It's time for Africa to finance its own healthcare

Context

Financing the health system in Africa remains a major problem. The Abuja Declaration (2001), in which governments pledged to devote 15% of their national budgets to health, set targets that the majority of African countries have yet to meet. Although several African countries have slightly increased their spending on health, fewer than one in five have reached their target.

The need and urgency to increase health system financing in Africa was also highlighted in the ALM Declaration during the African Leaders Meeting (ALM) in February 2019.

The ALM declaration called on African leaders to increase national health budgets and restructure African health systems. Better still, it demanded that national resources be mobilized for health, that current budgetary inefficiencies be corrected and that more efficient systems be financed. It encouraged the business sector to seize investment opportunities in the health sector and called for better cooperation between the different sectors.

According to a recent UNDP report, “Health challenges in Africa: what role for the digital age”, 36 out of 57 African nations suffer from a serious shortage of healthcare workers. While high-income countries spend more than $4,000 per person on healthcare, African countries spend between $8 and $129 per person. This under-funding is bound to have a significant impact on healthcare systems in Africa in general and in

West and Central Africa in particular, as the table below shows.

Figure 1. Health system performance in West and Central Africa

Countries	Coverage	Human Resources for Health	Service infrastructure		Supply Chain		Health Financing		
	RMNCAH: Antenatal care coverage (4+)	Core health personel (per 1000 population) - GHO	Density of health centres (per 100 000 population)	Density of hospitals (per 100 000 population)	Percentage of facilities with Essential Medicines	Percentage of facilities with Diagnostic capacity	Domestic General Government Health Expenditure (GGHE-D) as % General Government Expenditure (GGE)	Domestic General Government Health Expenditure (GGHE-D) per Capita in US$	Out-of-pocket (OOPS) as % of Current Health Expenditure (CHE)
Benin	52	7.5	5.5	0.4	41	51	4	6	44
Cameroon	59	10.2	0.8	0.8	52	78	3	9	70
Cape Verde	72	20.4	3.8	1.0			10	90	26
Central African Republic	38	2.7	2.0	0.5	27	37	5	2	43
Chad	31	4.1		0.7	44	31	6	6	61
Congo	79	17.2			17	37	4	30	50
Gabon	78	33.0	2.2	3.5			9	142	23
Gambia	78	17.3	1.7	0.7	46	56	3	4	24
Guinea	51	4.4	3.5	0.4	14	35	4	5	50
Guinea-Bissau	65	16.0	33.0	56.4	32	55	13	17	35
Liberia	78	1.4	1.0	0.4	44	42	4	10	47
Mauritania	63	12.1	3.8	1.0	26	32	6	17	51
Niger	39	3.6	5.0	0.5	41	36	6	6	59
Sao Tome and Principe	84	25.8	2.1		39		7	42	14
Senegal	57	3.8	0.5	0.2	30	45	6	18	51
Sierra Leone	78	3.0	1.2		31	33	8	10	42
Togo	57	3.5	10.9	0.6	39	40	4.3	7.8	50.4

* Assessment of performance is based on regional benchmarking. Full methodology of approach and data sources available on RSSH Dashboard.
* Data sources: HFA (SPA,SARA,SDI); WHO, Global Health Observatory; WHO, Global Health Expenditure Database. Most recent year available per country.

To date, the Member States of the African Union have adopted a framework for the right to health that includes Agenda 2063 and the Sustainable Development Goals (SDGs). But despite these commitments, health systems remain weak due to insufficient investment and unsustainable dependence on external aid.

And yet, let’s not forget that investing in health improves human capital, stimulates the economy and reduces inequalities. Community health programmes are crucial. They reduce disparities precisely by guaranteeing access to essential services for vulnerable populations.

Mobilizing sustainable national financing for better health in Africa

It was against this backdrop that the first Task Force for Increased Domestic Resource Mobilisation for Health in Africa was launched at the African Union summit held in Nairobi on 12 July to reflect on and discuss the financing of health in Africa. Co-chaired by the Honourable Daniel Molokele of Zimbabwe and the Honourable Dr Rabi Maitournam of Niger, and supported by GFAN Africa, this working group is also supported by parliamentarians from ten African countries: Cameroon, Côte d’Ivoire, Democratic Republic of Congo, Ghana, Kenya, Niger, Rwanda, Senegal, Zambia and Zimbabwe.

Moved, no doubt, by the urgent need to formalize genuine collaboration between parliamentarians and

civil society, these parliamentarians proposed a toolbox for effective advocacy based around a platform for exchanging information, sharing best practice and strengthening political synergies.

More specifically, the launch of this working group led to a vibrant appeal to African leaders, partners and other stakeholders to make a greater commitment to mobilizing adequate and sustainable domestic resources for health on the continent. Below are the main commitments and recommendations contained in the Nairobi Declaration.

Commitments

The countries have undertaken to defend:

- Mobilizing national resources for health, including moving from commitment to action, co-financing Global Fund programs and those of other development partners for HIV, TB and malaria, to build equitable and resilient health systems based on a people-centred approach and integrated health services (treating HIV, TB and malaria as well as other health problems according to people's needs and disease burden);
- Strengthening the community health system, in particular by guaranteeing recognized status for community health workers (CHWs), funding community health strategies, supporting community-led responses and integrating community, rights and gender considerations into programmes to combat HIV, TB and malaria;
- Integrating universal health coverage as an objective in national health policy frameworks, strategically linking it to broader inter-ministerial priorities such as emergency preparedness, social stability, climate, economy and finance;
- Filling the financial and implementation gaps for HIV, TB, malaria, health systems strengthening, pandemic preparedness and response, and community health systems in countries' national strategic plans;
- Creating a forum for parliamentarians from different regions of Africa to exchange and share best practice; and
- Creating synergies with civil society on the mobilization of national resources for health in Africa.

Recommendations

At the end of the summit, a number of recommendations were also put forward for consideration:

- That African governments, as part of a multi-sectoral approach, work together with parliamentarians, civil society and the private sector to implement sustainable strategies for mobilizing national resources and significantly increasing health budgets, given that a healthy nation is essential to Africa's socio-economic transformation, as set out in Agenda 2063.

- With the aim of achieving universal health coverage by 2030, African governments are speeding up the institutionalization of CHWs to ensure the sustainability of their actions. This involves formalizing their integration into health systems, professionalizing their training and mobilizing the resources needed to pay them.

General comment

While this declaration is to be welcomed, the way in which African States usually follow up this type of commitment gives cause for extremely cautious optimism. In fact, as Christian Djoko points out, on the one hand, African states willingly agree to sign up to fine legal texts that are more or less binding but are very reticent when it comes to taking specific measures to ensure their effective implementation. That said, as popular wisdom recommends: “Give the runner a chance. Judge the bricklayer by the wall”. The stakes and challenges are too high to give in to resignation or give in to defeatism.

Link to the Declaration: https://impactsante.org/wp-content/uploads/2023/07/DECLARATION_MP_Nairobi_FR.pdf

Bibliographical reference: Christian Djoko, État de droit et droits de la personne en Afrique centrale : le cas du Cameroun, Paris, L’Harmattan, 2016, p. 94

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