

**A Call for a Massive Paradigm Shift from Just Health Financing
To Integrated Health, Population and Social Development Investment in Africa
(The Case for Progressing from Only 15% to 15%+)**

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Overview and Introduction:

1. This brief paper seeks to outline in broad terms, the basis for a required massive paradigm shift in 'health financing' in Africa. The key basis for the shift is that all available evidence over the past 9 to 10 years indicates that after an initial burst of progress, isolated health financing on its own has achieved mixed or limited success, and Africa's overall health burden and mortality is now greater in 2010 than it was in 2000.¹
2. In April 2001 African Heads of State meeting in Abuja, Nigeria laudably made the continents main financial commitment towards meeting the Health Millennium Goals by pledging to allocate at least 15% of domestic national budgets to health. Yet 9 years later the pledge remains largely unmet.²
3. However the problem is not only that the Abuja 15% Commitment has not been met by the majority of AU member states. The actual problem is that more broad based social development investment is required in addition to the 15% pledge.
4. In addition to this, the Abuja 15% Commitment as it presently stands contains an inbuilt flaw that needs to be corrected – both in content, and in the process through which the commitment was reached.
5. We should therefore no longer refer to Health Financing in Africa – but rather aim for *"Integrated and Needs Based – Health, Population and Social Development Investment"*. I.e. go from just 15% to 15%+

1. In December 2006, the Africa Public Health Alliance underlined at the launch of the 15% Campaign that Africa is losing at least 8 million lives annually to only 5 main causes: Malaria; TB; HIV and AIDS; Child Mortality and Maternal Death.

- i. **Malaria:** There were an estimated 247 million global episodes of malaria in 2006 of which 212 million cases were in the African region. From these, there were an estimated 881 000 deaths of which 91% were in Africa, and 85% were of African children under 5 years of age – Funding Gap US\$ 2.7 billion in 2010 (World Malaria Report 2008).
- ii. **Tuberculosis:** By 2006, there were an estimated 4,233,723 (4.2 million) cases of TB in Africa of which 2,807,688 (2.8 million) were new cases. This resulted in 639,089 African deaths - Funding gap of US\$10.7 billion for implementation of the Global Plan to Stop TB 2006-2015 (WHO Report 2008, Global Tb Control).
- iii. **HIV and AIDS:** In 2007 there were an estimated 22 million People living with HIV in Africa out of a global figure of 33 million. Of these new infections in Africa were 1. 9 million. And 1.5 million Africans died in the same year of AIDS related causes - Sub-Saharan Africa funding gap to meet Universal Access is about US\$ 12.5 billion. (WHO 2008 and 2009 Reports on Global AIDS Epidemic).
- iv. **Child Mortality:** An estimated 4.5 - 5 million African children under the age of 5 died in 2006 mainly of neonatal diseases, pneumonia, Malaria, diarrhoeal diseases, AIDS and measles. A staggering average of 14,000 infant deaths a day (UNICEF State of the Worlds Children Report 2008 and 2009)
- v. **Maternal Death:** Over half a million women die each year because of complications related to pregnancy and childbirth. Of the estimated 536,000 maternal deaths worldwide in 2005, developing countries accounted for more than 99 per cent, and about half or 265,000 Maternal Deaths, which are almost 100% preventable, were in sub-Saharan Africa – MNCH Funding gap of about US\$1 billion per year needed to improve services in the African continent alone between 2009 and 2015 - US\$ 6 billion. (WHO, UNICEF, UNFPA and The World Bank. 2007)

² Rwanda 18.8%; Botswana and Niger at 17.8%; Malawi at 17.1%; Zambia at 16.4%; and Burkina Faso at 15.8%

The Case & Recommendations for Both a Content, and Process Review of Abuja+10 Commitment in 2011:

