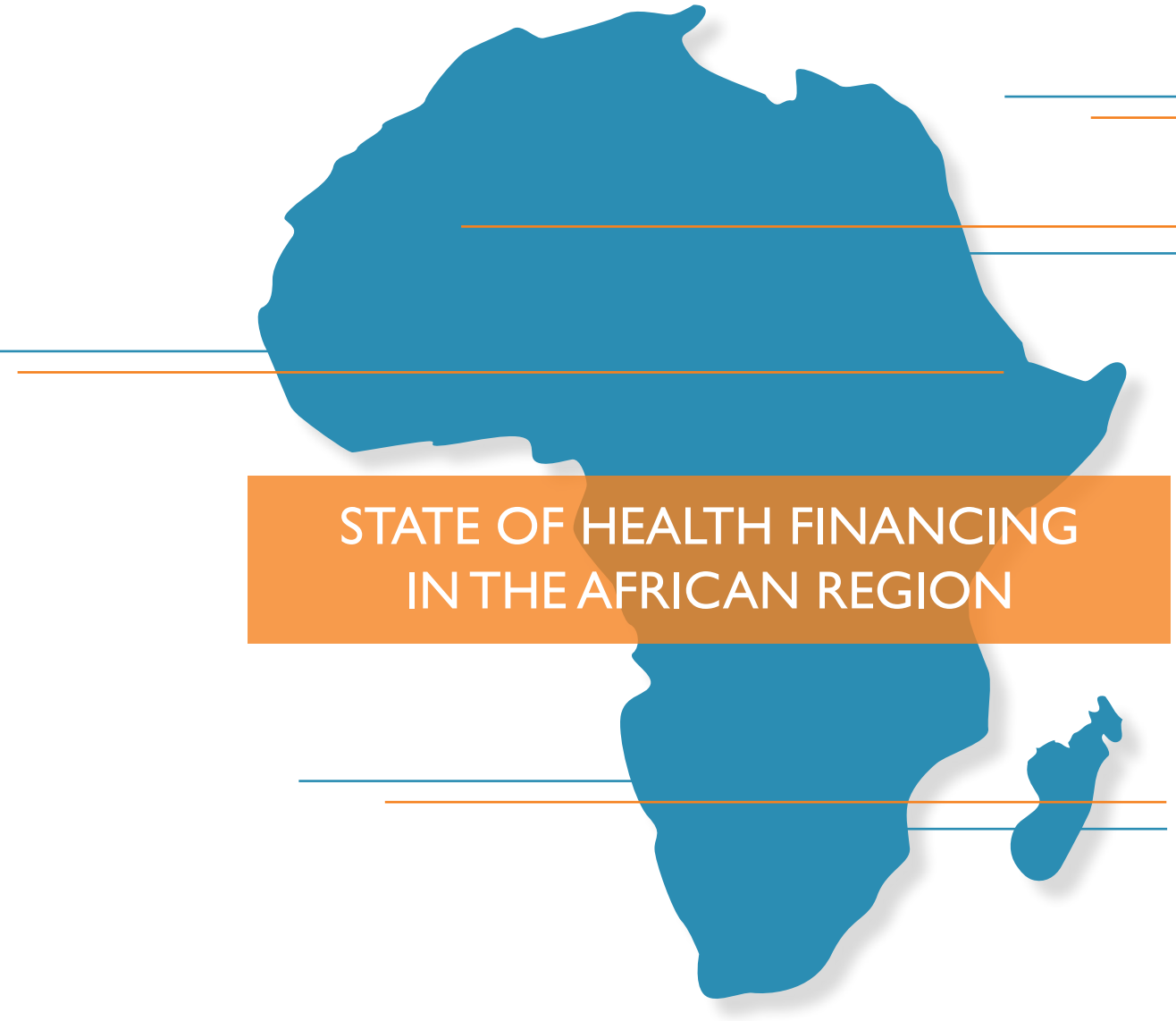

STATE OF HEALTH FINANCING IN THE AFRICAN REGION

January 2013

World Health Organization
REGIONAL OFFICE FOR Africa

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Abbreviations

CBHI	Community Based Health Insurance
CBRHAS	Community Based Reproductive Health Agents
CEMAC	Communauté Économique des États de l'Afrique Centrale
CFA	Communauté Financière Africaine
CHESS	Country Health Systems Surveillance and Intelligence
DMHIS	District-wide Mutual Health Insurance Schemes
DRC	Democratic Republic of Congo
GDP	Gross Domestic Product
GGE	General government expenditure
GGHE	General government health expenditure
GNI	Gross National Income
HEP	Health Extension Program
HEWS	Health Extension Workers
HHA	Harmonization for Health in Africa
HLTF	High-Level Taskforce on Innovative International Financing for Health Systems
IHP+	International Health Partnership
IMF	International Monetary Fund
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
NHIS	National Health Insurance Scheme
NHSP	National Health Strategic Plan
NCD	Noncommunicable Disease
ODA	Official Development Assistance
P4H	Providing for Health initiative
PBF	Performance Based Financing
PHC	Primary Health Care
RBF	Result Based Financing
THE	Total Health Expenditure
U5MR	Under 5 Mortality Rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAT	Value Added Tax
WHA	World Health Assembly
WHO	World Health Organization

Contents

Key messages of this report

The Member States of the African Region of the World Health Organization are on average still far from meeting key health financing goals such as the Abuja Declaration target of allocating 15% of the government budget to health. Out-of-pocket expenditure is still higher than 40% of the total health expenditure in 20 of the 45 countries studied, and in 22 countries the total health expenditure does not reach even the minimal level of US$ 44 per capita defined by the High Level Task Force on Innovative International Financing for Health Systems (HLTF). Only three countries have attained the Abuja Declaration and HLTF targets.

Many countries have limited capacity of raising public revenue mainly because the informal nature of their economies makes collection of tax and contributions difficult. This limits their opportunities for investing in health. Innovative resource mobilization instruments and prioritization of government spending on health may bridge the funding gap to some extent. External funds will still remain critical in many contexts but more should be done to ensure their effective use through improved predictability of funding flows and harmonization of their allocation with national priorities and mechanisms.

Several African countries have recently implemented successful health financing reforms that have increased access to health services and financial risk protection, moving them closer to the policy objective of universal health coverage (UHC). Many countries have put in place mechanisms to protect the poor and vulnerable population groups, including measures that have abolished or reduced user fees at the point of access to health services. Evidence has shown that for these measures to effectively increase the use of good quality health services, systemwide investments are required.

Wide variations can be observed in health outcomes in relation to some of the key aggregate health financing indicators. This calls for more in-depth and context-specific analysis of the design and operation of the existing health financing systems and solutions to improve some of the key indicators such as equity in resource allocation and efficiency in resource utilization.

Taking into account the challenges of raising sufficient financial resources for health, distributing the financial burden of health expenditure in an equitable manner and addressing the need for efficient use of the scarce resources, close collaboration between the ministries of finance and health is vital.

The interaction between the ministries of finance and health on policy can be enhanced by such actions as formation of interministerial committees and other policy-oriented bodies and institutions for dialogue and information sharing. The ministry of finance will need to support capacity building in financial management in the health sector and the ministry of health will need to engage the ministry of finance in sectoral planning, budgeting and implementation reviews.

Interministerial dialogue between the ministries of finance and health will need to be embedded within the process of developing a health financing strategy that is based on evidence and takes into account the constraints and opportunities in every specific context. Considering that the building blocks of the health system are interdependent and interlinked, development and implementation of health financing strategies must run parallel with efforts to strengthen all the other health system dimensions in order for a country to move towards universal health coverage.

Introduction

Health is increasingly recognized as a key aspect of human and economic development in Africa and countries are increasing investment in actions and reforms to improve health outcomes and accelerate progress towards meeting the health Millennium Development Goals (MDGs). The political will of the national leaders to put health in forefront of development has been reiterated at the continental level through actions such as the Abuja Declaration of 2001 on increasing government funding for health, the Addis-Ababa Declaration of 2006 on community health in the African Region and the 2008 Ouagadougou Declaration on primary health care and health systems in Africa. Health system financing is one of the key areas that offer important opportunities to translate these commitments and political will into results.

The need to develop strong health financing systems is a common objective of all countries. Even the richest countries are finding it increasingly difficult to keep up with rising health care costs, and the current economic downturn is adding more pressure on health spending. In low and middle income countries, which are where the vast majority of African countries are ranked, scarcity of funds for health is an even more acute problem. The average total health expenditure in African countries stood at US$ 135 per capita in 2010, which is only a small fraction of the US$ 3150 spent on health in an average high-income country [1]. Insufficient investment in the health sector or in actions to tackle the environmental and social determinants of health is a serious obstacle to improving health outcomes in Africa, particularly considering that the continent bears the bulk of the global morbidity and mortality burden for maternal and infant mortality and HIV/AIDS. In addition, the rise in noncommunicable diseases and injuries has put many countries under the pressure of a double burden of disease. The major constraint arising from funds shortage in most African countries is that the strategies and mechanisms that underpin health financing systems pose problems. In about half of African countries, 40% or more of the total health expenditure is constituted of household out-of-pocket payments, which is the most regressive way of funding health care. The reliance on this payment mechanism creates financial barriers to access to health services and puts people at the risk of impoverishment [2,3]. Furthermore, the current financial flows within the health systems are creating and exacerbating inefficiencies and inequities, for example through skewed allocation of funds to urban areas and specialized care.

These weaknesses in the health financing systems have been identified as the main underlying reasons for the limited progress towards achieving the health MDGs in Africa [4,5]. At the same time, the recent gains in survival of people living with HIV and reductions in mortality rates for malaria and measles are in danger of not being sustained if the key issues in health financing are not addressed. The overarching framework of analysis presented in this report is rooted in the concept of universal health coverage (UHC), which is defined as access to needed, good quality health services — promotion, prevention, treatment and rehabilitation — for everyone, without the risk of financial hardship as a result of having to pay to access these services [6].

This report focuses on health financing for areas that are considered the key levers in ensuring that countries are moving towards UHC. It aims to identify and analyse the major dynamics in performance of health financing systems during the last decade in the Member States of the WHO African Region and to shed light on some of the key problem areas. It will also look at the progress made by countries and the reforms and actions that these countries have implemented to improve their health financing systems. This document traces the key lessons learned and highlights successful country cases. Many African countries are struggling to address the weaknesses in their health system building blocks. This report, while having health financing as the entry point, will also briefly look at other health system dimensions that affect the progress towards UHC.

The main objective of this report is to provide a solid information basis for policy dialogue on health financing and health system development for UHC. It presents the current state of health financing in a manner that will support evidence-based policy discussions and policy making. In this way it responds to the current challenge of measuring, observing, evaluating and analysing data on health financing. A particular focus will be on issues in which dialogue on health financing will be crucial between the ministries of health and finance. Bringing evidence-based contributions to these interministerial policy discussions is a systemic objective since each country will need to reinforce the policy interaction between these two key ministries with a larger dialogue process that includes all the key stakeholders. Doing so will play a key role in strengthening health financing systems in the countries, ensure that they get value for money for their investment in health and help their efforts to move Africa towards meeting the MDGs and other crucial development targets beyond 2015.

Methodology

Sources of data

A data collection tool was developed and sent to the countries to collect data on the parameters of the health financing system, including sources of health financing and their level of importance, pooling mechanisms, level of dialogue among stakeholders on health financing, health outcomes, and strengths and weaknesses in the health system building blocks. Where gaps existed in health financing national health accounts data annually collected by WHO and verified by the countries before finalization were used.

Analysis

To assess the countries' ranking on various indicators, categorizations were used with point estimates set as much as possible at 2001, 2005 and 2010. These years were chosen because of their association with key milestones in health and availability of data. The milestones were the declaration made by Africa Union Member States to invest in health in Abuja (2001) and the World Health Assembly (WHA) resolution 58.33 of 2005 that urged WHO Member States to adopt the goal of UHC and develop their health systems and health financing systems to support this goal, a commitment further reinforced by the WHA resolution 64.9 on UHC in 2011. The most recent internationally comparable health expenditure data was available for 2010. Qualitative data were used to explain observations from the quantitative data.

