

Current State of Health in Africa

1. Introduction

In the health sector, the Millennium Development Goals (MDG) targets are, between 1990 and 2015, to reduce child mortality by two-thirds, maternal mortality by three-quarters; and to have halted and begun to reverse the spread of HIV, AIDS, tuberculosis, malaria and other major diseases. These goals are not only important in their own right, their attainment – which involves cross-cutting issues such as gender equality/empowerment and the impact of population on the environment – has a direct influence on the achievement of other MDGs.

However, despite increased international funding for – and commitment to – health, only modest progress has been made in meeting the health MDGs. This progress has been made mainly in disease-specific areas. It has become evident that improving health outcomes will not be possible without long-term strengthening of health systems which include sustainable and equitable social health protection.¹

Given poor progress overall towards these targets, on 24 June 2008 the EU (European Union) Council published its Agenda for Action on MDGs (see below).

This brief report summarises the progress of the various health sector initiatives included in the EU-Africa Strategy Action Plan of the MDG Partnership.

2. Statistical Overview²

It is estimated that 536,000 women – more than half of whom are in sub-Saharan Africa (SSA) – die each year as a result of complications of pregnancy and childbirth; and 400 mothers die for every 100,000 live births.³ In 2005-2006 the maternal mortality was 900 in SSA where there has been virtually no improvement since 1990. This highlights the difficulty of achieving this MDG. Thus greater focus and acceleration is urgently needed if progress is to be made.

HIV and AIDS

In 2007, 22.5 million people in SSA (some two-thirds of people worldwide) were living with HIV. The estimated proportion of the population infected has fallen since 2000, when HIV prevalence reached a peak of nearly 6%, to about 5% in 2007. However, in stark contrast to the overall slight improvement, the high prevalence rates in Southern Africa have translated into higher adult mortality rates and lower life expectancy. These have significant implications for health services and the economies of the affected countries.

Across SSA:

- Coverage for prevention of mother-to-child transmission (PMTCT) is only 5%
- Only 60,000 -100,000 of the 800,000 HIV positive children in need are on treatment.

Sexual and Reproductive Health

- 210 million women get pregnant yearly
- 20 million pregnancies end in unsafe abortions
- 67,000 women die from abortion complications - 13% of maternal mortality
- Complications of abortions are possible no matter the method of abortion
- Complications include trauma, haemorrhage and infection.

¹ Providing For Health (P4H) Initiative, 5 May 2008

² Based on WHO World Health Statistics 2008 except where other references apply.

³ The “maternal mortality ratio”.

Family planning has steadily decreased as an international priority in recent years, despite its documented impact on both maternal and child health and overall development, and its very clear relationship to HIV and AIDS.⁴ Within sub-Saharan Africa, use of family planning and unmet need vary greatly but, overall, 23 percent of married women are using family planning – 18 percent with a modern method and 5 percent with a traditional method. However, 25 percent of women report having an “unmet need,” meaning that they would prefer to stop having children or delay their next birth, but are not using any method of family planning.⁵

Malaria

SSA is also where 80% of the global burden of malaria occurs. Insecticide-treated nets (ITNs) are a cheap and highly effective way of reducing the burden of malaria. They prevent malaria transmission and reduce the need for treatment, thus lessening pressure on health services and averting deaths, especially in young children. The good news is that, in the majority of the 21 African countries with data from at least two national surveys, the proportion of children sleeping under ITNs increased five to ten times within five years.

Human Resources

A few, smaller economies have not recorded any rural-urban migration but the majority have seen a significant increase in urban population in the period 2000-2006 as people seek employment and better health and social services. Delivery of health services requires appropriate human resources but SSA suffers from an acute shortage of doctors and nurses. For example, only Mauritius and Seychelles have one physician per 1,000 population, while 29 countries have one physician or less per 10,000 population; and 31 countries have less than 10 nursing and midwifery personnel per 10,000 population.

3. Overarching Initiatives

The AU-EU Partnership adopted four mechanisms to direct, monitor and support activities that will accelerate the achievement of the MDG health targets:

1. **EU Agenda for Action on MDGs for SSA**, which focuses on health targets (see Box 1).
2. **International Health Partnership**, which works to ensure that donor adhere to aid effectiveness principles in their support to health interventions.
3. **High Level Taskforce on Innovative Finance for Health Systems** which seeks to agree the financing gap, raise more resources and secure G8 support.
4. **Network of African Parliamentarians on Health & Gender Development and Financing**, launched in November 2008 with leadership from the Pan African Parliament, the Economic Community of West African States (ECOWAS) Parliament, the East African Legislative Assembly (EALA) and Southern African Development Community Parliamentary Forum (SADC-PF), with the mandate to raise parliamentary awareness and ensure quicker policy and budget support for health.

4. Activities

Thirty-seven initiatives have been identified and adopted by the AU-EU MDG Partnership. These initiatives, being taken across the continent, are grouped under 13 “Activity” headings (see Annex A). Tracking progress on these activities involves a very large number of varied organisations (government ministries, donor agencies, regulatory bodies, public and private health organisations, manufacturers, consultants, etc.). As a result, and in the absence of recent reports on some initiatives, the progress reported here may not present an up to date

⁴ World Bank (2008). *2008 World Development Indicators* (Washington, DC: World Bank): 35.

⁵ Population Reference Bureau (2008). *Reproductive Health in Sub-Saharan Africa*. Washington , DC.

position. Indeed, one of the lessons from the EU-Africa Partnership is the need to improve communications and reporting, both to be able to monitor progress effectively, and then support initiatives that are falling behind schedule, and to avoid overlaps and duplication of effort.

Box 1 : EU Agenda for Action on MDGs for SSA

A commitment to support the attainment of:

- Target set in 2005 regarding universal access to reproductive health services;
- 2010 milestones to:
 - Save two million more children's lives each year in Africa;
 - Have 13 million more births in Africa attended by skilled health personnel each year;
 - Provide 50 million more women in Africa with modern contraceptives and more generally to have access to family planning services; and
 - Provide 75 million more bed nets.

In addition to meeting these targets, increased investment by the EU in the health sector is expected to contribute to:

- Additional funding for national plans, including through the International Health Partnership (IHP) and in the framework of the "Providing for Health Initiative";
- Getting as close as possible to universal and free access to HIV and AIDS prevention, mitigation and treatment by 2010; and
- Further support for the Global Fund to fight HIV, AIDS, Tuberculosis and Malaria (GFATM), as well as UNITAID.

The Agenda for Action requires an estimated € 6 billion contribution from the EU by 2010.

Activity 1: Affordable Quality Medicine

There has been discernable progress in improving access to affordable medicine through six of this activity's eight initiatives. These include four now well established and funded initiatives: the GFATM, UNITAID⁶, the Global Alliance for Vaccines and Immunization (GAVI), and the International Finance Facility for Immunisation (IFFIm). The pilot Advance Market Commitment, designed to incentivise the production of pneumococcal vaccines, has received wide support and this initiative is being expanded. The EU has committed to support financing research and development for neglected diseases, which is under discussion in the AFRO region, led by Kenya through the expert task force on financing.

A key initiative, the Medicines for Malaria Venture (MMV), supported by member states, aims to provide affordable treatment for malaria. This is a not-for-profit public-private partnership dedicated to reducing the burden of malaria in disease-endemic countries by discovering, developing and facilitating delivery of new, effective and affordable anti-malarial drugs. In February 2009, MMV and a private partner launched the first dispersible ACT for children. A clinical study reported in *The Lancet* showed that this product provides a high cure rate of 97.8%. Investigators have also reported that it had a good safety profile.

Six possible sources for financing medical supplies are already established (see Annex B) and additional innovative financing mechanisms will be examined as part of Activity 3.