6. ***On face value, the 2001 15% Commitment was based on a global trend of countries with the best performing health indicators and highest life expectancy spending at least between 11% and 21% of national budgets on health.*** (For instance based on global National Health Account figures: Costa Rica spends 21.5% of national budget on health; U.S 19%; Switzerland 18.5%; Denmark and Iceland 18%; Germany and Japan 17.9%; Canada 17.8%; Ireland 17.2%; Luxemburg 17.1%; France 16.7%; Netherlands 16.4%; UK 16.3% and so forth down to Cuba at 11.2%).³
7. However based on this trend: Haiti currently at 29.8%; Rwanda 18.8%; Botswana and Niger at 17.8%; Malawi at 17.1%; Zambia at 16.4%; and Burkina Faso at 15.8% should have also all met the health based MDGs.
8. ***The content based flaw in evaluating current health investment based only on % allocation, is that it does not take into account three crucial factors:*** (i) Size of the overall budget from which a % is to be allocated to health, and what % of that size is from external or non-domestic sources; (ii) Overall government per capita investment in health – excluding external sources – which sometimes amount to as much as 59% of health budgets⁴; and also (iii) Separate but interlinked government per capita investment in key public health related population and social development indicators such as: improved drinking water; improved access to sanitation; nutrition and education.
9. For instance, in addition to the % allocation to health outlined (in 6) above, the US also spends \$3,076 per capita, Switzerland \$3,347, Denmark \$4,677, Germany \$2,858, Japan \$2,242, Canada \$2,759, Ireland \$3,030, Luxemburg \$5,912, France \$3,139; Netherlands \$3,097; UK \$2,908 - to Cuba at \$332 and Costa Rica at \$275).
10. On the other hand: Haiti invests only per capita \$29; Rwanda \$14; Botswana \$290 (mostly HIV treatment related); Niger \$9; Malawi \$14; Zambia \$35; and Burkina Faso \$15.
11. ***But even higher per capita investment in health alone is not enough, and does not paint the whole picture. Other crucial investment in human and social development is necessary to maximise and achieve higher efficiency*** of both the per capita health investment and % allocation of budgets to health.
12. For instance Cuba and Costa Rica have achieved a status of being in the group of the countries with the highest life expectancy of between 78 years and 82 years, but with the lowest per capita health expenditure of the group. E.g. Cuba invests \$332 per capita on health and Costa Rica \$275, but still manage to have a higher life expectancy of 78.3 years and 78.8 years respectively – just above the U.S at 78.2 years but which spends \$3,076 per capita on health – almost 10 to 11 times what Cuba and Costa Rica spend on health.⁵
13. The position of both countries has been achieved based on social development investment that has ensured 98% (Costa Rica) and 91% (Cuba) of their population

³ World Health Statistics 2009

⁴ See Annex 3

⁵ WHO database; Human Development Index 2009; and Population Reference Bureau, Population Handbook, 5th Edition.

- has access to improved water sources respectively, and 96% and 98% access to improved sanitation, and 90% and 99% vaccination coverage, amongst others.⁶
14. This is compared to for instance countries, the 15 Countries most affected by Child Mortality (all African except Afghanistan) where roughly 50% of the population have no access to clean water, and between 48% and 89% have no access to improved sanitation. (See Table 1, 15 Countries most affected by Child Mortality).
 15. Consequently, even if all African countries were to meet the Abuja Commitment of allocating just 15% of budgets to health as it stands today, the desired objective of meeting the Health based Millennium Goals would still not be met. ***There is therefore a clear basis to call for Summit level review of the Abuja Commitments at Abuja+10 (in 2011) which takes into consideration need for both an increase in per capita investment in health, and separate but integrated increase in overall social development investment (hence from just 15% to 15%+).***
 16. Only Libya (74 years), Tunisia (73.9 years), Mauritius (72.8 years), Algeria (72.3), Cape Verde (71.7), Egypt (71.3), and Morocco (71.2) are six African countries to have life expectancy of above 70 years. They are also amongst few African countries to have health per capita investment of over \$100 (except Morocco and Egypt which are lower) but combined with reasonable social development investment.
 17. ***While the flaws in the content of the Abuja 15% Commitment need to be corrected, the process of correction is also crucial.*** The initial 15% Commitment was reached without adequate consultation of various key stakeholders including significantly the Ministers of Finance, Planning and Economic Development, and Chairs of African Parliamentary Committees of Budget and Finance.
 18. This has led to a constant questioning of the 15% Commitment by various policy makers, only partially corrected since 2008 when the Africa Public Health Alliance and 15%+ Campaign in partnership with the AUC and UNECA engaged the Ministers of Finance, Planning and Economic Development at their annual conference.
 19. ***The Special Health Ministers May 2010 meeting; July AU Summit on MNCH; September 2010 global review of the MDGs; 2010 review of the Universal Access Targets; and the 2011 review of the Abuja Commitment all offer key opportunities for both the content and the process of the 15% pledge to be urgently corrected.***
 20. Significantly, the crucial social investment required to ensure integrated and overall population and social development requires that all the social development policy makers also play a key role in the reviews.