Categorization of the countries on attainment levels for various indicators was based on several criteria:

Total health expenditure per capita: The High Level Taskforce on Innovative International Financing for Health Systems (HLTF) estimated that by 2009 a low income country would need to spend on average US$ 44 per capita to strengthen its health system and to provide an essential package of health services [7]. We categorized countries in three groups based on spending: less than US$ 20, US$ 20–US$ 44 and more than US$ 44. This US$ 44 estimate was projected to rise to US$ 60 by 2015.

General government expenditure on health (GGHE) as a share of total general government expenditure (GGE) was categorized based on the Abuja Declaration where governments pledged to allocate at least 15% of their total budget to health. This shows the level of priority of health system funding in the overall national development agenda. Three categories were used for GGHE/GGE expenditure: less than 10%, 10–15% and more than 15%.

GGHE as a share of gross domestic product (GDP): A study of 185 countries showed that GGHE as a share of GDP increased with a country's income. Other evidence shows that when government expenditure on health is greater than 5–6% of GDP, fewer households have financial difficulties in paying for health services [8]. We assessed the level of government health expenditure against the level of GDP.

Out of pocket payments as a share of total health expenditure: Evidence shows that catastrophic health expenditure and impoverishment remain low in countries where out-of-pocket expenditure is less than 15–20% of the total health expenditure. In addition, few households are shown to be impoverished where out-of-pocket expenditure is less than 20% of the total health expenditure [8]. Catastrophic expenditure is defined as out-of-pocket health payments exceeding 40% of household nonsubsistence spending. The three categories used to group the countries for the share of out-of-pocket payments in total health expenditure were less than 20%, 20–40% and more than 40%.

Expenditure on health from external sources as a share of total health expenditure: This factor shows to some extent the degree of donor dependence for financing of health services in a given country. For this factor we categorized the countries into three groups: less than 20%, 20–40% and more than 40%.

Maternal mortality ratio (MMR): WHO, UNICEF, UNFPA and the World Bank report on trends in maternal mortality for 2012 categorize MMR (maternal deaths per 100,000 live births), as very high if it is in the range of 300 and above and as extremely very high if it is 1000 or more [9]. We categorized the countries into four groups for MMR: up to 300, 301–600, 601–999 and greater than 1000.

Under-5 mortality rate: The UN Inter-agency Group for Child Mortality considers a country as "on track" if its under-5 mortality (deaths of children under 5 per 1000 live births) is less than 40 or if its annual average rate of reduction for 1990–2008 is 4% or more [10]. For under-5 mortality rate we had four categories: less than 40, 40–100 and more than 100.

Some countries have good practices that may serve as lessons for other countries considering implementing health financing reforms. These have been used as illustrations in the various sections of this report as appropriate. We looked, for example, at efforts by countries relating to innovative health financing mechanisms, in particular those identified in the World Health Report of 2010. These include a special levy on large profitable companies and currency transactions, diaspora bonds, a tax on financial transactions and tourism, an excise tax on tobacco and unhealthy food, selling franchised products, and voluntary solidarity contribution through mobile phones.

The analysis in this report assesses how organization of the health financing system in a given country supports the objectives of increasing financial risk protection, enabling effective and equitable access to services and improving the quality of health services. It also attempts to relate the health outcomes to a given level of funding and to the organization of the health financing system.

Results and discussion

Macroeconomics, government income and external funds

Twenty-six of the forty-five countries assessed for this report are categorized as low income countries in the World Bank classification and had a gross national income (GNI) per capita below US$ 1005 in 2010 (in current prices). Only Equatorial Guinea had a GNI per capita higher than US$ 12,275 in 2010 and was classified as a high-income country. Annex I shows details of how the countries are categorized.

Available funds for health

• Total health expenditure

Almost all health financing systems in the African Region are pluralistic, with funds originating and flowing through several sources and mechanisms, including the government, donors, households, employers and nongovernmental organizations. Total health expenditure is an aggregate measure that puts together all the different revenue collection sources. It gives an idea of the total level of funds available for health from public, private and external sources and reflects the importance of health care in the overall economy.

In 22 of the 45 countries the level of funding for health is below the minimum level of US$ 44 per capita recommended for 2009 by the High Level Task Force on Innovative International Financing for Health Systems. Table 2.1 shows the trend of total health expenditure for the African Region over a period of 10 years.

We note that over the years more countries have been increasing expenditures on health although the rates vary among the countries. For example, Rwanda more than doubled its per capita expenditure on health over a period of 10 years, with a large part of this increase attributed to external funds. On the other hand, six countries have remained below the expenditure level of US$ 20 per capita. Eleven countries have persistently spent over US$ 44 per capita over the same period. Annex II shows detailed total health expenditure per capita levels for 2010.

Table 2.1: Trends in total health expenditure per capita in current US$

Year	Less than US$ 20	US$ 20–US$ 44	More than US$ 44
2001	Benin, Burkina Faso, Burundi, Central Africa Republic, Chad, Comoros, DRC, Eritrea, Ethiopia, Gambia, Ghana, Guinea Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Niger, Nigeria, Rwanda, Togo, Uganda, Tanzania **(24 countries)**	Angola, Cameroon, Congo, Côte d'Ivoire, Guinea, Lesotho, Mauritania, Senegal, Sierra Leone, Zambia **(10 countries)**	Algeria, Botswana, Cape Verde, Equatorial Guinea, Gabon, Mauritius, Namibia, Sao Tome and Principe, Seychelles, South Africa, Swaziland **(11 countries)**
2005	Burundi, Central African Republic, DRC, Eritrea, Ethiopia, Gambia, Guinea, Liberia, Madagascar, Malawi, Mozambique, Niger, Rwanda, Tanzania **(14 countries)**	Angola, Benin, Burkina Faso, Chad, Comoros, Congo, Côte d'Ivoire, Ghana, Guinea-Bissau, Kenya, Lesotho, Mali, Mauritania, Senegal, Sierra Leone, Togo, Uganda, Zambia **(18 countries)**	Algeria, Botswana, Cameroon, Cape Verde, Equatorial Guinea, Gabon, Mauritius, Namibia, Nigeria, Sao Tome and Principe, Seychelles, South Africa, Swaziland **(13 countries)**
2010	Central African Republic, DRC, Eritrea, Ethiopia, Madagascar, Niger **(6 countries)**	Benin, Burkina Faso, Burundi, Chad, Comoros, Gambia, Guinea, Kenya, Liberia, Malawi, Mali, Mauritania, Mozambique, Sierra Leone, Togo, Tanzania **(16 countries)**	Algeria, Angola, Botswana, Cameroon, Cape Verde, Congo, Côte d'Ivoire, Equatorial Guinea, Gabon, Ghana, Guinea-Bissau, Lesotho, Mauritius, Namibia, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, South Africa, Swaziland, Uganda, Zambia **(23 countries)**

Many countries have already recognized the importance of addressing health funding challenges in order to reinforce their health system and to move towards the goal of UHC. Chad, for example, is already laying a foundation involving all stakeholders in developing a plan and strategy to address the weaknesses in its health sector (Box 2.1).

Box 2.1: Addressing funding challenges to move towards universal health coverage in Chad

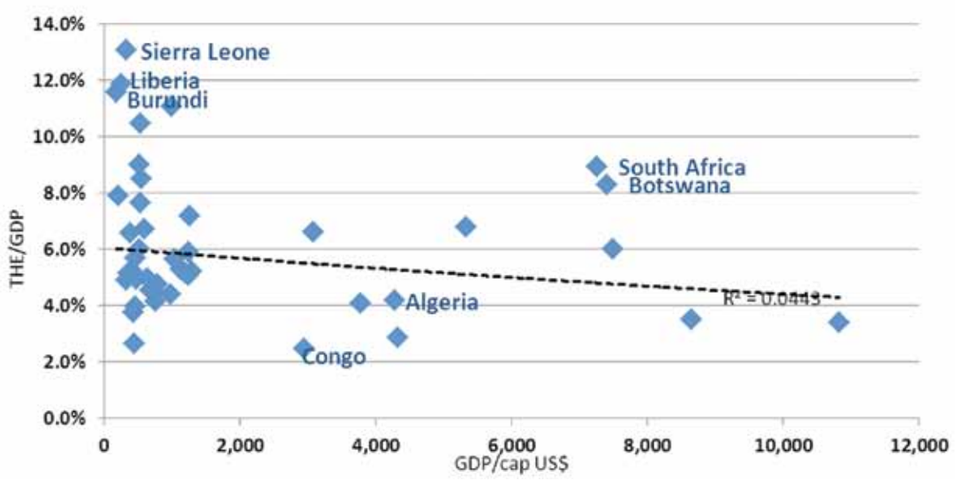
The Ministry of Health of Chad, in collaboration with the Ministry of Planning, Ministry of Finance and Ministry of Labour, has developed a national strategic plan (NHSP) with a medium-term expenditure framework. All major technical and financial development partners in health participated in the development of NHSP and committed themselves to facilitate its implementation, monitoring and evaluation. Within the context of improving management of funds in the health sector, Chad signed the IHP+ (International Health Partnership) Compact in May 2011 to increase aid effectiveness and harmonization in line with the Paris Declaration principles. In addition to these partnership commitments, Chad has initiated a dialogue through the Providing for Health (P4H) network and soon will propose a roadmap for implementing a health financing strategy to move the country towards UHC. Efforts will be focused on reducing financial barriers to access to health services, given that currently private household payments for health are more than 50% of the total health expenditure and that out of this 95% comes from out-of-pocket payments.

While Chad has been looking at ways to increase the volume and effectiveness of external aid, the challenges for raising the necessary domestic funds to support future plans and strategies are many. In order to increase funds, one option would be to reallocate more to the health sector from the existing government financial resources. But reaching the levels of the Abuja target will be an important challenge given that currently general government health expenditure represents only 3% of the general government budget (2010 levels). Lack of financial resources is certainly a major constraint in moving towards the goal of UHC, although addressing other health system components is also crucial. For example, there is a need to tackle the shortage in qualified health workers, who in 2011 stood at 0.24 per 1000 habitants, and their poor motivation.

International and historical evaluations have shown that a rich country is likely to spend a bigger share of its national budget on health than a poor country, although the evidence on this correlation is not fully conclusive [11]. Looking at different country income groups, one observes that low and lower middle income countries spend around 6% of their GDP on health, the upper middle income countries about 7%, and OECD countries around 10%.

Figure 2.1 shows a mixed pattern for the African Region. There is a crowding of countries with GDP per capita levels of less than US$ 2000 and within that group there are significant differences in the share of GDP allocated to health expenditure. But this factor needs to be interpreted alongside other parameters. For example, for countries such as Burundi, Liberia and Sierra Leone external funding for health is a major component of the total health expenditure and it pushes up the overall expenditure levels against a backdrop of very low levels of GDP per capita. On the other hand, for countries with low levels of external funding such as Congo, Algeria or South Africa the trend seems to be for the higher total health expenditure against GDP to be associated with higher levels of GDP per capita.

Figure 2.1: Total health expenditure as a share of GDP and GDP



In the future, with Africa still on a projected path of economic growth [12], the focus should turn to how the economic expansion will affect availability of funds for health. Will health expenditure grow faster, slower or at the same pace as per capita income? The answer to this question will necessarily vary from country to country, but as there are most probably going to be "push" factors, such as the rise in noncommunicable diseases or in the ageing population, and "pull" factors, such as investment growth in high technology that will be similar to high-income countries elsewhere, it is probable that many African countries will follow the same pattern of "excess growth" (health spending outpacing economic growth) that has been observed in the high-income countries. Looking at the very low levels of per capita spending and of total health expenditure as a share of GDP in most African countries, especially in health spending from domestic sources, this would be a welcome outcome in most countries, but it should not mask the need to also look at how to avoid inefficiencies in utilization of resources, which is an objective for all countries at all income levels.