Local Production

While commitments have been made to support increasing the capacity for regional and local production of generic medicines (Activity 1a), there is as yet no report of increased production or

⁶ UNITAID is an international facility for the purchase of drugs against HIV/AIDS, Malaria and Tuberculosis

when that may be expected. The May 2008 progress report on Pharmaceutical Manufacturing Plan for Africa identified six priority areas to be taken forward in partnership with RECs, WHO, the World Bank (WB), etc. Unfortunately the tension between health objectives and trade objectives has been heightened by the recent global economic downturn. Hence it may be unrealistic to expect any real progress on developing production in SSA over the next few years. This, in turn, means even greater emphasis is needed to facilitate the import of generic and affordable patented drugs.

Regulatory Capacity and Pharmaceutical Manufacturing Plan

In March 2008 progress on Phase II of the Pharmaceutical Manufacturing Plan for Africa was discussed in Addis Ababa and responsibilities were assigned for coordinating activities in six priority areas: mapping; situation analysis and compilation of findings; manufacturing agenda; intellectual property issues; political, geographical, economic considerations; financing. However, it is not yet clear how this plan will strengthen regulatory capacity through EU/AU cooperation (Activity 1b).

Importation

While there is ongoing EU support for Trade Related Aspects of International Property Rights (TRIPS) and Member State (MS) support for United Nations Conference on Trade and Development (UNCTAD) assistance to African countries, there is no report of specific progress in facilitating the import of generic and affordable patented drugs in accordance with the TRIPS provisions on compulsory licensing and parallel imports (Activity 1c).

Mechanisms to Fight Counterfeit Medicines

The Medicines Transparency Alliance, the initiative for strengthening mechanisms to fight counterfeit medicines (Activity 1d) and supported by several EU member states, is increasing its profile and effectiveness. Three African countries (Ghana, Uganda, and Zambia) are among the seven Medicines Transparency Alliance (MeTA) pilot countries and have made a high-level political commitment to sign up to MeTA's core principles, to increase accountability at all levels of the medicines supply chain, and to work with the private sector and with civil society in order to take MeTA forward. One of its activities is improving publicly available information on the price, quality, availability and promotion of medicines. For example, in Zambia, theft was cut by providing information on the delivery of medicines in rural health centres to local health committees made up of members of the local community.

WHO Inter-Governmental Working Group

Progress is being made towards encouraging political support for the WHO Inter-Governmental Working Group (IGWG) (Activity 1e). The IGWG has developed a global strategy and plan of action (GSPA) on public health, innovation and intellectual property. Over the past 18 months, WHO MS and other stakeholders met in three meetings of the IGWG (and also in regional consultations and other multilateral meetings linked to the IGWG), to discuss ways to foster innovation, build capacity and improve access to health products to achieve better health outcomes in developing countries. Additionally, their work was enhanced by written submissions from Member States on various negotiating texts, as well as inputs from a wide range of stakeholders through two web-based public hearings; and in January 2009 a working group met to discuss a presentation on the platforms, lessons and challenges for GSPA public private partnerships for product development.

Activity 2: Training and Retention of Health Workers

Five initiatives are supporting the training and retention of health workers. However, it is noticeable that expected outcomes are couched more in terms of eventual health outcomes

instead of the intermediate (and more easily measured) resources required to deliver those outcomes. Among the initiatives is the Global Health Workforce Alliance which organised the first Global Forum on Human Resources for Health held in Kampala, Uganda from 2-7 March, 2008. It called for immediate and sustained action to resolve the critical shortage of health workers around the world. Attendees at the Forum endorsed the Kampala Declaration and the Agenda for Global Action. This high profile event was attended by nearly 1500 participants, including donors, experts and ministers of health, education and finance.

Budget support is essential for the training and retention of health workers. The 2008 G8 summit that took place in July 2008 issued a communiqué that US \$60 billion in aid for diseases would be delivered over five years. The summit also endorsed scaling up the number of health workers to 2.3 per 1,000 in key countries, which should equate to 80% of mothers being accompanied in childbirth by a trained health worker. This would ultimately ensure that a further 1.5 million health workers are recruited in Africa.

Activity 3: Creation and Reinforcement of Social Health Protection Systems

EU Member States held a meeting in February 2008 on Health Financing and Social Protection in Health, reviewed existing know-how and experience, and agreed how to proceed with the development of a policy initiative in this area. A conference was to be held in May 2008, following which a joint paper was to be developed for deliberation and then approval by the EU Council in November 2008. At present there is no report of how far this initiative has progressed. Similarly, there is no news to report on the Providing for Health initiative (P4H) since the paper circulated in May 2008.

Activity 4: Health Systems, Management Information Systems (MIS), Fees, and Health Education

Among efforts to strengthen district and national health systems, including participatory and action-led health management information systems, in 2008 WHO issued v4 of its assessment tool for Assessing the National Health Information System. This is a very useful tool whose use should be promoted. Its adoption is also a management indicator as well as an important step towards achieving consistency in health sector data.

Activity 5: Water and Sanitation

Some EU member states, through their bilateral programmes, are contributing to the implementation of the Agenda for Action in water and sanitation. However, there is insufficient data to know to what extent the EU collectively is meeting its commitment (made in June 2008) to increase aid for water and sanitation to SSA by €2 billion each year by 2010.

In September 2008 the Netherlands and UK announced a new joint initiative on water and sanitation which would provide €106 million over five years to help up to 20 poor countries develop and implement their own national water and sanitation plans. Also in September 2008 the EC Commission published "*Towards sustainable water resources management: A Strategic Approach*" which gives guidance to practitioners involved in the development and management of water resources in developing countries.

Activity 7: Maputo Action Plan

The United Nations Children's Fund (UNICEF) consultation meeting on health fees, held in February 2009, agreed to recommend that countries provide a basic package of quality health services, free at the point of delivery, for women of reproductive age and children. Focusing on providing social health protection to client groups linked to the MDGs 4 (children) and 5

(pregnant women), this policy, if fully implemented, could contribute significantly to tackling maternal and infant mortality.

Activity 8: Child Survival and HIV and AIDS, Malaria and Tuberculosis

While there are no specific reports of action to implement the African child survival strategy, and the follow up of the Abuja Call for Accelerated Action towards universal access to HIV, AIDS, tuberculosis and malaria services in Africa, EU member states are continuing to provide assistance by supporting the preparation of proposals for Global Fund financing. Most recent Global Fund performance is summarised in Annex C.

Activity 10: Telemedicine and E-Health

In Gabarone in March 2007 the Telemedicine Task Force had discussed how to explore and test possibilities to improve access to health services through the use of telemedicine and e-health. Three pilot projects were proposed: one focusing on the health workforce (scaling up numbers, improving performance, increasing quality); a second on clinical services (increasing health service coverage, reaching isolated areas); and a third aimed at strengthening the intelligence gathering capacity of health systems and their ability to use information for decision making. However, there is, as yet, no report on these projects.

Other Activities

There are no reports of items relating to Activities 6, 9, 11, 12 and 13.

Missing from the statistics (Section 2) and under any of the MDG Partnership activities is specific inclusion of any initiative to address the needs of people with disabilities. Reliable estimates are not available⁷ but there appears to be general acceptance that at least 20 percent of the poor in Africa suffer disability.⁸ This topic deserves greater attention because health services have to do much more to cater for the wide-ranging needs of disabled persons.

5. EU Support for the Health Sector

The following summarises the level and performance of EU support for health in SSA⁹:

- Overall Commission funding to the health sector is below policy commitment and benchmarks, despite significant new support for the Global Fund.¹⁰
- There is a shortage of international assistance for strengthening health systems.

Analyses by the Commission, EU Member States and WHO have identified key issues in the overall level and distribution of health funding which the international community must address (see Box 2).

⁷ World Bank (2008). *Disability and Poverty: A Survey of World Bank Poverty Assessments and Implications*. Washington DC.

⁸ See www.includeeverybody.org.

⁹ European Court of Auditors, *Special Report No 10/2008 on EC Development Assistance to Health Services in Sub-Saharan Africa*.

¹⁰ Ninth European Development Fund (EDF) assistance committed directly to the health was only 5.5% of total EDF commitments compared with the 15% target set by the European Parliament. Ninth EDF General Budget Support actually used for national health budgets was rather less than €200 million.

Box 2 : Key Issues in the Overall Level and Distribution of Health Funding

EU Member States and Commission health experts concluded in 2006 both that health's share in overall EU Overseas Development Assistance (ODA) was insufficient at 6.6% and that EU health assistance was not correlated to countries' needs in terms of their health financing gap.

DG Development has estimated that, if they were to deliver minimal health services, 32 Sub-Saharan African countries would have a total financing gap of €9,767 million, even if they met the target set by African Heads of State at their 2001 Abuja Summit to allocate 15% of their national budget to health.

A WHO study on health assistance identified a number of "health donor orphans" and concluded that there was no clear correlation between a country's health situation and the amount of health assistance it received. More health aid is given to countries with high HIV and AIDS prevalence, even if the overall health situation in other countries is as bad or worse.

6. Conclusions and Recommendations

The foregoing summary of progress suggests that there are a considerable number of initiatives across the health sector in SSA, to the extent that priorities may become subsumed, available resources dissipated and overlaps arise. This is borne out by the difficulty in keeping track of the progress on these initiatives. Put crudely, the shopping list is too long. Perhaps increased focus on fewer initiatives – those that have an immediate impact on the MDG target outcomes – would, through a concentration of resources and effort, yield earlier, discernable results.

Despite the efforts, SSA taken as a whole, looks unlikely to meet health related MDGs. Politico-economic problems in some countries are hindering progress but, more generally, urban population growth is exacerbating the problems of poverty and access to health (and social) services. Some countries are experiencing a double burden of disease with increases in non-communicable chronic diseases in addition to fighting infectious diseases. This again calls for more attention to areas where progress can be accelerated.

Annex A

AU-EU Partnership Activities for Achieving Health MDGs

Thirty-seven initiatives have been identified and adopted by the AU-EU MDG Partnership. These initiatives are grouped under 13 “Activity” headings:

1. **Affordable quality medicine:** Develop joint strategies to enhance access to affordable quality medicines, in particular for HIV/AIDS, malaria, tuberculosis, other endemic diseases and meningitis through activities that will:
 - Enhance capacity for regional and local production of generic medicines;
 - Strengthen regulatory capacity through EU/AU cooperation on implementing the Pharmaceutical Manufacturing Plan for Africa;
 - Facilitate the import of generic and affordable patented drugs in accordance with the TRIPS provisions on compulsory licensing and parallel imports;
 - Strengthen mechanisms to fight counterfeit medicines;
 - Encourage political support for the WHO IGWG process aimed at improving the availability and accessibility of priority medicines for Africa and cooperation on issues relating to public health, innovation and intellectual property.

2. **Train and retain health workers:** Increase the capacity of African countries to train and retain health workers, including through the implementation of the Africa Health Strategy 2007–2015 and the European programme for action to tackle the shortage of health workers in developing countries (2007–2013).

3. **Social health protection systems:** Identify joint actions to initiate the creation or reinforcement of social health protection systems.

4. **Health systems, MIS, fees and health education:** Identify joint actions to strengthen district and national health systems, including participatory and action-led health management information systems, the elimination of fees for basic health care, strengthening preventive health care systems and health education, and stronger involvement of civil society partners.

5. **Water and sanitation:** Jointly address environmental health challenges by implementing water and sanitation programs and projects, in conjunction with the partnerships on energy and climate change.

6. **Research on health systems and synergies with traditional medicine:** Improve operational research on health systems and synergies with traditional medicine, including through the implementation of the action programme of the African Decade on Traditional Medicine.

7. **Maputo Action Plan:** Support the implementation of the Maputo Action Plan to operationalise the continental policy framework for sexual and reproductive health and rights 2007-2010 within the context of established EU positions that are in line with the International Conference on Population and Development (ICPD) processes.

8. **HIV and AIDS, malaria, and tuberculosis:** Implement the African child survival strategy, and the follow up of the Abuja Call for Accelerated Action towards universal access to HIV/AIDS, tuberculosis and malaria services in Africa.

9. **Coordination:** Coordinate African and European positions in appropriate international fora and negotiations.
10. **Telemedicine and e-health:** Explore and test possibilities to improve access to health services through the use of telemedicine and e-health within Africa and beyond.
11. **International Year of Sanitation:** Seize the opportunities presented by 2008 being the UN International Year of Sanitation, and prepare a joint statement for the Conference on Sustainable Development 16.
12. **Twinning:** Promote twinning initiatives and other appropriate exchanges to accelerate progress towards health MDGs.
13. **International health agreements:** Support the implementation of – and adherence to – international health agreements.

Annex B

Possible Sources for Financing Medical Supplies

UNITAID: An international drug purchase facility financed primarily from the proceeds of a solidarity tax on airline tickets. It aims to provide long-term, sustainable and predictable funding to increase access and reduce prices of quality drugs and diagnostics for the treatment of HIV/AIDS, malaria and tuberculosis in developing countries. It intends to do this by: negotiating low prices for already existing forms of medication; purchasing them in high quantities; and encouraging the development of forms that are not yet available and of drugs that are not yet affordable.

Multi-donor Trust Funds: MDTFs can be used as a platform for attracting and pooling donor funds, leveraging additional resources both from donors and governments, using innovative results based financing approaches to create stronger incentives for better performance and strengthen key links between health and finance ministries.

European Commission MDG contract: The MDGc offers the potential to provide more predictable long term funding whilst retaining a strong performance based approach, to address key bottlenecks which cannot be addressed by action at the sector level alone and to create a platform on which other donors could provide support.

GAVI and Global Fund support for health system strengthening: The EU Commission is one of the Global Fund's founding partners and its fourth largest contributor. GAVI and Global Fund are currently providing support necessary to protect and sustain benefits of investments aimed at improving access to essential services related to immunisation and key communicable diseases.

International Financing Facility for Immunisation¹¹: IFFIm has the potential to raise large amounts of funding – in a predictable manner - and to frontload support where there is a strong case for doing so and it is financially justified.

The Advance Market Commitment: AMC donors make an upfront financial, legally binding, commitment to buy vaccines at a set price, if and when vaccines are available, meet minimum pre-specified criteria and are demanded by developing countries.

¹¹ In late November 2008 a note clarifying the management structure that would best support the Draft Terms of Reference of the Taskforce was circulated. The Taskforce comprises a small number of leading international figures acting in their individual capacity and not as representatives of their government or agency. It will make recommendations on: (1) the mix of innovative international financing mechanisms needed to deliver the extra resources required; and (2) promote international support for these recommendations to ensure that they are implemented. The Taskforce aims to conclude its work within 12 months by convening three or four times over the period to develop and build support for its recommendations. The aim will be to gain agreement from the international community on Taskforce recommendations before the Italian G8 summit in July 2009 and to complete the process by the UN General Assembly and the IMF/World Bank Annual Meetings in the autumn of 2009.

Annex C

Global Fund Performance Indicators for Sub-Saharan African 31 December 2007

HIV and AIDS	% of target	Activities
Anti-retroviral Therapy (ART)	93 %	1,100,000 people on ART
HIV Counselling and Testing	101 %	16 million people reached
PMTCT	64 %	100,000 HIV positive pregnant women received a full course of PMTCT treatment
Support to Orphans	116 %	2 million orphans provided with care and support
Tuberculosis		
DOTS Treatment	86 %	800,000 people on treatment
Malaria		
ITN	63 %	35 million nets distributed
Anti-Malarial Treatment (ACT)	43 %	37 million malaria treatments delivered

Other Indicators

Care and Support 107 % 1.7 million people received care and support

People Trained 105 % 1.8 million people trained to deliver services

Source : Global Fund.