Cross Cutting Nature of Investment in Reproductive & Sexual Health; Health Workforce; & Education:

21. With respect to RSH, broadly speaking countries with lower Maternal Mortality⁷ and higher life expectancy, are also amongst African countries with highest investment in and access to family planning e.g. Tunisia (62.6%), Algeria (61.4%), Egypt (59.2%) – compared to countries most affected by Maternal Mortality where up to

⁶ Main causes of Child Mortality in Africa being: Neonatal causes 37%; Pneumonia 19%; Diarrhoea 17%; Other 10%; Malaria 8%; Measles 4%; Injuries 3%; AIDS 3% - UNICEF State of Children's Report 2009.

⁷ Main causes of Maternal Death are: Hemorrhage 34%; Other causes 30%; Sepsis infections 10%; Hypertensive disorders 9%; HIV/AIDS 6%; Anemia 4%; Obstructed labour 4%; Complications of abortion 4%- UNICEF State of Children's Report 2009, UNFPA, WHO Database.

between 47% and 94% have no access to family planning. They also have lower adolescent fertility rates (women aged 15-19), lower infant mortality, and generally speaking less HIV – making RSH and Gender Equity in Health important pillars of social development. (Table 2, 15 Countries most affected by Maternal Mortality).

22. ***It is also clear that other key indicators such as health workers (which reflects on overall investment in education and work conditions) are crucial areas where poor investment has a massive impact on cross cutting health sector performance.*** For instance, comparing countries of different population categories: Canada and Kenya have roughly similar populations of 32.5m and 36.5m respectively. However Canada has 62,307 doctors / Kenya 4,506 doctors; Canada 327,224 Nurses / Kenya 37,113 nurses; and Canada 27,084 pharmacists / Kenya 3,094 pharmacists. (See Annexe 3 / Table 3 for various global comparisons).
23. Significantly, the gap in health workforce is distorted by brain drain (fuelled by more developed countries policy of not investing in training adequate numbers of their own health workers).
24. ***However the example of countries like Cuba not only able to meet their own health workforce needs, but also export a surplus demonstrates clearly that it is possible for more developed countries to do the same, and should be asked of them.*** Cuba compared to Malawi for instance has 66,567 doctors to Malawi's 266 doctors for populations of 11.6 million and 13.5 million, also still manages to export a surplus.
25. However it remains the case that African countries need to improve policy and budget support for both training and retention of health workers.
26. ***Based on clearly identified and irrefutable global, but especially African health workforce shortages – without which no health (and in fact few) MDGs will be met - there is clear case for review of health MDGs in 2010 which includes a target for countries to reach a recommended ratio of health workforce to population.***

Conclusion - Not just a Health, Population and Social Development Case – But Also An Economic Development Case:

27. The case for “*Integrated and Needs Based – Health, Population and Social Development Investment*” is not just a moral or social development case, it is also an economic development case.
28. Societies with the overall healthiest workforce and highest life expectancy, are also the most knowledge based, industrialised or sustainable economies. It cannot reasonably be expected that any society with a low healthy life expectancy of 41 years and falling can accumulate the knowledge, expertise and experience for long-term sustainable social and economic development.
29. “The High Level Task Force (HLTF) for Innovative Financing asserts that improved health outcomes will require increased funding and more efficient and effective use of resources. In low-income Sub-Saharan Africa (SSA) countries...**additional average annual investment per capita in the coming five years (2011 -2015)... between US\$ 21 to US\$ 32...could see 4million lives saved (of which 90% mothers and children), prevention from stunting of 3.8 to 5.1m children, increased economic gains in excess of \$6bn per year** and stronger and more sustainable health systems. The choice of investment strategies will depend on countries’ current health system status, policies and priorities” but overall improved investment is crucial. ⁸