• Domestic funds for health

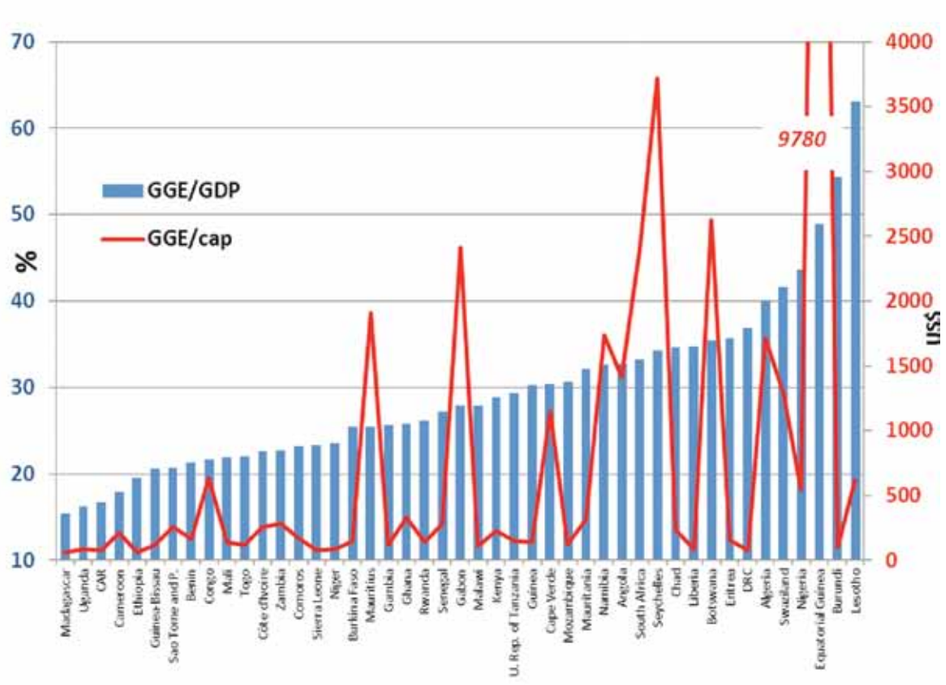
The capacity of a country to take advantage of economic growth by raising public financial resources through taxation and other revenue generation mechanisms sets the boundaries for government expenditure and determines the government's capacity to deliver essential services and to invest in public goods. The question of revenue generation for health within the objective of building a

sustainable and effective health financing system that relies largely on prepayment and pooling is firmly interlinked with a government's overall revenue raising capacity.

Many African countries have shown to have limited capacity of raising public revenue mainly because the informal nature of their economies makes tax collection difficult, including payroll tax collection for social health insurance. The performance, accountability and administration of the tax system are often an additional problem for many countries [13].

Figure 2.2 gives an overview of the public financial capacity in African Region countries in absolute US dollar terms and relative to the size of the economy.

Figure 2.2: General government expenditure (GGE) as a share of GDP and GGE per capita (GGE/cap) in current US$ (2010)



As can be seen from Figure 2.2, there is great variation among the countries in their capacity to mobilize public financial resources. Countries with high GDP in absolute per capita terms are able to spend more, even when their government expenditure as a share of the economy is low. This explains to a large extent why Gabon, for example, has a government expenditure of US$ 2410 per capita while Malawi, with a similar share of GGE over GDP (28%), spends only at US$ 110 per capita on health.

According to the International Monetary Fund (IMF), 20 of the 45 countries in sub-Saharan Africa can be viewed as significant exporters of natural resources. Among these 20 countries, 10 collect more public revenues from natural resources than from all other revenue sources together. The situation of public finances in these countries is very different from that in the countries without or with limited revenue from natural resources. But even in these countries the question of sufficiency and sustainability of public funds is crucial, if only because in only 2 of these 20 countries are revenues from natural resources projected to increase markedly during 2011 to 2016 [12].

The capacity of countries to generate public financial resources is to a large extent a question that lies outside of the health sector. However, since the health sector is in most cases one of the two or three leading sectors for public expenditure, there is a need for the health ministry to be proactive in its approach to general government revenue generation. In many countries the health sector has been one of the leading actors when countries have implemented new or additional mechanisms for public revenue collection (see the Box 2.2 on Gabon). Health advocates for sure wish that these additional revenue streams would be earmarked for health but usually they are not. In any case, raising more public revenues should indirectly benefit the health sector, whose share, even it is not increased, will be from a larger cake.

To decrease reliance on out-of-pocket payments, the countries will need to find ways to increase health funds that come from prepaid sources and are subsequently pooled. The potential to identify new sources of tax revenue such as sales taxes and currency transaction fees exists. Ghana, for example, has funded its national health insurance scheme (NHIS) partly by increasing the value-added tax (VAT) by 2.5%. A review of 22 low income countries showed that they could collectively raise US$ 1.42 billion through a 50% increase in tobacco tax. Innovative resource mobilization instruments including public-private partnerships and multisectoral engagements could help reduce the funding gap and serve as good mechanisms for lobbying the state to increase the health budget. Some innovative health financing mechanisms from some of the countries are shown in Table 2.2.

Table 2.2: Innovative health financing mechanisms in some African countries

	Special levy on large profitable companies	Levy on currency and other financial transactions	Tobacco and alcohol excise tax	Other taxes earmarked for health
Cape Verde			√i	
Comoros			√ii	
Gabon	√	√		
Ghana				√
Guinea				√iii
Zimbabwe	√iv			

There are good practices in the Region, for example in Gabon (Box 2.2) and Ghana (Box 2.5).

Box 2.2: Innovative financing mechanisms in Gabon to augment health funds

Gabon introduced new taxes in 2009 to raise additional funds to subsidize health care for low income groups. One was a tax on money transfers whereby a 1.5% levy on the post-tax of profits was imposed on companies that handle remittances. The second was a 10% tax on mobile phone operators in the country. The two taxes raised an equivalent of US$ 30 million for health in 2009. These funds are used to protect low income groups against financial risks and to reduce barriers to accessing health care. They support enrolment of the low income population in national health insurance and social security schemes. This mechanism of raising funds for health for low income groups is an example that can be emulated by other countries in the African Region.

Other countries have mechanisms to increase the general government revenue base. Although these funds are not earmarked for health, an increase in government revenue will indirectly impact the capacity of the government to finance health services. Innovative tax and levy mechanisms in some countries include those associated with tobacco, alcohol[1], environmental pollution[2], petroleum products[3], community support, currency transactions[4] and risky behaviour such as drunken driving[5]. Many of these taxes and levies target behaviour and products that negatively affect health, and this is why from a public health perspective they are a good thing even if they do not create additional revenues (if, for example, the consumption of taxed products outbalances the proceeds). Moreover, if these taxes and levies are successful in reducing adverse health effects of some products and unhealthy behaviour and so reduce the need for costly care for chronic conditions and noncommunicable diseases, some of the cost pressure on health care would be alleviated in the medium to long term.

As figure 2.2 shows, African countries have different limit levels in raising public revenues. It is clear that even by capturing higher shares of the economy for government spending some countries with a very challenging macroeconomic context simply cannot mobilize the financial resources for health that would ensure access to and availability of the needed health services. In such cases external funding for health will be of great importance in the short to medium term. It should be emphasized that while health aid has increased substantially in the last decade, there are still important funding gaps.

• External funds for health

In the majority of African Region Member States, external sources account for less than 20% of total health expenditure, as shown in Table 2.3. But some countries face special circumstances, such as Malawi, where donor funding consistently accounted for more than 40% of the total health expenditure between 2001 and 2010. Burundi and Tanzania registered a significant increase in the relative importance of donor funding between 2005 and 2010. Annex III shows details on donor resources for health for the countries in the different categories.

Table 2.3: External sources of health financing as a percentage of total health expenditure

Years	Less than 20%	20–40%	More than 40%
No. of countries in 2001	32	10	2
No. of countries in 2005	25	12	7
No. of countries in 2010	24	14	6

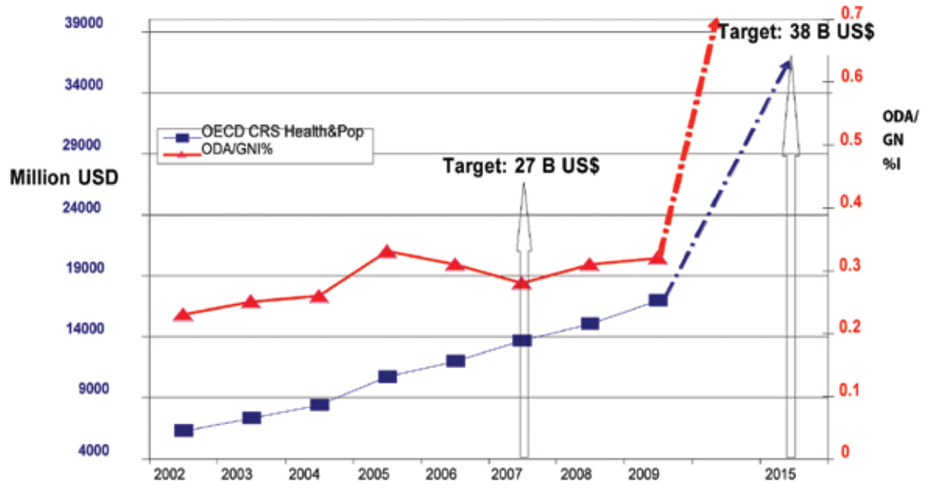
[1] Sierra Leone, Gambia, Swaziland
[2] Gambia
[3] Kenya
[4] Swaziland
[5] Swaziland

Several issues have been raised regarding external sources in financing health services. On the one hand, concerns have been expressed regarding reliance on donor funding to finance key health interventions. In a panel discussion organized by members of the Harmonization for Health in Africa on 30 September 2011 during the 61st session of the WHO Regional Committee in Yamoussoukro, Côte d'Ivoire, ministers of health and ministers of finance emphasized that external resources should only play a catalytic role, and the bulk of funding for health should be mobilized from domestic sources.

HLTF highlighted the need to increase donor investment in health in low income countries to scale up coverage of health interventions to meet MDG targets. The panel discussion involving the ministers of health and ministers of finance on health financing in Yamoussoukro in September 2011 similarly noted that it would be possible to achieve a large increase in available international resources for health if the donor countries would fulfil their promise to allocate 0.7% of their gross national income (GNI) to official development assistance (ODA). In 2009 only 5 out of the 22 donors met this requirement.

The trends in ODA for financial assistance for health for all recipient countries not just Africa and for ODA/GNI are shown in Figure 2.3. The two targets for health ODA in absolute terms (US$ 27 billion and US$ 38 billion) were set by the Commission on Macroeconomics and Health for donor funding for health. It can be observed that the slow progress in total ODA as a share of donor countries' GNI has been counterbalanced from the health sector point of view by the larger increase in health ODA. However, even with the substantial increase in health ODA, the 2015 target of US$ 38 billion is still a faraway objective. But the gap narrows to some extent when external funds not counted in ODA are included, such as those from foundations and other private donors.

Figure 2.3: Trends in official development assistance for health (health and population) - total disbursements for 2002–2009 in constant 2009 dollars



Source: Organization for Economic Co-operation and Development, Development Assistance Committee, Creditor Reporting System

External sources play a significant role and so the focus should be in addressing identified challenges to their effective use. Improving predictability of donor funding and harmonization of donor funds with national priorities and mechanisms are among the issues that need to be addressed. A sectorwide approach was mentioned as a solution for better coordination and harmonization among the development partners themselves and between development partners and the countries. In this regard a compact in line with IHP+ principles should be developed, signed by all parties, enforced and monitored. The country teams noted that the health sector needs to develop a clear policy and a strategic plan as an investment framework for all available funding. Coordination structures should be established at the national and decentralized levels and a results and accountability framework binding for all parties should be developed. In addition, the capacity of the ministries of health needs to be strengthened and collaboration between the ministries of health and finance should be improved to monitor donor aid for health.

There are examples of countries that have made significant progress in improving harmonization and alignment of development assistance such as Benin, as shown in Box 2.3.

Box 2.3: Harmonizing and aligning technical and financial support of development partner agencies in Benin

The Government of Benin has expressed a strong commitment to make progress towards UHC. An Intersectoral Technical Committee (ITC) was set up to work on a draft bill and to propose an action plan. The leadership of this process is held by the Ministry of Health.

Several development partners are actively involved in health system strengthening and health financing in Benin, but each of these has a unique focus. The WHO is concerned with health service provision and the national health plan, the World Bank with the recently formed National Health Insurance Agency (ANAM), the American, Belgian and Swiss bilateral cooperation agencies with the community based health insurance (CBHI) networks and the French bilateral cooperation agency with the UHC stakeholder process. In order to avoid parallel working streams and to align development partner support with the bigger picture of UHC development goals, the Government chose to follow the approach provided by the Providing for Health (P4H) network.1

A joint P4H team comprising all the major development partners involved in UHC-related work started a process that included the development of a joint support plan based on the results of a situation analysis. The joint support plan produced aims at harmonizing the technical and financial support of each partner agency within the P4H Benin network and aligning the actions of each agency with the national UHC strategy and with the work done under the ITC.

The objective of the joint support plan is not only to harmonize and align the support from the partner agencies (this is an intermediary objective) but also to leverage this harmonization in order to catalyse the reduction in fragmentation within the health financing system by, for example, supporting a process for absorbing user fees when exemption mechanisms are implemented under the ANAM health insurance plan.

Previous panel discussions on health financing between ministers of health and ministers of finance concluded that keeping external funding "in the budget" allows ministries of health more control over allocating these funds towards the priority areas as identified in national sector health plans. There could be a cause for joint advocacy involving the ministries of health and finance for donors to enforce concrete actions that follow the spirit and content of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action.

Extent of government prioritization of health

In majority of cases, even when external funds will be critical, there is scope for governments to allocate more money for health. In this regard, the 2001 Abuja Declaration urging African Union States to allocate "at least 15%" of national budgets to the health sector was a landmark. This commitment was further reaffirmed in the Maputo Declaration in 2003. Unfortunately this target had been achieved by only 5 countries by 2010 as shown in Table 2.4. During the same period 13 countries had reduced their relative government allocation to health while in 4 others the trend had not changed. The average amount allocated to the health sector by African Region countries stands at 9.8% [14]. It is important to note however that allocations to the health sector as a percentage of total government budget ranged from 2%[6] to 20%[7]. Annex IV shows detailed country data.

Table 2.4: General government health expenditure as a share of general government expenditure (GGHE/GGE)

Years	Less than 10%	10–15%	More than 15%
No. of countries in 2001	22	21	2
No. of countries in 2005	20	17	8
No. of countries in 2010	19	21	5

Discussions between ministers of health and finance on health financing have noted that in Africa, the relatively strong political commitment to health sector development has not always translated into channelling of more public spending for health. Reaching the health expenditure objectives has often been difficult because of inadequate funds allocation, and has further been compounded by budgetary cuts that have not spared the health sector. The country teams provided suggestions on what could be done to increase the current low allocations for health. Some acknowledged that the political will was there but the revenue base was small and as such efforts must be made to increase domestic revenue. Majority of the countries mentioned strengthening budget execution and demonstrating results from funding already provided as a way of showing return on investment. This calls for strengthening of monitoring mechanisms, and in this regard the countries emphasized the need to institutionalize national health accounts (NHAs).

[6] Guinea
[7] Rwanda

The countries have recognized that it is logical to consider as important both the Abuja Declaration target of allocating 15% of the government budget to the health sector and the recommendation of the HLTF to allocate at least US$ 44 per capita to deliver an essential package of health services [7]. Over a third of the countries in the African Region have not managed to raise health spending to the level of US$ 44. Only Botswana, Rwanda and Zambia have managed to meet both the Abuja and the HLTF targets as shown in Table 2.5 [14]. In the case of Botswana, this could be attributed to the high levels of government spending on health and for Rwanda it is more of a combination of multiple sources of funding and high levels of external financing. It is also important to take note of the fact that Equatorial Guinea has significantly high health expenditure per capita but has not been able to attain the Abuja target.

Table 2.5: Total health expenditure against GGHE/GGE

	GGHE/GGE more than 15 %	GGHE/GGE less than 15 %
Total health expenditure per capita more than US$ 44	Botswana, Rwanda, Zambia **(3 countries)**	Algeria, Angola, Cameroon, Cape Verde, Congo, Côte d'Ivoire, Equatorial Guinea, Gabon, Ghana, Guinea-Bissau, Lesotho, Mauritius, Namibia, Nigeria, Sao Tome and Principe, Senegal, Seychelles, South Africa, Swaziland, Uganda **(20 countries)**
Total health expenditure per capita less than US$ 44	Madagascar, Togo **(2 countries)**	Benin, Burkina Faso, Burundi, Central African Republic, Chad, Comoros, DRC, Eritrea, Ethiopia, Gambia, Guinea, Kenya, Liberia, Malawi, Mali, Mauritania, Mozambique, Niger, Sierra Leone, Tanzania **(20 countries)**

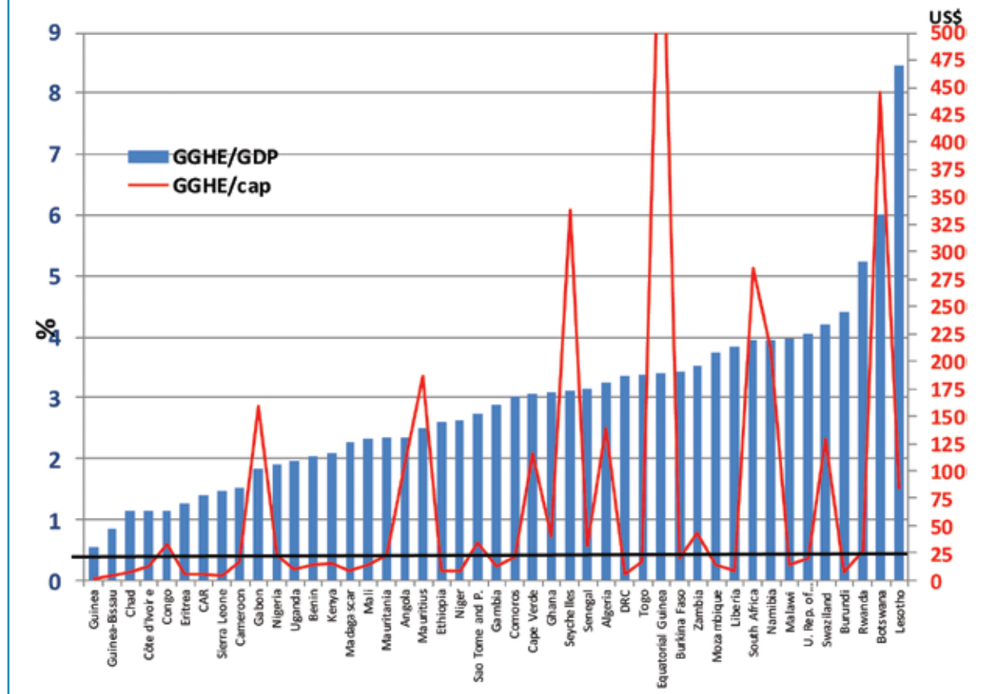
In order to realize increases in allocation of funding for the health sector, collaboration between the ministries of health and finance has to be improved and the misconception that health is an unproductive sector demystified. The countries have suggested ways in which these issues could be addressed. Among these is setting up of interministerial committees and strategic alliances for continued dialogue and information sharing, health sector participation in bilateral and multilateral engagements between the government and partners, and finance ministry support for capacity building in financial management in the health sector. In addition, the countries pointed out the need for finance ministries to participate fully in health financing processes right from agenda setting through to implementation and monitoring of interventions.

Involving finance ministries in planning, budgeting and reviews in the health sector; widely broadcasting health sector achievements and challenges; conducting evidence-based dialogue and developing position papers to show the contribution of health in overall development were among the ways suggested to demystify the misconception that health is an unproductive sector.

General government expenditure on health

Taking into account the capacity of the countries to generate public financial resources and their priorities in allocating them, it is obvious that countries will be at different positions in their volume and share of public funding for health. This is demonstrated in Figure 2.4.

Figure 2.4: General government health expenditure (GGHE) as a share of GDP and GGHE per capita in current US$ (2010)



In most of the countries funds available for public health constitute less than 4% of GDP, which is well below the often used target of 5–6% of GGHE as a share of GDP. Figure 2.4 shows also that in a majority of the countries per capita government health expenditure does not reach US$ 25.

As already indicated, the macroeconomic context, the ability to raise revenue and the priority given to health in government budgets all influence the volume of available public funds for health. In many countries most of the population falls outside of the formal economic sector, making it hard to collect direct taxes or contributions, and governments rely mainly on indirect taxes such as VAT and duty taxes or other revenues such as those originating from natural resources. This means that the core funding for health in most countries will rely on general government revenue transfers, either through earmarking directly at the source or through normal budget allocation mechanisms.

This underscores the importance of interministerial dialogue involving the ministries of health and finance in order to secure a sufficient, stable and sustainable revenue base for health system financing.

Ultimately the level of government funding for health will depend to a large extent on political choices. Reaching the Abuja target, for example, will ultimately depend on political decisions regarding priorities of government action. Countries with a high level of political will behind health financing reform and actions have shown that governments can mobilize financial resources for health, even in complicated macroeconomic situations. However, while the need to raise more financial resources for health is a reality for all African countries, the question of efficient and transparent use of resources is of fundamental importance. Many countries could already achieve more with the existing resources through efficiency gains. Health financing policy dialogue will need to focus on several aspects of efficiencies, and although there are some common causes of inefficiencies as indicated in chapter 4 of the World Health Report 2010 on health financing and universal coverage [6], every country will need to make a thorough assessment of its health delivery system to understand the sources of inefficiencies in its particular case.

In the next section we go into more detail on why the level of public health financing as compared to the level of total health financing matters and why it is essential in moving towards UHC.

• Financial risks and barriers to access to health services

Countries with a low level of public investment in health have high out-of-pocket payments. Out-of pocket payments are well documented as a hindrance to accessing health care. The health financing strategy for the African Region (2006), the World Health Assembly (WHA) 58.33 resolution (2005) and the WHA64.9 resolution (2011) urge Member States to move towards prepayment mechanisms of financing health services. Previous meetings between ministers of health and ministers of finance on health financing have reiterated the need to move away from direct out-of-pocket spending on health towards prepaid and pooled mechanisms. This strategic direction should be part of the objective of covering population groups who cannot contribute directly to health financing by ensuring cross-subsidization in health financing between population groups, making the health financing system more equitable.

As shown in Table 2.6, out-of-pocket payments account for over 40% of the total health expenditure in a significant number of countries. Annex V shows details of countries in the different categories. Some studies have pointed out that where out-of-pocket spending is below 20% of the total health expenditure, catastrophic health expenditure drops to negligible levels [8].

Table 2.6: Out-of pocket payments as a share of total health expenditure

Period	Less than 20%	20–40%	More than 40%
No. of countries in 2001	8	14	23
No. of countries in 2005	8	18	19
No. of countries in 2010	10	15	20

As shown in Table 2.7, although some countries have reached the level of total health expenditure recommended by HLTF (US$ 44 per capita), reliance on out-of-pocket payments is still significant. The level of these payments is higher than the level at which financial risk protection can be ensured

(which is 20% of the total health expenditure). Countries that have reached the US$ 44 per capita mark but have a high level of out-of-pocket payments still need to focus on developing and strengthening pooled prepayment mechanisms.

Table 2.7:Total health expenditure and level of out-of-pocket payments (2010)

	Out-of-pocket payments less than 20%	Out-of-pocket payments more than 20%
Total health expenditure per capita more than US$ 44	Angola, Botswana, Lesotho, Namibia, Seychelles, South Africa, Swaziland **(7 countries)**	Algeria, Cameroon, Cape Verde, Congo, Côte d'Ivoire, Equatorial Guinea, Gabon, Ghana, Guinea-Bissau, Mauritius, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Uganda, Zambia **(16 countries)**
Total health expenditure per capita less than US$ 44	Malawi, Mozambique, Tanzania **(3 countries)**	Benin, Burkina Faso, Burundi, Central African Republic, Chad, Comoros, DRC, Eritrea, Ethiopia, Gambia, Guinea, Kenya, Liberia, Madagascar, Mali, Mauritania, Niger, Sierra Leone, Togo **(19 countries)**

Botswana has for long been able to translate its economic development into a health financing strategy and system that has minimized out-of-pocket payments to less than 20% of the total health spending as shown in Box 2.4.

Box 2.4: Significant government investment in health resulting in financial risk protection and improved access to services in Botswana

The current health financing system in Botswana provides a high level of financial risk protection compared with other sub-Saharan African countries. The tax-based system ensures coverage of the population for a wide range of services. Out-of-pocket spending in Botswana is only 8% of the total health expenditure, which is among the lowest for African countries. Government expenditure on health, at around US$ 446 per capita, is also much higher than African Region's upper middle income average of US$ 228 per capita and of upper middle income countries in the world. In many ways Botswana is closer to UHC than other African countries.

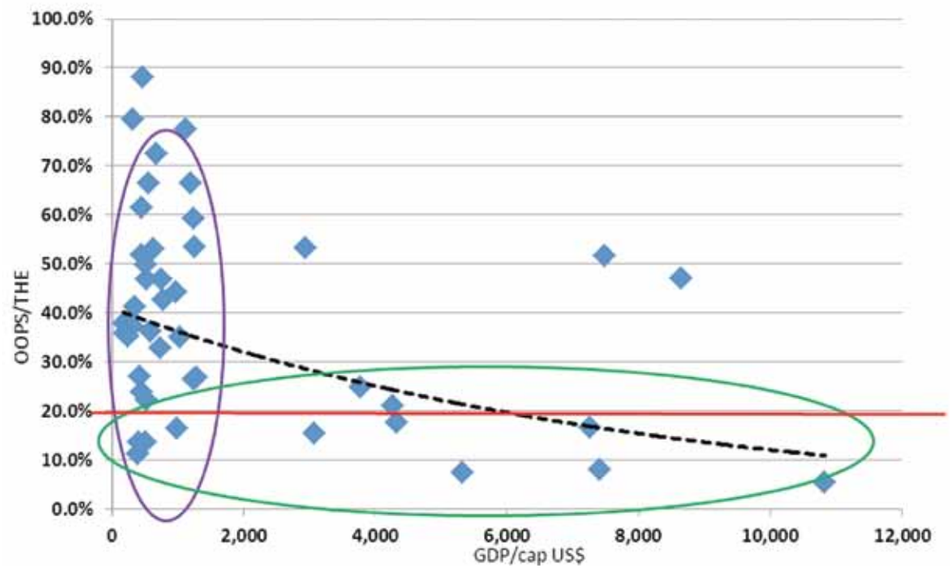
Botswana is the only country in the African Region to meet the Abuja target to spend more than US$ 44 per capita on health and to have less than 20% of the total health expenditure coming from out-of pocket spending (see Table 2.5).

In Botswana where there have been big achievements in public health, the question of health financing reform will of necessity not be the same as for countries where UHC is still a faraway goal. One of the main questions for Botswana will be to find efficiency gains in the current system and ways to allocate funds for the various levels of care in order to increase efficiency and equity. Regardless of the policy choices made by the Government of Botswana, this case shows that when moving towards UHC the question is not always how to build a new health financing system, it is also about keeping the good parts of the existing system and always looking for opportunities where more or fewer incremental actions could be taken to move closer to the goal of UHC and to safeguard the achievements already made.

There is some level of correlation between the countries' economic development and the possibilities of decreasing out-of-pocket expenditure. From global figures, out-of pocket spending decreases as you move along the country income classifications. Thus, in low and lower middle income countries out-of-of pocket expenditure represents on average 50% of the total health expenditure while in the high-income countries (those with GNI per capita over US$ 12,276) this share is only 13%.

In figure 2.5, a comparison between countries in the WHO African Region shows an overall trend of decrease in out-of pocket expenditure with the rise in economic development. But this trend seems to hide a much more complex picture, where the out-of-pocket expenditure share in the total health expenditure is significantly different between countries at the same level of economic development. On the other hand those countries have similar low shares of out-of-pocket spending but very different income levels. This would suggest that there possibly are other constraints besides economic factors that are bringing down the share of out-of-pocket payments. This clearly shows that health financing policies matter — they can drive down out-of-pocket payments even in poor settings. On the other hand in some rich countries out-of-pocket payments can be very high.

Figure 2.5: Out-of-pocket payments as a share of total health expenditure and GDP per capita in current US$ (2010)



Caution is warranted in the interpretation of data showing very low out-of-pocket payment levels. In countries with such data, access to good quality services might be low, meaning that the levels of out-of-pocket payments simply reflect low levels of service use. Data are needed on both service use

and out-of-pocket payments for a valid assessment. It is outside the scope of this report to go into country-specific analyses, but this serves as a reminder that in addressing the objective to reach UHC goals two sides of the coin need to be tackled: financial risk protection and access to services. Access

to services will be poor if the overall investment in health is low and does not ensure availability and quality of the health services. Also, the question is not necessarily on the overall out- of-pocket spending in a given country, but rather that within that country-specific situation analysis the distribution of these payments needs to be a key issue. If the out-of-pocket expenditure is concentrated on the high income population groups and they do not suffer financial hardship, then the situation is completely different from the context where the poorer population groups have high levels of out-of-pocket expenditure and when there is a risk of pushing them (further) into poverty. A pro-poor health financing approach will need to focus on extending financial risk protection also to the poorer population groups. Ghana has been making such pro-poor choices in the development of its health insurance scheme as shown in Box 2.5.

Box 2.5: Organizing prepayment and pooling through the National Health Insurance Scheme in Ghana

In order to improve access to health services, Ghana embarked on a health financing reform process in the late 1990s. This development, which ultimately led to the establishment of the Ghana National Health Insurance Scheme (NHIS), was pushed forward by strong political will that has survived democratic transitions in political power during the past decade.

The NHIS implementation process relied on existing mutual health insurance organizations (MHOs) established in the early 1990s often with the help of international donors and agencies. The voluntary, community-based MHOs started out at the local level, pooling risk for a limited number of people, often not more than 1000. The NHIS process brought together these fragmented units into building blocks (which became the districtwide mutual health insurance schemes (DMHIS)) of a national system that was formalized through the National Health Insurance Act (Act 650) in 2003 and that was effectively rolled out from 2005.

The NHIS is built as a health financing pooling mechanism into which funds from multiple sources are channelled. Most of the NHIS funds come from a VAT levy, a 2.5% part of the regular VAT that is earmarked directly for NHIS. Another source is the redirection of 2.5% of the payroll tax from the Ghana pension scheme for formal sector workers. The contributions of NHIS members represent only a small fraction of the total revenue of NHIS and these contributions often stay at the DMHIS level and are not accounted for at the national level. NHIS aims at supporting revenue progressivity by cross-subsidies from the formal sector payroll tax and by VAT exemptions on some primary necessity products.

NHIS coverage was revised to 34.7% in 2011 against the 60% estimated in 2009. Since the inception of the scheme, those exempted from premium payments constitute over 50% of the total members, with children under 18 years forming the biggest part of that group. The number of exempted indigents and pensioners is very low. Paying members from both the formal and informal economic sectors constitute less than 10% and about 20% of the membership, respectively. The current government has stated its commitment to introduce a one-time premium payment. This will further change the dynamics of NHIS revenue collection.

Rwanda has been able to pool resources from several sources to ensure coverage of majority of the population through a prepayment mechanism as shown in Box 2.6.

Box 2.6: National level health financing strategy with decentralized operationalization in Rwanda

Rwanda has experienced fairly steady economic growth during the last 15 years but on average the country still remains very resource constrained with an estimated GDP per capita of slightly over US$ 500. Even with these financial constraints, Rwanda has been able to move towards a health financing system that has increased coverage from pooling mechanisms and reduced reliance on direct out-of-pocket payments.

Rwanda has successfully integrated community-based mutual health insurance schemes ("mutuelles") within a national health financing system that is tailored to focus on increasing coverage among those outside the formal employment sector who are the vast majority of the population. This bottom-up health financing system pools resources at the mutuelle level from households, the government, employers and external partners, thus enabling risk sharing at the community level and permitting extension of coverage to also those who cannot directly contribute. Anchoring the health financing mechanism at the grassroots has allowed the communities to play an active role in assuring a significant level of adherence of the population to payment of premiums and in reinforcing the accountability and transparency of the health financing system as a whole.

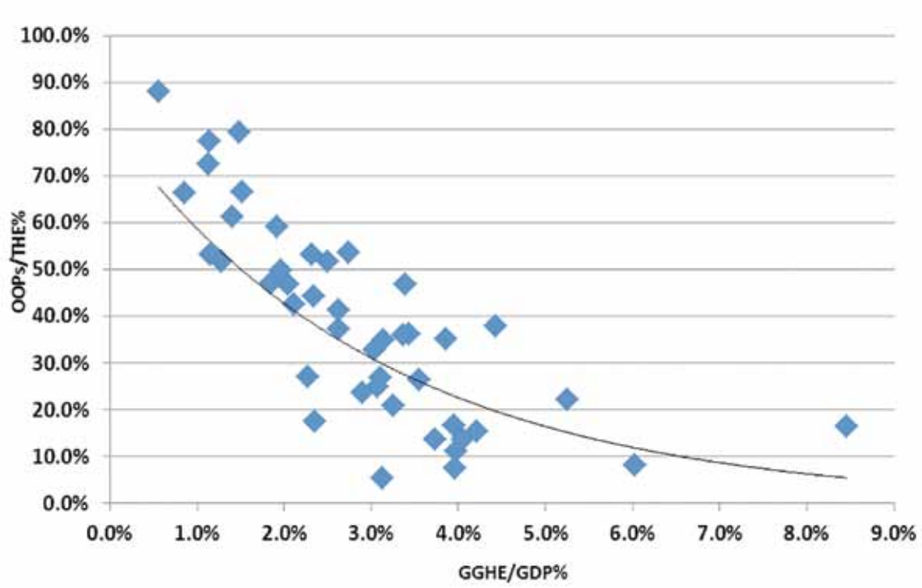
While the operationalization of the health financing system and strategy happens at the local level, there is strong national stewardship consisting of laws and guiding instruments that give a top-down framework for the mutuelle-based system. The organization and coordination of the intermediary and peripheral levels of the health financing system are backed by the expertise inside the Ministry of Health, especially through the technical unit that supports the district and subdistrict levels in managing and monitoring the mutuelles (Cellule d'Appui Tchnique aux Mutuelles de Santé).

While the mutuelles have been reinforcing access to health services and financial risk protection, another stream of public and external funding has been flowing through a performance-based financing system that has subsequently increased the quantity and quality of services provided.

These reforms in the health financing system have been one of the key elements behind the remarkable improvements in many of the health outcomes in Rwanda where maternal mortality and under-5 mortality have been significantly reduced [15]. The right health financing policy choices have ensured that Rwanda achieves good value for its (and its development partners') investments.

Countries implementing health financing reforms that increase government health expenditure through various strategies and mechanisms normally witness a decreasing share of out-of-pocket spending. As Figure 2.6 shows, the countries with low levels of public health expenditure (measured as a share of GDP) have high levels of out-of-pocket spending (as a share of total health expenditure) and vice versa. Increasing government health expenditure and lowering financial barriers to access to health services are converging objectives in most contexts. Although health financing reforms and actions are not necessarily about more spending, in some contexts, for example, it might more important to focus on improvements in efficiency.

Figure 2.6 – Government health expenditure as a share of GDP and out-of-pocket payments as a share of total health expenditure



Several countries have put in place mechanisms to protect the poor and vulnerable groups. Voucher schemes for pregnant women, for example in Uganda and Kenya, and social grants for marginalized groups have been implemented though largely on a pilot basis. In majority of the countries, private not-for-profit organizations are significant players in health service provision. Subsidies have been extended to this subsector to enable them to provide free services to specific groups or for certain diseases or to provide services at highly subsidized fees to enable access by the larger population.[8] In some countries where fees exist, for example in Tanzania, there are exemption mechanisms for reproductive and child health services, chronic illnesses and epidemic diseases and for the poor. Experience with exemption mechanisms is varied, more especially as they relate to the poor because of the challenges of implementing a robust system of identifying them. In majority of cases it has been shown to be ineffective [16,17]. Some countries have abolished or reduced fees at the point of access in several ways as shown in Table 2.8. Some like in Uganda and Malawi have implemented blanket targeting to provide services for free to all while others have geographical targeting such as Zambia. In all countries that have abolished or reduced fees at the point of access maternal and child health services are provided free in public facilities.

[8] Kenya, Lesotho, Malawi, Swaziland, Uganda

Table 2.8: Some of the countries that have abolished user fees or provide formal exemptions

Country (year)	Maternal health	Child health	Total population	Disease categories
Benin	Free C-section	Under-5s	PHC and SHC1	Malaria, hemodialysis
Burkina Faso (2006)	Reduction of 80% for C- section and delivery fees	Neonatal care, 80% subsidy		
Burundi (2005)	Pregnant women and deliveries	Under-5s		
Cape Verde			There is also the basic Protection National Centre of Social Pension (9700 CNPS)[1]	
Congo (2010)	Pregnant women and deliveries			Free malaria treatment for under-15s
Côte d'Ivoire	Pregnant women	Under-5s		
Ghana (2008)	Pregnant women	Under-5s		
Guinea (2011)	Deliveries			
Kenya (2007)	Deliveries	Under-5s		HIV, malaria, TB
Lesotho (2008)			At PHC level	
Liberia (2007)			In late 2011 a user fee assessment was carried out with a view of reintroducing user fees by 2013	
Madagascar (2008)	Free deliveries			
Malawi			EHP free for all	
Mauritania				Malaria, HIV, Tuberculosis, hemodialysis
Niger (2006)	deliveries	Under-5s		
Senegal (2006)	Deliveries and free C-section		Students and people older than 60 years (SESAME programme)	
Sierra Leone (2010)	Pregnant women & lactating mothers	Under-5s		Malaria
Togo (2010)	Free C-section	Under-5s		Tuberculosis and leprosy
Uganda (2001)			All population1	
Zambia (2006)			All in rural districts	

Evidence points to the need for careful attention to the design and implementation details of health service delivery prior to abolishing fees. In majority of cases, the effects have been generally positive with respect to utilization of health services though sustainability in the medium to the long term has been varied. Implementation processes are poorly understood and require system wide investments [18]. Significant investments need to be made to improve service delivery if the poor are to have financial risk protection. Uganda serves as an example of how this is done (see Box 2.7).

Box 2.7: Lessons from abolition of user fees in Uganda

In response to cries of the poor that good health is central to poverty reduction, and that fees charged in health facilities are a hindrance to accessing care, the Government of Uganda abolished user fees for health services in all public facilities from March 2001. It was hoped that this would improve utilization of health services especially among the poor, reduce household out-of-pocket expenditure and subsequently help realize improved health outcomes.

The overall government strategy as defined in strategic development documents is for additional emphasis on economic transformation and wealth creation. In light of this, there has been a shift of emphasis from social sectors, including health. As a consequence, allocations to health in the total government budget have stagnated at around 9–12% for the last 10 years. At the sector level, efforts were made to increase funds allocated to primary health care. Unfortunately, close to 80% of primary health funds are spent on wages. But even with this the staffing posts filled by trained personnel account for only 56% of the workforce. Recurrent non-wage allocations are very low and increases have been insignificant.

Over a period of 10 years, reductions in the cost burden of health arising from not using health care services were higher among the poor than the national average, but only in the short term. The percentage of patients choosing private health providers increased significantly, except among the absolute poor. Currently 29% of households still experience catastrophic health expenditures. Out-of-pocket expenditure as a percentage of total health expenditure increased from 38% in 2001 to 50% in 2010. There is a need to significantly increase investment in the health sector and address system gaps in service delivery if the poor are to have more effective financial risk protection. There is also a need to build effective partnerships with the private sector, which is still an important source of health care funding.

The private sector is a significant player in health service delivery in majority of countries in the African Region and if the ultimate aim of providing financial risk protection is to be achieved addressing user fees in the public sector alone will not entirely tackle the problem [19]. Alongside abolition of fees in the public sector, effective partnerships with the private sector to ensure quality of services provided and control of pricing need to be put in place. The countries highlighted several opportunities for increasing collaboration with the private sector. Putting in place policies and regulatory frameworks is a prerequisite to effective partnerships. Contractual arrangements could be made with the private sector in service delivery, ambulance services, training and supply chain management, which are some of the areas in which the private sector is considered to offer better value for money.

In countries where user fees have been abolished or exemptions from fees are extended to certain groups, the challenge will be to develop mechanisms for increasing funding for health from alternative sources. These mechanisms need to be implemented as system wide approaches with the objective of ensuring financial sustainability. Burundi has implemented a countrywide performance-based financing (PBF) mechanism for replacing the revenue from user fees and to counter the negative effect on staff motivation (see Box 2.8).

Box 2.8: Systemic health financing reform through combination of user fee exemptions and performance based financing in Burundi

In 2006, seeking to improve access to care, the newly elected President of the Republic of Burundi called for exemption of user fees for pregnant women and children under the age of five. Taking into account the lessons learned from other countries and Burundi's own problems in the first years of user fee exemption, Burundi scaled up in 2010 its performance-based financing (PBF) schemes into a national mechanism that was designed to support the user fee exemption programme.

The PBF strategy and mechanism had several advantages:

- Creating a formalized channel for effectively replacing the revenue from user fees at the facility level;
- Putting in place, through the incentives for increasing quantity and quality of care, a counterforce for the demotivation of health workers that is often observed when the workload increases substantially following introduction of user fee exemptions;
- Instituting a verification and validation system for tracking the implementation of the user fee exemption at the facility level;
- Reducing the administrative burden through simplifying the facility reporting responsibilities to a simple two-page document on the number of services provided and the amount of money for reimbursement.

The literature and experience show that there is not one way of implementing PBF or results-based financing (RBF). The strategy used in Burundi involved linking the PBF approach with user fee exemptions for pregnant women and children under 5. This created the basis for a larger institutional reform that addressed the challenge of lowering financial barriers to access to health care while at the same time offering a systemic approach to address the problems that user fee exemptions can create. This strategic approach seems to have paid off since the utilization of health services in Burundi has continued to increase and the country has avoided the often observed patterns in which initial increases in utilization are not sustained in the long run.

• Other health system components to support universal health coverage

Alongside health financing, there are other health system bottlenecks that pose a challenge to achieving the health MDGs in the African Region. The big burden of communicable diseases that is added to the increasing burden of noncommunicable diseases has overstretched the capacity of existing health systems. Coverage with essential interventions is low in a majority of the countries, the quality of services is poor and referral systems are weak. Inequity in access is a concern that needs innovative ways to address in order to reach the most vulnerable groups in poor rural communities. Ethiopia serves as an example of a country that has improved access to basic health care through efficient and innovative ways as shown in Box 2.9.

Box 2.9: Improving access to basic health care in Ethiopia

In 2004 the Government of Ethiopia made a bold decision to strengthen and expand its PHC system by launching the health extension programme (HEP). HEP was designed to ensure significant basic health care coverage in the country over five years through providing a staffed health post for approximately every 5000 people. The aim of this community-based health care delivery system is to improve access and equity in health care through focusing on sustained preventive health actions and increased health awareness.
Every health post is staffed by two female health extension workers (HEWs), who are high school graduates with one year training in health. The training programme for HEWs includes 16 major packages under five components: (i) hygiene and environmental sanitation (i.e. construction, usage and maintenance of sanitary latrines), (ii) family health service (i.e. family planning, vaccination), (iii) disease prevention and control (for HIV, TB and malaria), (iv) health education and communication and (v) nutrition.
By May 2008, 24,500 HEWs had been trained and deployed, which was 82% of the 30,000 targeted by the Ministry of Health by 2010/11. The health service extension programme is implemented through an outreach programme centred around:

- Rapid vocational training of health extension workers, with the goal of providing two trained HEWs per Kebele;
- Construction and equipping of health posts, one per Kebele, through accelerated expansion of PHC facilities;
- A community promotion programme involving volunteers and private sector community promoters, and traditional birth attendants working under the health extension workers and providing support to households for behaviour change, for example on breastfeeding, complementary feeding, immunization, use of bed nets, and clean delivery. Former frontline health workers such as community-based reproductive health attendants and traditional birth attendants are incorporated into the system as volunteers.
- Strengthening the quality of and demand for clinical care particularly in treatment of diarrhoea and malaria in children, assisted delivery, early referral for mothers and children with danger signs, and HIV testing and counselling, as well as prevention of mother to child transmission of HIV.

Significant achievements have been made since the programme started among which is the improvement in the uptake of family planning and immunization services.

In regard to human resources for health (HRH), 36 out of the 46 countries in the African Region are categorized as facing a HRH shortage crisis. Africa's current shortage of health workers (physicians, nurses and midwives) is estimated to be at least 817 992. [20] To deal with this shortfall, most countries would have to increase their human health resources by at least 140% and revamp their institutional capacity to produce additional health workers. Several challenges exist in achieving this goal, among which is brain drain, inequitable distribution of the available workforce, failure to attract and retain qualified staff especially in rural areas, low remuneration, reliance on expatriates in some countries like Swaziland and insufficient training capacity in some countries.

In an effort to address the human resources crisis, several incentives have been started in some countries and these range in implementation from pilots to full-scale implementation. Among these are performance recognition under PBF models,[9] giving autonomy to public hospitals,[10] providing access to better health care for health workers,[11] salary top ups and allowances,[12] scholarships for health workers in rural areas after serving for agreed periods, [13] and free or subsidized accommodation for health workers.[14]

[9] Kenya, Burundi, Democratic Republic of Congo, Kenya, Liberia, Malawi, Rwanda, United Republic of Tanzania, Uganda, Zambia
[10] Kenya, Malawi
[11] Swaziland, Zambia
[12] Malawi, United Republic of Tanzania, Uganda
[13] Malawi, United Republic of Tanzania, Uganda
[14] Malawi, Uganda

Some countries have been able to attract staff to remote areas and to retain staff in their posts through motivation incentives. But implementation of such schemes has been plagued by such challenges as their poor design, inadequate funding and problems associated with implementation logistics. Some countries have not institutionalized the incentive schemes, rendering them vulnerable to political and administrative changes. Other countries such as Ethiopia have succeeded in using rural extension workers to provide basic health services at a community level as shown in Box 2.9.

Most of the countries have national pharmaceutical policies and strategic plans and essential medicines lists but the use of these tools varies from country to country. In a majority of the countries the challenges to improving access to affordable essential medicines have been identified as weak logistic systems, weak regulation and quality control mechanisms, low numbers of pharmacists, weak monitoring systems for medicines, and weak capacity for quantifying need, forecasting and procurement. Improving access to affordable essential medicines is critical for the achievement of the MDGs, particularly MDGs 4, 5, and 6. Since the MDG Gap Task Force began monitoring the situation in 2007, it has not registered any clear improvements in improving access to essential medicines in developing and transition economies. In many countries, availability remains grossly inadequate and prices are high, making medicines unaffordable to large sections of the population of developing countries [22]. Voluntary pooled procurement mechanisms with the potential to negotiate favourable prices have not been used optimally. In many countries strengthening of nationally coordinated laboratory services has until recently received inadequate attention. This has resulted in laboratory services receiving low national priority in financing, planning and service delivery.

The options suggested to improve access to medicines include establishing and strengthening quality control and regulatory mechanisms, forging effective partnerships with the private sector in selected areas such as sharing of specialized technology, and strengthening supply chain management, monitoring and procurement.

All the countries appreciate that evidence-based dialogue and decision making are central to efficient health service delivery. However, in majority of countries health information systems face major challenges that hinder their role to gather and deliver the evidence needed to inform policy dialogue and action. Many of the countries have not succeeded in putting in place integrated monitoring and evaluation frameworks binding to all health sector stakeholders. Often there is a vicious circle where underinvestment in health information systems results in data of poor quality that users are not willing to use in the policy process. There is also a lack of capacity to synthesize and apply evidence, causing its low demand, which finally leads to low resource allocation for data collection and quality control. Research development suffers several setbacks including lack of policies, lack of a systematic approach to prioritizing the research agenda, lack of funding for research, and reliance on donor funding, which does not necessarily support prioritized research needs. Although information technology has the potential to improve health service delivery and monitoring, most of the countries are poorly equipped to take full advantage of that opportunity.

Institutions and opportunities exist to help the countries to strengthen their monitoring and evaluation systems such as the Commission on Information and Accountability for Women's and Children's Health, the platform for Country Health Policy Process (CHPP), the International Health Partnership (IHP+) and the network of National Health Observatories. These provide funding and technical assistance for countries for health monitoring systems.

Other critical challenges include weak leadership and governance, limited community involvement, weak intersectoral collaboration and fragmented partnerships. Failure to harmonize programmes with existing partnerships, fragmentation of programmes and poor priority setting have resulted in missed opportunities to maximize the inherent synergies among the health system components. There are examples of countries that have made significant progress in strengthening government leadership and harmonization in the health sector, an example of which is the Democratic Republic of Congo (Box 2.10).

Box 2.10: Strengthening health systems through improving accountability and avoiding fragmentation in the DRC

In an effort to strengthen its health system the DRC has developed several policy documents such as the National Health Strategy (NHSP) (2011–2012), the policy for procurement and distribution of medicines and supplies, and norms for decentralization and implementation of PHC based on the district level. In addition, the DRC has high numbers of qualified health workers, high-level health institutions and schools of medicine and a forum for regulation of health management information systems. However, implementation of these reforms needs particular attention for the reforms to serve their role to support the achievement of universal health coverage. The health financing system needs to be strengthened to support implementation of these reforms through for example increasing domestic funds allocated to health and reinforcing the management of health facilities by standardizing accounting tools and financial audits with other dockets of the Ministry of Finance and Budget.

The country report highlighted that out-of-pocket payments still were high, but the NHSP suggests important strategies to address this such as developing a prepayment mechanism, improving collection, allocating and properly managing public funds allocated to health, and improving the coordination of funding from ODA by developing or expanding district steering committees for planning and financial management.

Health system building blocks are interdependent and interlinked. Although the focus of this report is health financing we note that efforts must be made to strengthen all health system building blocks if a country is to effectively move towards universal health coverage.

Health outcomes and health financing

The way health services are financed has an effect on health outcomes. Reliance on out-of-pocket payments has been shown to have a negative impact on access to services, which in turn affects health outcomes. On the other hand, countries that have implemented prepayment pooling mechanisms, including those specifically covering the poor have been able to improve coverage with essential health services. Two outcomes, maternal mortality ratio and under-5 mortality rate, are considered in this report.

• Maternal mortality ratio (MMR)

MMR, maternal deaths per 100,000 live births, is categorized as very high if it is 300 or higher and as extremely very high if is 1000 or higher. Nine countries have very high MMR and Chad has extremely very high MMR, as shown in Table 3.1. Annex VI shows the details of MMR for the different countries.

Table 3.1: Maternal mortality ratio (MMR)

	Below 300	301–600	601–999	Above 1000
2010	Algeria, Botswana, Burkina Faso, Cape Verde, Comoros, Equatorial Guinea, Eritrea, Gabon, Madagascar, Mauritius, Namibia, Sao Tome and Principe, South Africa, Togo **(14 Countries)**	Angola, Benin, Congo, Côte d'Ivoire, DRC, Ethiopia, Gambia, Ghana, Kenya, Malawi, Mali, Mauritania, Mozambique, Niger, Rwanda, Senegal, Swaziland, Uganda, Tanzania, Zambia, Zimbabwe **(21 Countries)**	Burundi, Cameroon, Central African Republic, Guinea, Guinea-Bissau, Lesotho, Liberia, Nigeria, Sierra Leone **(9 Countries)**	Chad **(1 Country)**

Source: WHO, UNICEF, UNFPA and the World Bank estimates, 2010

• Under-5 mortality rate

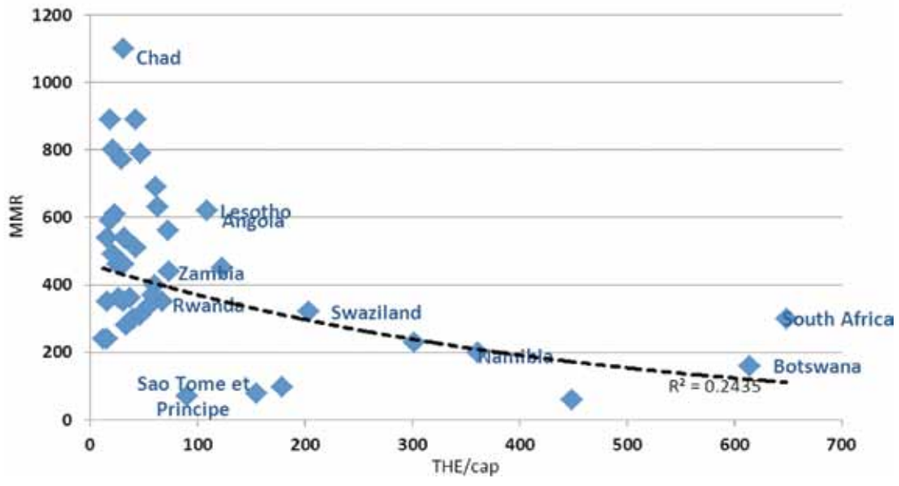
Under-5 mortality rate is considered high for a majority of countries in Africa and most are not on track to meet the related MDG. Over a period of 10 years, 12 countries registered a reduction in under-5 mortality rates while for 23 countries the rate has persistently been over 100 (see Table 3.2).

Table 3.2: Under-5 mortality rate (UMR)

	Below 40	40–100	Above 100
1990	Mauritius, Seychelles **(2 Countries)**	Algeria, Botswana, Cape Verde, Gabon, Kenya, Lesotho, Namibia, South Africa, Swaziland, Zimbabwe **(10 Countries)**	Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, DRC, Equatorial Guinea, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Togo, Uganda, United Republic of Tanzania, Zambia **(33 Countries)**
2010	Algeria, Cape Verde, Mauritius, Seychelles **(4 Countries)**	Botswana, Congo, Eritrea, Gabon, Gambia, Ghana, Kenya, Lesotho, Madagascar, Malawi, Namibia, Rwanda, Senegal, South Africa, Swaziland, Uganda, Tanzania, Zimbabwe **(18 Countries)**	Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Côte d'Ivoire, DRC, Equatorial Guinea, Ethiopia, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Mozambique, Niger, Nigeria, Sierra Leone, Togo, Zambia **(23 Countries)**

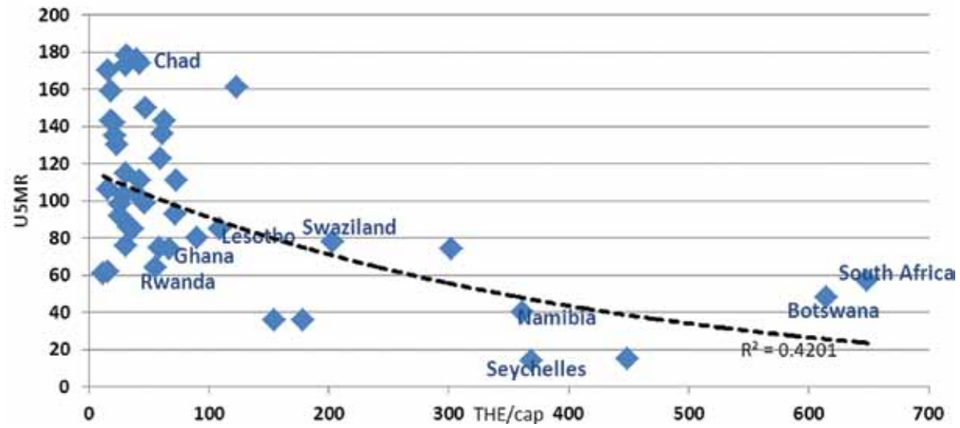
Figures 3.1 and 3.2 show maternal and under-5 mortality rate data for the different countries against the total health expenditure per capita. We acknowledge that improving health outcomes is more complex and goes far beyond addressing health financing challenges alone, and we are not attempting to portray a linear relationship between health outcomes and health expenditure. Evidence shows that how health financing systems are organized influences the extent to which the population accesses health services and subsequently affects health outcomes in low income countries [23]. Although in this analysis we only depict the level of funding for health systems and not their organization, we can still make a general statement on the outcomes achieved by the different countries at a given level of expenditure, limitations withstanding.

Figure 3.1: Maternal mortality ratio (MMR) and total health expenditure per capita (THE/cap), 2010



Figures 3.1 and 3.2 shows that there are countries with a much higher total health expenditure per capita like South Africa but have outcome indicators comparable to countries with much lower spending like Rwanda and Ghana. In such cases, and looking at health financing alone, there is need to look at how the health financing system is organized and how funds are allocated and utilized. In the case of South Africa, although the share of out-of-pocket payments in the total health spending is below 20% and coverage through a prepayment mechanism is high, there is great inequality: 16% of the population (largely upper middle and upper income groups) are covered but largely through private health insurance, health spending per capita for the insured group is about five times greater than for the poorest 40% of the population, and the poorer population groups are excluded from health services. In this context, even with high levels of total health expenditure, inequity in its distribution is a contributing factor to poor health outcomes, particularly for the low income groups and those without private health insurance.

Figure 3.2: U5MR and total health expenditure per capita, 2010



As Figures 3.3 and 3.4 show, the countries with high levels of government health expenditure (measured here as a share of GDP) have in general better health outcomes, though there is considerable variation around this trend and better outcomes do not simply follow from more spending. The causalities are not easy to identify and there are health system and non-health system factors that affect the outcomes. But what can be said is that figures 3.3 and 3.4 reflect the fact that while a minimum level of total health funding is needed for a health system to fulfil its function and positively influence health outcomes, it is government funding in particular that ensures that the positive effects are more equitably distributed, which in turn will improve overall health outcomes.

Figure 3.3: U5MR and GGHE as a share of GDP, 2010

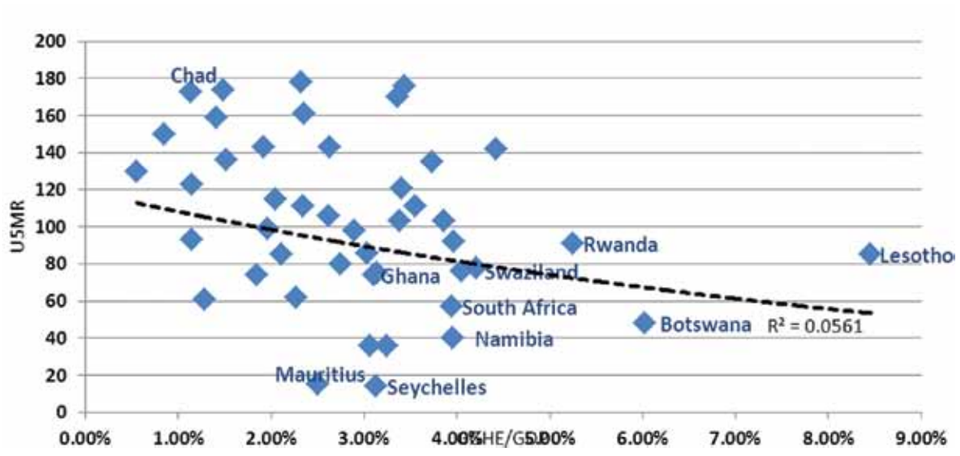
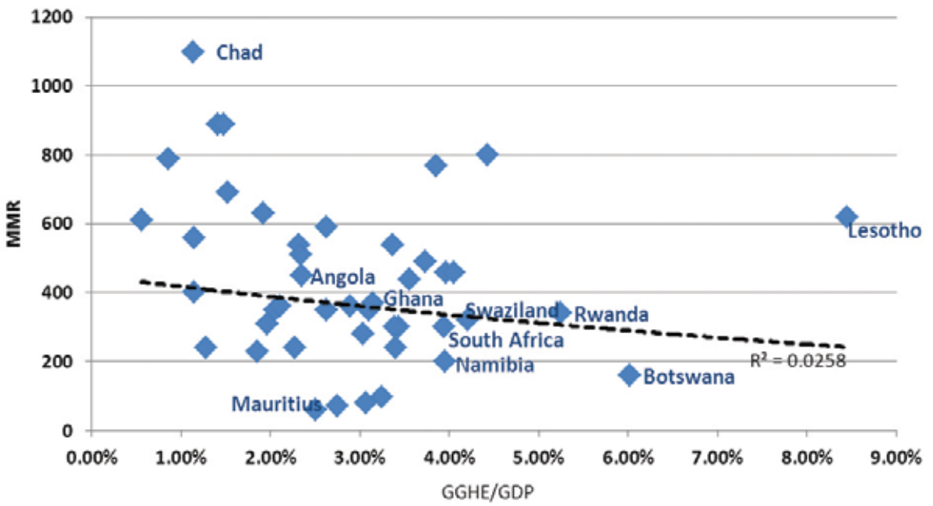


Figure 3.4: MMR and GGHE as a share of GDP, 2010



Conclusion

This document gives an overview of the health financing situation in the member states of the WHO African Region. It presents the key factors that determine a country's performance in health financing and it provides a solid basis for monitoring and evaluating progress.

Several African countries have recently implemented successful health financing reforms. For example Ghana has moved from out-of-pocket payments to the use of prepaid and pooled funds; Botswana is looking at policy options for creating efficiencies that will help sustain its achievements and prepare for future challenges, and Rwanda has implemented a national health financing mechanism that covers the vast majority of the population and has been a key element in increasing access to health services. Many other African countries are looking for innovative ways to improve funding for health.

For countries in which health systems financing has been improving and for countries with more acute need for reforms and action, there is need to constantly track health financing progress in order to adapt to changing situations and implement reforms and actions that keep them on the right track to achieve the health financing goals that will support the objective of UHC.

This report shows that despite progress in many countries, the Member States of WHO African Region are still on average far from achieving their health financing goals to meet the Abuja targets of allocating 15% of government budgets to health and reducing the share of out-of-pocket expenditure in total health expenditure. For example, in 20 out of 45 countries out-of-pocket expenditures are still higher than 40% of the total health expenditure and in 22 countries the level of total health expenditure does not reach even the very minimal target of US$ 44. This cross-country analysis demonstrates that on average the health financing systems in Africa are not sufficiently funded and do not ensure sustainable progression and equity in the way funds are collected and pooled.

In light of these cross-country observations, there is a great need to increase investment in health and to focus on the way health systems are financed. Countries will need to translate this general message into an in-depth, in-country situation analysis that is relevant to their context and policy aims. This analysis will serve to provide a solid evidence basis for developing a health financing system. There are no blueprints and every country will need to find its own mix of actions and reforms that will move it towards the health financing target and ultimately the goal of UHC, taking into account the evidence and information produced. This calls for every country to develop a health financing strategy that is based on evidence and that takes into account its constraints and opportunities.

The ministries of health cannot do this alone. The policy dialogue around health financing and health financing strategy will need to engage all the key stakeholders. Particular focus should be given to the interaction between the ministries of health and finance, as the results in this document show the issues in increasing health funding and developing a health financing system that supports the objective of UHC will to a large extent depend on overall government financial and fiscal position. The dialogue between these two ministries should take into account aspects of efficiency and accountability, which will need a context-specific analysis but were not fully included in this cross-country document. Another key aspect of the discussions between the two ministries should be on the need to emphasize the value of investing in health to save lives and improve health, which in turn will support economic growth. Analysis of the linkages between health outcomes and health financing at the country level will need to reflect the complexities in causalities, but the lesson drawn from this document is that good health outcomes cannot be generated if health financing systems are weak.

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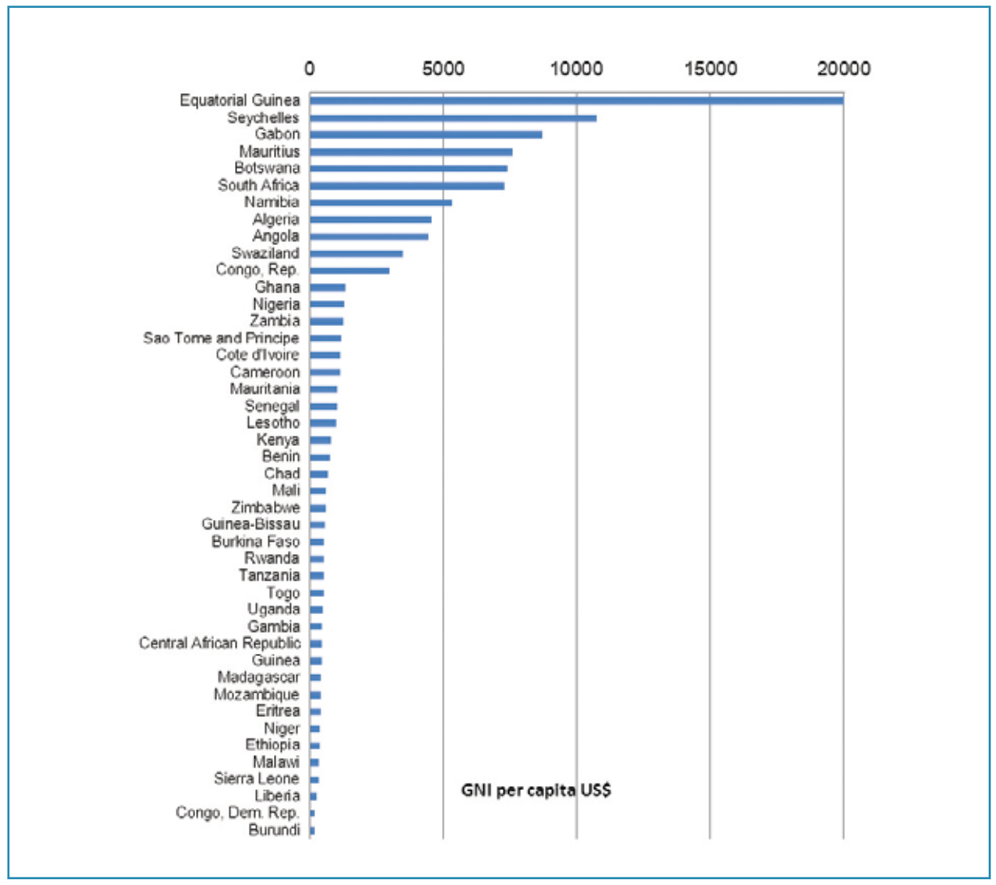
Annex

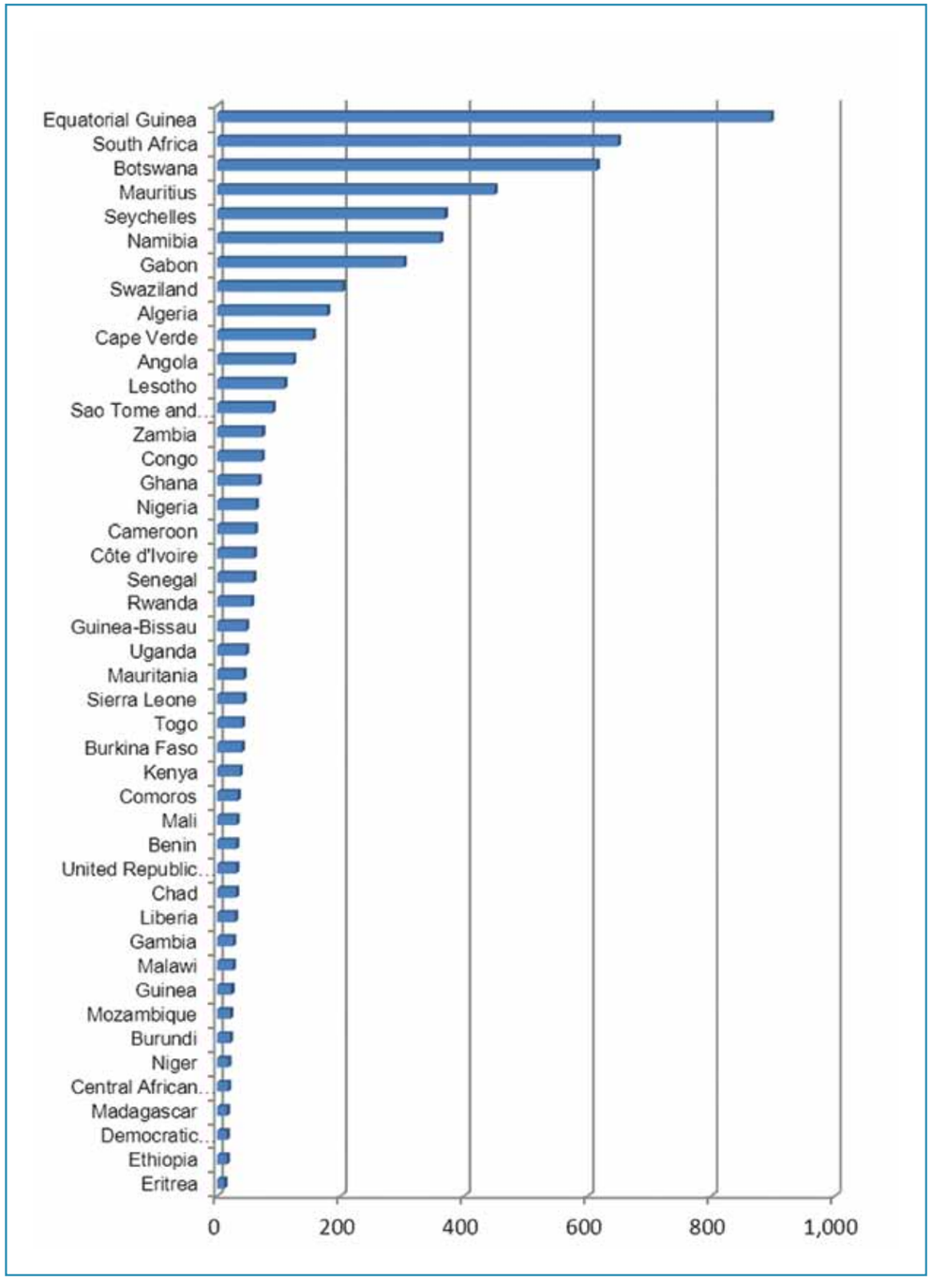
Annex I: Country categorization by GNI per capita in US$ at current prices

Year	LIC–1005	US$ 1006–3975	US$ 3976–12,275	More than US$ 12,275
2010	Burundi, Congo DRC, Liberia, Sierra Leone, Malawi, Ethiopia, Niger, Eritrea, Mozambique, Madagascar, Guinea, Central African Republic, Gambia, Uganda, Togo, Tanzania, Rwanda, Burkina Faso, Guinea-Bissau, Zimbabwe, Mali, Chad, Benin, Kenya, Lesotho **(26 countries)**	Senegal, Mauritania, Cameroon, Cote d'Ivoire, Sao Tome and Principe, Zambia, Nigeria, Ghana, Congo Rep., Swaziland **(10 countries)**	Angola, Algeria, Namibia, South Africa, Botswana, Mauritius, Gabon, Seychelles **(8 countries)**	Equatorial Guinea **(1 country)**

Figure 1: GNI per capita in US$ in current prices



Annex II: Total health expenditure per capita for the African Region in current US$ (2010)



Annex III: External sources as a share of THE for AFR countries:

	Less than 20%	20-40%	Over 40%
2001	South Africa, Botswana, Mauritius, Swaziland, Gabon, DRC, Namibia, Congo Seychelles, Côte d'Ivoire, Cameroon, Sierra Leone, Nigeria, Lesotho, Togo, Angola, Equatorial Guinea, Guinea, Burkina Faso, Zambia, Kenya, Liberia, Cape Verde, Central African Republic, Senegal, Burundi, Benin, Ghana, Mali, Tanzania, Mauritania, Gambia **(32 Countries)**	Ethiopia, Guinea-Bissau, Comoros Mozambique, Chad Niger, Uganda, Madagascar, Eritrea, Rwanda **(10 countries)**	Sao Tome and Principe, Malawi **(2 countries)**
2005	South Africa, Mauritius, Gabon, Equatorial Guinea, Seychelles, Swaziland, Nigeria Botswana, Côte d'Ivoire, Cameroon, Guinea, Angola, Congo, Sierra Leone Central African Republic, Guinea-Bissau, Mali, Chad, Namibia, Lesotho, Senegal Mauritania, Cape Verde, DRC, Togo **(25 countries)**	Benin, Kenya, Ghana, Comoros, Uganda, Sao Tome and Principe, Burundi, Niger, Tanzania, Burkina Faso, Ethiopia, Madagascar **(12 countries)**	Zambia, Liberia, Mozambique, Gambia Rwanda, Malawi, Eritrea **(7 countries)**
2010	Equatorial Guinea, Mauritius, South Africa, Gabon, Angola, Congo, Seychelles, Chad Madagascar, Nigeria, Côte d'Ivoire, Mauritania, Guinea, Cape Verde, Cameroon, Central African Republic, