pregnancies.

57.    Efforts to address challenges pertaining to Adolescent Sexual Reproductive Health (ASRH) are stymied by lack of or inadequately targeted policies. In most cases, ASRH challenges are defined and addressed within broad frameworks of gender policies and programmes with the result that most special needs are either insufficiently dealt with or altogether neglected. Most health facilities do not have ASRH-friendly corners which put off some adolescents in need of ASRHR services. A related challenge is that, in many COMESA Member States, policy and legal mandates for ASRH are scattered in several ministries and departments which, *inter alia*, attenuates their impacts on adolescents. Dispersion of mandates across multiple ministries and departments also makes it difficult to coordinate, monitor and evaluate programme outcomes and impacts.

58.    It has also been established that conflicting definitions of the age for consensual sex and marriage contribute to compromising the health of adolescents. Ages for consensual sex and marriage, for instance, vary between and across COMESA Member States and range from 16 to 21 years. Lack of a uniform age for consensual sex promotes sex tourism as potential offenders go to countries where the age limit suits

their need for sex with minors. Weak law enforcement of laws against sexual offenders and corruption further compound interventions in support of health for adolescents.

59.     Another challenge relates to the simultaneous existence and operation of dual legal systems in some Member States, i.e. Customary/unwritten and Statutory/written laws. The duality crystallises interpretational challenges in regard to, for instance, age for marriage. In most traditional communities, a girl becomes eligible for marriage as soon as she attains the age of puberty, while in many jurisdictions the legal age is determined at 18 and above.

60.     Inadequate or non-domestication of internationally-agreed gender-related conventions, such as the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW), Convention on the Rights of the Child (CRC), African Charter on the Rights of Women and Children (CRWC), and African Solemn Declaration on Gender (ASDG), negates efforts that are targeted at improving adolescent sexual and reproductive health. Promotion of adolescent reproductive health further suffers from lack of or inadequate adolescent-friendly education programmes. In addition, development of most adolescent sexual and reproductive health policies and programmes anecdotally involve adolescents with the result that they do not feel ownership of, let alone connected to, even the most well-intentioned interventions.

## 4. Maternal Health

61.     Maternal health is central to the overall health of women and requires appropriate packages for management of maternal conditions to prevent mortality, diagnosis and treatment of related infections and diseases. Pregnancy and child-bearing are associated with risks such as death and, in the case of working pregnant women, possible loss of employment and career development opportunities. Maternal health also includes safeguarding the health of the unborn baby through a combination of antenatal health care services. The new-born baby must be prevented from death during the first 28 days, or the neonatal stage. According to UNICEF, "…most child deaths occur at home, before reaching health facilities…" and, therefore, "…preventing fatalities by improving child health through the community is at the core of the approach called Integrated Management of Childhood Illness (IMCI)". Prevention and treatment of child illnesses turns on the tripod of improved skills of health workers, robust health systems and improved family and community practice.

62.     Evidence demonstrates that most maternal-related deaths are largely due to poor access to maternal health services, shortage of suitably qualified medical staff, shortage or inadequate supply of drugs and long distances to nearest health facilities, including high poverty levels which result in poor diets. While all these factors also contribute to neonatal deaths, poor family and community health practices have equally been cited among drivers of deaths among new-born babies.

63.     Women suffer from the double challenge of motherhood and their productive role. In most cases, pregnant women continue to work and participate in various economic activities almost throughout pregnancy. Most work environments, however, have limited or no maternal health-friendly facilities. Similarly, there is hardly any evidence of work-based neonatal care facilities in many workplaces in the region. In the case of Cross-Border Trade (CBT), women face serious maternal health-related challenges as most

transit routes and border-crossing points do not have user-friendly facilities.  This gap causes expectant female cross-border traders and lactating mothers to use common facilities which do not meet their special needs.

## 5. Social Protection

64.    According to the International Labour Organisation (ILO), only "20 per cent of the world's population has adequate social security coverage and more than half lack any coverage at all". Social protection, of which social security is part, guarantees access to health, food and shelter. Generically, social protection refers to the entire gamut of social assistance, social insurance/social security, protection and livelihood and empowerment programmes. Social protection policies ring-fence livelihoods and welfare of people suffering from critical levels of poverty, deprivation, discrimination, social exclusion and vulnerability to risks and shocks.

65.    Traditionally, social protection policies and programmes have been preventive in nature through the protection of the welfare of targeted populations using instruments such as pensions, health insurance, sickness and maternity benefits. Protection and livelihood and empowerment programmes create conditions for enhancing and ring-fencing livelihood capacities for vulnerable populations. Lastly, social protection also encompasses transformative policies that employ various policy, legal and regulatory instruments for enhancing the welfare of targeted populations. In light of these elements, access to social protection by all should be seen as part of inalienable Human Rights which all countries should provide for their citizens.

66.    Inclusive, well-designed, targeted and equitable social protection policies and programmes ensure access to basic needs such as food, health, education and humane living conditions. Evidence, however, suggests that, in instances where national social protection policies have been developed and implemented in the region, they have suffered from, *inter alia*, poor targeting, non-inclusiveness, under-funding, dispersion of mandates and delayed disbursement of earmarked resources. In order to address this challenge, COMESA has developed a Social Charter as a framework for guiding Member States in their development and implementation of national social protection policies and programmes.

67.    Specifically, the Charter Urges Member States to "…to create an enabling environment so that every worker shall have a right to adequate social protection and shall enjoy adequate social security benefits", (COMESA Social Charter, Article VII). This should be attained through the:

    i.  Reduction of people's exposure to risks through the introduction of social insurance programmes such as pension and health insurance schemes;
    ii.  Reduction of inequities and improvement of social integration through changes in laws, budgetary allocations as well as retribution measures;
    iii.  Enhancement of the capability of the vulnerable groups to protect themselves against risks, hazards and loss of income through labour market programmes such as public works, small business or enterprise development, micro-finance as well as skills development and training;
    iv.  Promotion of social assistance and welfare programmes as a way of mitigating the impact of vulnerability of groups like persons with disabilities, the elderly,

children, orphans, and persons affected and infected by HIV and AIDS and other communicable diseases;

v. Establishment and strengthening of capacity building programmes for the beneficiaries of social assistance so that they graduate to become self-reliant; and

vi. Building of disaster risk management mechanisms to reduce the socio-economic impact of random shocks or disasters through effective planning and response as well as promoting the integration of disaster risk management programmes into sustainable development planning and programming at all levels.

68. Article XIII of the Charter calls upon Member States to ensure the attainment of the best state of physical and mental health for their citizens through "…making available equitable and readily accessible medical assistance and health care through strengthened health systems especially in rural and poor urban areas with an emphasis on primary health care" (*ibid.).* Member States are also urged to ensure the best state of physical and mental health for their citizens through:

i. Implementing comprehensive programmes to prevent the transmission of infectious and communicable diseases such as sexually transmitted infections (STI), HIV and AIDS, cholera, malaria, hepatitis, tuberculosis (TB) and yellow fever and other communicable diseases by providing contextualized education, information, communication and awareness, including putting in place protective and preventive measures;

ii. Expanding the availability as well as accessibility of anti-retroviral treatment (ART) and encourage the uptake of HIV Testing and Counselling (HTC) and other HIV and AIDS related programmes such as Prevention of Mother to Child Transmission (PMTCT);

iii. Instituting and strengthening programmes that address health pandemics such as HIV and AIDS, cholera, Malaria, hepatitis, TB and yellow fever and other communicable diseases and monitor progress of these programmes;

iv. Promoting the prevention of all diseases and occupational accidents as well as risk exposures;

v. Promoting access to Sexual Reproductive Health (SRH) services such as use of modern family planning methods and health information relating to such;

vi. Promoting the involvement of men in family planning and access to medical services and information to enhance men's health screening for preventable diseases;

vii. Promoting programmes to prevent maternal and child mortality; and

viii. Promoting the establishment of programmes to prevent alcohol, drug and other substance abuse and related crimes (*ibid.*).

## 6. Cultural and Traditional Practices

69. Culture and tradition are important in preserving and passing from generation to generation positive inherited life practices and survival skills. However, some aspects of certain cultural and traditional practices tend to compromise health and to hinder adoption of health-seeking behaviours. Initiation ceremonies that, for instance, teach young girls and boys how to handle sexual partners contribute to early marriage and illicit sex. Female Genital Mutilation (FGM) which is practised in some cultural settings,

on its part, compromises the health of girls and women. In many Member States, efforts have been made to address these and other negative cultural practices but success has been limited due to, *inter alia*, inadequate involvement of traditional leaders and women and girls in the design of interventions. Experience further shows that little has been done to explore how culture and tradition influence health-seeking behaviours.

## 7. Child Marriage

70.    Child marriage is any contraction of a formal marriage (willingly or forced), or union before the age of 18. Child marriage is rife in many Member States and is fuelled by, among others, poverty, inadequate educational opportunities and negative cultural and traditional beliefs.  The practice limits opportunities for affected children to acquire academic and professional skills and locks them into inter-generational poverty. Child marriage also gravely compromises the health of affected children as, quite often, they are prematurely made to take on responsibilities that should, ordinarily, be performed by adults.

## 8. Palliative Care

71.    According to the World Health Organisation (WHO), Palliative Care (PC) is:

> "…...an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (WHO Report, 2002).

72.    Experience with most national health systems in the region demonstrates that PC is associated with non-mainstream health care delivery infrastructure. Consequently, it has mostly been offered by Faith-Based Organisations (FBOs) and other Civil Society Organisations (CSOs) and not by public health facilities. This challenge has been compounded by the non-integration of PC in national health systems and its non-prioritisation in national budget frameworks. Most hospices in the region, for instance, are rarely funded by central governments. In cases where they benefit from central government resources, these are often routed through mother bodies of FBOs or other CSOs.

73.    Emerging health care challenges that have come in the wake of rising cases of life-long and life-threatening ailments such as HIV, BP and other lifestyle-related illnesses, have strengthened the case for the integration of PC in national health systems. Life-long illnesses demand dedicated life-long care which is not amenable to formal health care settings such as hospitals and clinics. There is, therefore, a strong case for mainstreaming palliative care in national health budget frameworks with a view to ensuring that PC facilities receive direct budgetary support. HIV-related illnesses have particularly constrained the carrying capacity of formal health care settings and, therefore, well-supported PC facilities will immensely ease the pressure on existing facilities.

## 9. Disability

74.     There is a global consensus that, by dint of being human, persons with disabilities have the same and equal rights as other citizens to opportunities for self-actualisation and participation in the economic and social development of their respective societies and the world as a whole. In underlining this universal Principle, the Convention on the Rights of Persons with Disabilities (CRPD) states its objective as "…to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity (Convention on the Rights of Persons with Disabilities, Article I). According to the CRPD, persons with disabilities "include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" *(ibid)*.

75.     Disability comes in several forms and can affect any person at any time in life. Some disabilities develop before birth, while others develop after birth and as one grows. There are several forms of disability but common ones include blindness, deafness, physical impairment, dumbness, mental disorder/illness and mental retardation.

76.     Albinism is regarded as a form of disability. People living with albinism are facing many challenges in Africa, especially persecution. This persecution is based on the belief that certain parts of albino people transmit magical powers. This superstition, which is present in some parts of the African Great Lakes region, has been promulgated and exploited by some witch doctors and others who use such body parts as ingredients in rituals, concoctions and potions with claim that their magic will bring prosperity to the user. As a result, people with albinism have been persecuted, killed and dismembered, and graves of albinos dug up and desecrated. At the same time, people with albinism have also been ostracised and even killed for exactly the opposite reason, because they are presumed to be cursed and bring bad luck.

77.     Many Persons with Disabilities (PWDs) are poor, inadequately educated and trained, economically-vulnerable, lack access to productive resources, face scarce prospects of employment, are generally in poor health and have poor access to decent accommodation, clean water and sanitation. Women with disabilities further suffer the double challenge of disability and gender-related inequities.

78.     Children with disabilities are often considered too expensive to maintain and are discriminated in the allocation of family resources for education. PWDs with chronic disabilities also face social exclusion, discrimination, stigma and isolation. The combination of these attributes makes PWDs extremely vulnerable to disease and, therefore, strengthens the case for data and information to inform and guide health policies and programmes for addressing barriers that limit their enjoyment of good health and full Human Rights.

## 10. Mental Illness

79.     Mental illness is commonly understood as any disease or condition that influences the way a person thinks, feels, behaves, and/or relates to others and to his

or her surroundings. Patients suffering from mental illness may exhibit various forms of violence or reclusiveness. Most societies in the region look at mental patients as "lost members" of communities and, therefore, shun them. In addition, mental illness is a neglected disease in the region and is not prioritised in many national health systems and budgets. Health facilities for building skills and addressing mental health-related challenges are few and far between in the region. Many COMESA Member States, for instance, have only one designated national referral mental hospital and limited training facilities.

80.     Non-prioritisation of mental health in most national health budget frameworks in the region means that even in cases where mental health-related facilities exist, they are poorly serviced both in terms of personnel, medicines and logistics. The limited complements of mental health specialists lead to backlogs of patients in need of care. Care and treatment for mental patients are further stymied by high levels of stigma and discrimination which are rife even within families.

## 11. Socio-economic Consequences of Disease Burdens

81.     Disease burdens, especially prolonged ones, pose acute existential challenges to humans, animal life and the environment. Suddenly, production, distribution, marketing and coping systems get disrupted in ways that leave communities disoriented and in urgent need of immediate restitutive interventions. The outbreak of the Ebola virus in the West African States of Liberia, Sierra Leone and Guinea is a test case of the instant devastation that infectious diseases can do to national socio-economic infrastructure and life. In just a few months, the Ebola pandemic swiftly spread and literally overwhelmed social and economic infrastructure to an extent that it had to take concerted international effort to stem the tide of loses of human life and property. By January 15, 2015, Ebola had already killed 3,496, 2,943 and 1,781 people in Liberia, Sierra Leone and Guinea, respectively (WHO).

82.     Disease burdens on the scale of epidemics create conditions for self-replication as some people, especially in rural communities, develop phobia for health facilities. This happens as people fear that attendance of health facilities may increase their vulnerability to infection. Consequently, some will, rather, retain infected family members in their homes instead of taking them to designated health screening and treatment facilities. In such cases, the risk of the virus spreading to others gets heightened and contributes to the negation of efforts to contain it.

83.     Disease burdens may also feed on cultural perceptions some of which interpret widespread disease outbreaks as a form of divine punishment. In such environments, holders of such views would avoid conventional medical facilities in favour of traditional healing practices or resort to spiritual diviners. Depending on the magnitude of a disease burden, existing diagnostic and treatment health systems might be severely compromised to levels where they might create fertile grounds for other infections.

84.     In economic terms, disease burdens might bring affected economies to a screeching halt as local and foreign investor withhold investments. Foreign investors, for example, are particularly averse to prolonged epidemics and pandemics and might temporarily postpone investing decisions in countries that are epicentres a chronic disease. Existing businesses also get adversely affected, and some may even close,

due to fear of infection, illness or death of employees. During chronic disease outbreaks, distribution of goods immediately get affected as people shun markets which are often considered as high-risk centres due to overcrowding. Prolonged disease outbreaks might also weaken household food security as labour is withdrawn from agricultural activities.

85. According to the Fifty-ninth session of the WHO Regional Committee for Africa that met between the 31st of August and 4th of September 2009, in Kigali, Rwanda, on strengthening outbreak preparedness and response in the African region in the context of the current Influenza pandemic:

> A pandemic could have serious humanitarian, social and economic impact on Member States of the African Region because of overstretched health systems due to the high burden of communicable and non-communicable diseases as well as inadequate human resources, overcrowding of slums in urban areas, and lack of clean water, adequate sanitation, food hygiene and infection control (WHO).

86. In the COMESA region, a number of countries have from time to time experienced natural disaster-induced disease burdens such as Cholera and Bilharzia. These and similar other disease burdens have largely been as a result of flash floods and unsanitary environments. Mozambique, Malawi and Zambia, for instance, have in various rain seasons experienced flash floods that had led to outbreaks of Cholera and other water-borne diseases.

## 12. Gender Dimensions of Disease Burdens

87. Disease outbreaks do not discriminate but equally affect both men and women. Experience, however, shows that, due to gender-assigned societal roles and obligations, women and girls are often disproportionately affected by prolonged disease burdens relative to their male counterparts. This is usually the case largely because the burden of caring for sick family members usually falls on women and girls. Caring for sick family members has several socio-economic implications among which are staying away from work and missing out on skills training and promotion opportunities (for those in formal employment), missing school lessons (for school-going girls) and missing out on business opportunities (for those in business).

88. In Africa, women's participation in Cross-Border Trade (CBT) accounts for significant proportions of family incomes and household food security. According to the United Nations Economic Commission for Africa (UNECA), women cross-border traders also make significant contributions to national economies. In Benin, Mali and Chad, for example, women cross-border traders account for 64%, 46% and 41% of Gross Domestic Product (GDP). The scenario in the COMESA region should be similar to this pattern as women predominate cross-border trading. Given the predominance of women in cross-border trading, together with the fact that women bear the heaviest burden of disease and care for ailing family members, prolonged disease burdens have the potential to severely compromise female participation in regional economies.

## 13. Research and Development

89.     Like any other sector, the health sector requires evidence-based data and information for informing and guiding policy and programme development and implementation. Currently, the COMESA region, with the exception of Kenya, has weak capacity for health Research and Development (R&D) due to a combination of limiting factors. These include lack of or inadequate identification of health R&D as a policy priority area for the sustainable provision of reliable health services, lack of or poor budgetary allocations to health R&D, unattractive service conditions for health R&D-related personnel and poor health research infrastructure and environments.

90.     Health R&D in the region further suffers from lack of or inadequate identification and prioritisation of research issues. Mindful of this and other gaps, the High-Level Ministerial Meeting on Health Research in Africa that was held in Abuja, Nigeria, resolved to build consensus around a set of priority health research areas. These include:

i.    Infectious diseases such as Malaria, TB, HIV, AIDS and neglected tropical diseases (e.g. African trypanosomiasis, Buruli ulcer, leishmaniasis, and lymphatic filariasis);
ii.   Reproductive and sexual health;
iii.  Child health;
iv.   Non-communicable diseases, including cardiovascular disease, diabetes, cancers, sickle cell disease, injuries etc.;
v.    Malnutrition; and
vi.   Mental health, including drug and substance abuse (High Level Ministerial Meeting on Health Research in Africa, Abuja, Nigeria, 8-10 March 2006).

91.     The ability to translate these commitments on the ground at both national and regional levels will, to a large extent, depend on strong political will and willingness to commit requisite budgetary resources.

## 14. Health Management Information Systems

92.     Experience demonstrates that robust and inclusive health systems are often anchored on evidence-based Health Management Information Systems (HMIS). Reliable HMIS also promote appropriate targeting of health services and efficient use of scarce health resources. Currently, all COMESA Member States have one form of HMIS or the other. It would, however, appear that most national HMIS are characterised by data and information that are, in some cases, outdated and limited in scope and, therefore, not able to address current and emerging health challenges. Some also suffer from data and information gaps which are largely attributed to inadequate data and information capture.

93.     In certain cases, poor data and information storage and retrieval systems further compound effective utilisation of HMIS for informing health policy and health service delivery. Building of reliable and sustainable HMIS in some Member States has been stymied by the resource-constrained nature of national economies.

## 15. Production of Essential Medicines and Commodities

94.     Although it is possible to provide efficient and effective health services even in the absence of domestic capacity to manufacture common medicines and medical

supplies, production of the same within the COMESA region would have the potential to improve access to quality health care by all. Some Member States lack even the basic ability to manufacture essential drugs and supplies largely due to scientific and technological inadequacies. This challenge is compounded by lack of capacity to take advantage of international health-related agreements and conventions that incorporate provisions for domestic production of medicines and medical supplies.

95.     In most cases, for example, Member States have failed to take advantage of health-related provisions under the Trade-Related Aspects of Intellectual Property Rights (TRIPs) to establish domestic capacity for production of and/or to improve access to medicines and medical supplies. While TRIPs ring-fence intellectual property rights of prototype manufacturers of health products, they provide flexible conditions that allow countries that have the potential to manufacture medical commodities. Paragraph 17 of the Declaration on the TRIPs Agreement and Public Health, for instance, puts emphasis on "…promoting access to medicine and promoting research and development into new medicines…" and adds that "For developing and least developed countries this means promoting domestic capacity for research and development into new medicines" (Felix Maonera, *et. al*, COMESA study on Public Health: 57).

96.     In light of this, there have been calls for Member States to pro-actively review their legislation and policies with a view to creating enabling domestic environments for production of medicines and medical supplies. Specifically, COMESA Member States are urged to ensure that their:

> …patent legislation…fully exploit the flexibilities in the TRIPS Agreement and as affirmed in the Doha Declaration…provide for straightforward, easy to use, fast and transparent procedures for the issuance of compulsory licenses and setting royalties (*ibid.:57).*

97.     COMESA Member States should take advantage of these provisions as it is only Kenya that "has a vibrant pharmaceutical industry (about 36 companies) in the production of essential drugs as well as supplying about 50% of the COMESA regional market requirements" (*ibid.: 36*). Lack of domestic capacity to manufacture essential drugs has often resulted in periodic shortages of medicines in some COMESA Member States leading to unnecessary losses of life. A related challenge is the inability to take advantage of available technology transfer opportunities with respect to the manufacture of medicines, medical supplies and equipment.

98.     Currently, there are several prototypes for manufacturing medicines, medical supplies and equipment which may be adopted under pertinent patent arrangements. In order to promote adoption of these, a Pharmaceutical Manufacturing Plan for Africa (PMPA) was developed. Realisation of the PMPA will, however, depend on several factors among which is the willingness of African countries to cooperatively create enabling policy, legal and regulatory environments for partnerships (especially PPPs). COMESA Member States can, within the context of its COMESA Industrialisation Policy: 2015-2030, take national and regional initiatives to establish capacity for production of medicines, medical supplies and equipment, especially through Public Private Partnerships (PPPs).

## 16. Alcohol, Drugs and Substance Abuse

99.    Consumption of alcohol, drugs and substances is an escalating challenge in the COMESA region. Their abusive consumption are increasingly contributing to rising cases of, *inter alia*, mental illness, HIV infections, violence and Sexual and Gender-Based Violence (SGBV). Abuse of alcohol, drugs and substances has direct and indirect socio-economic consequences. Alcohol, drug and substance abuse is often manifested in reduced productivity and can have telling negative effects on the profitability of businesses. If left unchecked, alcohol, drug and substance abuse might lead to increased incidences of work-related accidents, injuries and death and, consequently, unplanned medical expenses. Business persons who abuse alcohol, drugs and substances, on their part, may fail to run their businesses or travel to meet business and trade commitments.

100.    The burden of alcohol, drug and substance abuse is also evident in unplanned expenditures on treatment and rehabilitation which leads to diversion of scarce national health resources from productive sectors. Rehabilitation of drug addicts and their re-incorporation into society are costly undertakings and enormous drains on national resources.

## 17. African Traditional Medicine

101.    Traditional medical practice is deeply rooted in all African societies and traditional healers enjoy high esteem and respect. Compared to modern medical practice, traditional medicines had been practised from time immemorial. Traditional medicines are widely used in most poor countries and the **"…**World Health Organization estimates that 80% of the populations of Asia, Africa and Latin America use traditional medicine to meet their primary health care needs…." and adds that for "…many people in these countries, particularly those living in rural areas, this is the only available, accessible and affordable source of health care" (WHO).

102.    Some regional organisations in Africa have also acknowledged the positive role that traditional medicine and traditional medical practitioners play in the treatment of sexual reproductive health-related illnesses. In its Sexual and Reproductive Health Strategy, for example, SA**DC** states that "Traditional medical practitioners have been acknowledged as important players in the management of different aspects of SRH, especially STI, HIV and AIDS" (SADC).

103.    Experience, however, shows that traditional medicines are often not researched, let alone documented, with the result that knowledge and skills are orally passed on from one generation to another. Traditional medicines also suffer from an undercurrent of mistrust by conventional/modern medical practitioners which has resulted in missed opportunities to maximise health service delivery, especially in rural and hard-to-reach areas where conventional health facilities are few and far between. In reference to the same, WHO succinctly observed that:

> "…despite the health benefits such collaboration could bring to the populations, decades of disregard of traditional medicine practices and products has created mistrust between the two sectors hampering all the efforts being made to promote this potentially useful partnership" (African Health Monitor, Issue #13, August 2010).

104.    Cognisant of this challenge, WHO has since "…the early 1970s …repeatedly advocated for the recognition of Traditional Health Practitioners (THPs) as Primary Healthcare (PHC) providers and for the integration of traditional medicine in health systems" (*ibid.*). In 1978, traditional medicine and traditional practitioners were officially recognised by the "…Alma Ata Declaration…as important resources for achieving Health for All" (*ibid.*). Since then, there have been several commitments, resolutions and declarations on traditional medicine. These include, among others, the WHO Strategy for Traditional Medicine: 2002-2005 and the resolution on Promoting the role of Traditional Medicine in Health Systems: A Strategy for the African Region (*ibid.).*

## 18. Public Private Partnerships

105.    Production of medicines, medical supplies and equipment is expensive as is associated with specialised scientific R&D some of which is often beyond the budgetary ability of almost all COMESA Member States. The usually prohibitive investments may, however, be ameliorated by Public Private Partnerships (PPPs) which often "…takes on significant financial, technical and operational risks and is held accountable for defined outcomes" (Global Health Group). In addition, PPPs in the health sector assist governments to release resources for allocation to other needy sectors. Given the private sector's often superior endowment of skills, PPPs in the health sector create space for venturing into scientifically and technologically-sophisticated medical R&D.

## 19. Community Involvement

106.    There is now broad consensus that the best and most cost-effective way to maintain a healthy population is through effective people-level primary health care interventions. Simple health practices, such as hand-washing, good and balanced diets and clean environments, contribute to the prevention of infections at minimal cost to the government and the community. Primary health care systems and interventions pre-empt huge expenses on treatment and care and help to conserve scarce health resources. Experience, however, shows that, for primary health care to be effective, it needs meaningful involvement of targeted communities. In emphasizing the same, the 1978 Alma Ata Declaration noted that primary health care:

> …requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources (Alma Ata declaration 1978).

107.    Traditionally, communities have been considered as end-consumers of health care services and, consequently, have often been crowded out of health service planning and delivery systems. Non-involvement of communities in health service planning and delivery, invariably, results in, among others, wrong identification of priority needs and targeting, under or over-budgeting and sub-optimal people-level outcomes and impacts.

108.    When communities are not involved in health planning, they usually develop resistance as they do not feel any ownership of programmes and might even become hostile to health workers. In order to address this challenge, there is need for deliberate initiatives to ventilate communities with intentions of planned programmes in a language

that they understand and in ways that do not breach their cherished culture and traditions. Beneficiaries must also be assured that their views will be respected and eventually taken into account when formulating health policies and plans.

## 20. Civil Society Organisations

109.     Over the years, Civil Society Organisations (CSOs) have increasingly become significant partners of governments in the delivery of social services. In fact, the positive role that CSOs play in the delivery of health care has long been acknowledged by WHO which stated that:

> One of the most significant developments in the recent past has been the 1978 Alma Ata declaration, which is considered a landmark for recognising people's participation in health systems as central to Primary Health Care and for recognising the role that organised social action plays in securing health gains (WHO).

110.     The role of CSOs in health service delivery is particularly important in resource-constrained environments. In such cases, CSOs help bridge funding and skills gaps resulting in less pressure on national budgets. Compared to the public sector, CSOs also often have the ability to rapidly respond to health crises due to their limited bureaucratic inertia. Effective CSO contribution to health service delivery has, however, tended to be compromised by inadequate coordination which has resulted in, among others, unnecessary competition for resources, duplication of effort and poor targeting resulting in sub-optimal people-level outcomes and impacts.

## 21. Coordination

111.     Apart from UN health-related conventions and agreements to which COMESA Member States are party, all RECS have their respective health-related conventions and agreements. Most of the health conventions and agreements to which Member States commit themselves are almost similar in intent and often target the same populations and resources. It is also significant to note that most Member States stride one or more RECs in terms of membership which results in their committing resources to otherwise similar health challenges.

112.     In order to address this challenge, efforts have been made to establish programme convergences between and among certain regional health programmes with a view to, *inter alia*, synergising utilisation of resources. Anecdotal evidence, however, shows that there is more to be done to establish effective and sustainable convergences in health policy planning and programme implementation. At national level, all COMESA Member States have national health policy and legal frameworks which are implemented almost in *silos* with little regard for regional health policies and the need for coordination and synergies.

113.     A regional health coordination framework would, therefore, have several dividends principal among which would be coordinated approaches to programme implementation and synergised utilisation of scarce health resources. In addition, some COMESA Member States currently fail to implement globally-agreed health instruments largely due to inadequate internally-generated resources. Consequently, a regional institutional health framework would ensure that severely resource-constrained Member

States benefit from synergised human, financial and material resource pools in realising globally-agreed health instruments. Coordination of national, regional and international health instruments by COMESA is an imperative given the expanded free trade area that now includes COMESA itself, SADC and EAC.

114. The expanded free trade area comprises 26 out of the 54 African countries and, once fully implemented, will result in a mammoth investment and trade bloc. It will, invariably, lead to an unprecedented spike in social mobility and its attendant risk of increased transmission of communicable diseases. This will call for mechanisms for coordination of pro-active diagnostic and reactive interventions which may only be possible within the framework of a centralised health unit at the COMESA Secretariat. Apart from COMESA, there are other RECs, such as EAC, SADC, Arab Maghreb Union (UMA), Economic Community of Central African States (ECCAS), Economic Community of West African States (ECOWAS) and the Inter-Governmental Authority on Development (IGAD), that also have their respective health frameworks.

115. COMESA is obliged to work and collaborate with these RECs in executing health-related programmes with a view to avoiding any possible duplication of effort and waste of scarce health resources. Collaborative work is also important as some Member States stride one or more RECs in terms of membership. Work and collaboration should also be encouraged with UN health-related agencies such as WHO, UNICEF and UNFPA. COMESA should further work and collaborate with health-related international organisations such as the International Planned Parenthood Association (IPPA), Safe the Children (StC), Plan International (PI) and the Population Council (PC).

## 22. COMESA Health Initiatives

116. Commitments to establishing mechanisms for addressing disease burdens are outlined in Chapter 14, Article 110, of the COMESA Treaty. At the regional level, Member States are committed to "…undertaking concerted measures to co-operate in health through:

  i. The control of pandemics or epidemics, communicable and vector-borne diseases that might endanger the health and welfare of citizens of the Common Market;
  ii. The facilitation of movement of pharmaceuticals within the Common Market and control of their quality;
  iii. Joint action in prevention of drug trafficking;
  iv. The training of manpower to deliver effective health care; and
  v. The exchange of research, development and information on health issues.

117. Realisation of these regional commitments is expected to be achieved through a number of Member State-level initiatives. These include a combination of policy, legal and regulatory measures such as national drug policies, ensuring that the manufacture, distribution, quality and therapeutic value of pharmaceuticals comply with acceptable international standards. Others include the development of joint action plans to combat disease outbreaks, harmonisation of drug certification procedures, cooperation in research and development of drugs and assuring high quality of pharmaceuticals (COMESA Treaty, Chapter 14, Article 110).

118.    In working to realise objectives under Article 110, COMESA has undertaken several health-related initiatives which include, among others, the development of the COMESA Framework for the Multi-sectoral Programme on HIV and AIDS and the COMESA HIV and AIDS Policy. The Multi-sectoral Programme seeks to "contribute to the reduction of HIV and AIDS incidence and prevalence in the region" and to mitigate the negative impacts of the pandemic on national economies (Framework for the Multi-sectoral Programme on HIV & AIDS for COMESA: 2012 – 2015). Strategic interventions include mainstreaming HIV and AIDS in all COMESA programmes, reduction of the socio-economic impacts of HIV and AIDS on communities along regional transport corridors and intensifying work and collaboration with national, regional and international stakeholders.

119.    The COMESA HIV and AIDS Policy comprehensively addresses, among others, challenges related to maternal health, sexual and reproductive health and rights, paediatric HIV, gender and HIV and adolescent sexual and reproductive health. It also addresses health-related challenges in child labour and child marriage. At national level, all COMESA Member States have domestic health-related policies, laws and regulations that provide frameworks for production, procurement, distribution and consumption of medicines.

120.    COMESA has also developed a Social Charter whose Article XIII commits Member States to taking all necessary measures "to attain the best attainable state of physical and mental health for their citizens" (COMESA Social Charter, Article XIII). Specifically, COMESA Member States are committed to:

i.    Making available equitable and readily accessible medical assistance and health care through strengthened health systems especially in rural and poor urban areas with an emphasis on primary health care;

ii.    Implementing comprehensive programmes to prevent the transmission of infectious and communicable diseases such as sexually transmitted infections (STI), HIV and AIDS, cholera, malaria, hepatitis, tuberculosis (TB) and yellow fever and other communicable diseases by providing contextualized education, information, communication and awareness, including putting in place protective and preventive measures;

iii.    Expanding the availability as well as accessibility of anti-retroviral treatment (ART) and encourage the uptake of HIV Testing and Counselling (HTC) and other HIV and AIDS related programmes such as Prevention of Mother to Child Transmission (PMTCT);

iv.    Instituting and strengthening programmes that address health pandemics such as HIV and AIDS, cholera, Malaria, hepatitis, TB and yellow fever and other communicable diseases and monitor progress of these programmes;

v.    Promoting the prevention of all diseases and occupational accidents as well as risk exposures;

vi.    Promoting access to Sexual Reproductive Health (SRH) services such as use of modern family planning methods and health information relating to such;

vii. Promoting the involvement of men in family planning and access to medical services and information to enhance men's health screening for preventable diseases;

viii. Promoting programmes to prevent maternal and child mortality; and

ix. Promoting the establishment of programmes to prevent alcohol, drug and other substance abuse and related crimes (COMESA Social Charter).

121.    In designing responses to epidemics and pandemics, it has been realised that regionally-designed response mechanisms are not by themselves sufficient if they are not backed by strong political will and resources.

122.    Some COMESA Member States also belong to other Regional Economic Communities (RECs), such as the Southern African Development Community (SADC) and the East African Community (EAC), which have their own health frameworks.  In the case of SADC, there is the SADC Protocol on Health which seeks to raise health standards for all SADC citizens through promoting, coordinating and supporting efforts of Member States to improve access to high-impact health interventions. It commits Member States to national and collaborative interventions in the following priority areas:

i.    Health research and surveillance;
ii.    Health information systems;
iii.    Health promotion and education;
iv.    HIV and AIDS and sexually transmitted diseases;
v.    Communicable and Non-communicable Disease control;
vi.    Disabilities;
vii.    Reproductive health;
viii. Health human resources development;
ix.    Nutrition and food safety; and
x.    Violence and substance abuse (SADC Protocol on Health).

123.    Acknowledging that a healthy population is a prerequisite for sustainable human development and increased productivity, the Protocol emphasizes cooperation among Member States in addressing key health challenges such  as emergency health services, disaster management, and bulk purchasing of essential drugs. SADC also has the Sexual and Reproductive Health Strategy: 2006-2015 which "…provides a policy framework and guidelines for healthy sexual and reproductive life in the region" (SADC). The Maputo Plan of Action (MPA), on its part, acknowledges the fact that the right to health in Africa is increasingly coming under threat. Specifically, the MPA isolates poor sexual and reproductive health as a leading cause of maternal morbidity and mortality and commits State parties to:

i.    Integrating HIV/AIDS services into sexual and reproductive health and rights;
ii.    Promoting family planning as a crucial factor in attaining the Sustainable Development Goals;
iii.    Supporting the sexual and reproductive health needs of adolescents and young people as a key SRH component;
iv.    Addressing unsafe abortions through family planning;
v.    Delivering quality and affordable health services to promote safe motherhood, child survival, and maternal, newborn and child health; and

vi. Adopting strategies that would ensure reproductive health commodity security (Maputo Plan of Action, September 2006).

124.  Other regional health-related instruments include the African Union (AU) HIV and AIDS Policy, EAC Regional HIV Bill, SADC HIV and AIDS Strategic Framework, AIDS Watch Africa Strategic Framework, Abuja Declaration and the Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa.  The Abuja Declaration on HIV-AIDS, TB and other related diseases, Abuja Call for Accelerated Action towards Universal Access to HIV-AIDS, TB and Malaria Services and the Kampala Declaration on Actions on Maternal, New-born and Child Health also form part of the raft of regional interventions that are meant to contribute to the attainment of health for all.