⁸ “Investing for Health in Africa” – Harmonisation of Health in Africa April 2010

Annexe 1 / Table 1: 15 Countries Most Affected By Under 5 Mortality – With Key Indicators

Under 5 Mortality Global Ranking - by most affected country	15 Most Affected Countries - Deaths per 1000 live births¹	Population with Access to Improved Drinking Water²	Population with Access to Improved Sanitation³	Prevalence of Child Malnutrition⁴	Vaccination Coverage⁵	Govt Per Capita Investment in Health at Int \$ exchange rate.	Govt exp. on health as % of total govt exp. (As per Abuja 15% Target)
1. (262)	Sierra Leone	53%	11%	28.3%	60%	\$ 4	7.8%
2. (257)	Mozambique	22%	30%	32.9%	85%	\$ 9	6.2%
3. (209)	Chad	48%	9%	33.9%	20%	\$ 16	13.8%
4. (206)	Equatorial Guinea	43%	51%	10.6%	33%	\$353	6.9%
5. (198)	Guinea Bissau	57%	33%	17.4%	63%	\$ 13	4.0%
6. (196)	Mali	60%	45%	27.9%	68%	\$ 15	12.2%
7. (191)	Burkina Faso	72%	13%	35.2%	79%	\$ 14	15.8%
8. (189)	Nigeria	47%	30%	27.2%	54%	\$ 10	3.5%
9. (181)	Rwanda	65%	23%	18.9%	97%	\$ 14	18.8%
10. (180)	Burundi	71%	41%	38.9%	92%	\$ 1	2.4%
11. (176)	Niger	42%	7%	39.9%	66%	\$ 9	17.8%
12. (172)	Central African Republic	66%	31%	21.8%	54%	\$ 5	10.9%
13. (170)	Zambia	58%	52%	23.3%	80%	\$ 35	16.4%
14. (168)	Mozambique	42%	31%	21.2%	72%	\$ 11	12.5%
15. (161)	Congo (DRC)	46%	31%	28.2%	69%	\$ 2	5.8%

*Table & Analysis by Africa Public Health Alliance & 15%+ Campaign. (Based on latest available comparable data 2007 - 2009). *Main data sources: WHO, UNICEF, UN Pop. Div., UNFPA, Interagency Group for Child Mortality Estimation, World Bank.*

- **Summary Conclusions:** Countries most affected by Under 5 Mortality have under invested in public health and social development (nutrition; sanitation, drinking water) which all impact on - (especially) poor vaccination coverage and weak health systems. Increase in per capita investment on health must be combined with increased investment in social development.
- **Special Comparative Note on Health & Social Development Investment:** Countries least affected by Under 5 Mortality have: between 90%-100% access to clean drinking water; 90%-100% improved sanitation; less than 1% of population affected by malnutrition; and 97% -100% Vaccine Coverage - in addition to between \$332 (Cuba) and \$5,912 (Luxemburg) per capita investment in health. (Cuba ranking enhanced by best global health worker to population ratio – including urban / rural distribution).

¹ **Under 5 Mortality Rate** - Probability of dying between birth & exactly five years of age, expressed per 1,000 live births.

² **Improved Drinking Water:** Percentage of the population with sustainable access to improved water source (household connections, public standpipes, boreholes, protected dug wells, protected springs and rainwater collection). Not considered as improved water sources are - unprotected wells, unprotected springs, vendor-provided water, bottled water (unless water for other uses is available from an improved source), and tanker truck-provided water.

³ **Improved Sanitation:** Percentage of the population with access to adequate excreta disposal facilities, such as a connection to a sewer or septic tank system, a pour-flush latrine, simple pit latrine or a ventilated improved pit latrine. An excreta disposal system is considered adequate if private or shared (but not public) and can effectively prevent human, animal and insect contact with excreta. Improved sanitation includes connection to public sewers, connection to septic systems, pour-flush latrines, simple pit latrines, and ventilated improved pit latrines. Not considered as improved sanitation - are service or bucket latrines (where excreta is manually removed), public latrines, and open latrines.

⁴ **Child Malnutrition:** Percentage of children under age five whose weight for age is more than two standard deviations below the WHO Child Growth Standards median.

⁵ **Immunization coverage:** Percentage of the target population vaccinated. DTP3 coverage is calculated by dividing number of children receiving their third dose of DTP by the number of children surviving to their first birthday. (DTP3: Third dose of diphtheria toxoid, tetanus toxoid and pertussis vaccine. Coverage with three doses of DTP vaccine is generally used as a proxy for a fully immunized child. DTP coverage is also an indicator of health system performance.)

Annexe 2/ Table 2: 15 Countries Most Affected By Maternal Mortality – With Key Indicators

Maternal Mortality Global Ranking- Deaths per 100,000 live births¹	15 Most Affected Countries	Births Attended by Skilled Health Personnel²	Nurses and Midwives per 10,000³	Family Planning⁴	Hospital Beds per 10,000⁵	Govt Per Capita Investment in Health at Int \$ exchange rate.	Govt exp. on health as % of total govt exp. (As per Abuja 15% Target)
1. (2100)	Sierra Leone	42%	5.0	5.3%	4.0	\$ 4	7.8%
2. (1800)	Afghanistan	14%	5.0	10.3%	4.0	\$ 9	6.2%
3. (1800)	Niger	18%	2.0	11.2%	3.0	\$ 9	17.8%
4. (1500)	Chad	14%	3.0	2.8%	4.0	\$ 16	13.8%
5. (1400)	Angola	47%	14	6.2%	8.0	\$ 62	5.0%
6. (1400)	Somalia	33%	2.0	N/A	N/A	\$ NA	NA
7. (1300)	Rwanda	52%	4.0	17.4%	16	\$ 14	18.8%
8. (1200)	Liberia	46%	3.0	NA	NA	\$ 2	9.8%
9. (1100)	Burundi	34%	2.0	19.7%	7.0	\$ 1	2.4%
10. (1100)	Congo (DRC)	74%	5.0	31.4%	8.0	\$ 2	5.8%
11. (1100)	Guinea Bissau	39%	7.0	7.6%	7.0	\$ 13	4.0%
12. (1100)	Malawi	54%	6.0	41.7%	11	\$ 14	17.1%
13. (1100)	Nigeria	35%	17	12.6%	5.0	\$ 10	3.5%
14. (1000)	Cameroon	63%	16	26.0%	15	\$ 10	6.7%
15. (980)	Central African Republic	54%	4.0	27.9%	12	\$ 5	10.9%

*Table & Analysis by Africa Public Health Alliance & 15%+ Campaign. (Based on latest available comparable data 2007 - 2009). *Main data sources: WHO, UNICEF, UN Pop. Div, UNFPA, Interagency Group for Child Mortality Estimation, World Bank.*

- **Summary Conclusions:** Countries most affected by Maternal Mortality have under invested in Human Resources for Health; Reproductive & Sexual Health; & Availability & Equitable distribution of clinics in urban rural areas. They also have highest Adolescent Fertility rate of between 100–199 per 1,000 women aged 15-19 years.
- **Special Comparative Note on Investment in Health Workers, Reproductive & Sexual Health & Per Capita Health Spending:** - Countries least affected by Maternal Death have skilled birth attendance rate of between 96% & 100%; 70 to 195 Nurses and Midwives per 10,000; & Family Planning coverage of 65% to 90%. They also have the lowest Adolescent Fertility rate of 0-42 per 1,000 women aged 15-19 years - in addition to between \$332 (Cuba) and \$5,912 (Luxemburg) per capita investment in health. (Cuba ranking enhanced by best global health worker to population ratio – including urban / rural distribution)

¹ **Maternal Mortality Ratio:** Annual number of deaths of women from pregnancy-related causes per 100,000 live births. Data adjusted based on reviews by the United Nations Children's Fund (UNICEF), World Health Organization (WHO), & United Nations Population Fund (UNFPA) to account for well-documented problems of underreporting & misclassifications.

² **Skilled Birth Attendant:** An accredited health professional - such as midwife, doctor or nurse - who has been educated & trained to proficiency in skills needed to manage normal (uncomplicated) pregnancies, childbirth & immediate postnatal period; including identification, management & referral of complications in women & newborns. Traditional birth attendants, trained or not, are excluded from the category of skilled attendant.

³ **Nurses & Midwives:** Nurses Includes professional nurses, auxiliary nurses, enrolled nurses & other nurses, such as dental nurses & primary care nurses. Midwives: includes professional midwives, auxiliary midwives & enrolled midwives. Traditional birth attendants are not included in this category & are counted as community health workers by WHO.

⁴ **Contraceptive Prevalence Rate:** Percentage of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time. Usually measured for married women or women living with a partner aged 15-49. Reflects all traditional methods as well as modern methods of contraception. Contraceptive prevalence rates are obtained mainly from household surveys, including Demographic & Health Surveys, Multiple Indicator Cluster Surveys, & contraceptive prevalence surveys. Unmarried women are often excluded from which may bias the estimates.

⁵ **Hospital Beds:** Includes inpatient and maternity beds (excludes cots and delivery beds).

Annexe 3 / Table 3

Comparative Impact of Per Capita Investment in Health & Key Indicators- Between G8 Countries & African Countries of Roughly Similar Population - & Between Best Performing Low/Middle Income Country (Cuba) & African Countries of Roughly Similar Population

	Population	Healthy Life Expectancy (HALE) – which is different from normal life expectancy ¹	Child Mortality - per 1000 live births (MDG 4)	Maternal Mortality - Per 100,000 live births (MDG 5)	People Living with HIV (as part of MDG 6)	No of Doctors	No of Nurses & midwifery personnel	No of Pharmaceutical personnel	Per capita govt expenditure on health - at international exchange rate \$USD	Govt expenditure on health as % of total govt expenditure (As per Abuja 15% Target)	External resources for health as % of expenditure on health
Canada	32.5m	72	6	7	73,000	62,307	327,224	27,048	\$2,759	17.8%	0.0%
Kenya	36.5m	44	121	560	1,500,000	4,506	37,113	3,094	\$ 14	9.7%	14.9%
France	61.3m	72	4	8	140,000	207,277	486,006	69,431	\$3,139	16.7%	0.0%
UK	60.5m	71	6	8	77,000	126,126	740,731	29,726	\$2,908	16.3%	0.0%
DRC	60.6m	37	161	1100	400,000 - 500,000	5,827	28,789	1,200	\$ 2	5.8%	51.9%
Germany	82.6m	72	4	4	53,000	284,427	662,000	46,953	\$2,858	17.9%	0.0%
Ethiopia	81 m	41	119	720	980,000	1,936	15,544	1,343	10	10.0%	42.7%
Japan	127.9m	75	4	6	9,600	270,371	1,210,633	241,369	\$2,224	17.9%	0.0%
Russia	143.2m	58	12	25	940,000	614,183	1,214,292	11,521	\$ 232	10.6%	2.1%
Nigeria	144.7m	42	189	1,100	2,600,000	34,923	210,306	6,344	\$ 10	3.5%	5.9%
Cuba	11.6m	68	6	45	6,200	66,567	83,880	NA	\$ 332	11.2%	0.2%
Malawi	13.5m	35	110	1,100	930,000	266	7,264	NA	\$ 14	17.1%	59.6%
Zambia	11.6m	35	170	830	1,100,000	1,264	22,010	1,039	\$ 35	16.4%	38.1%

Table & Analysis by Africa Public Health Alliance & 15%+ Campaign. (Based on latest available comparable data 2007 - 2009). *Main data sources: WHO, UNICEF, UN Population Division, UNFPA, Interagency Group for Child Mortality Estimation, World Bank, UNAIDS.

¹ Average number of years that a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury.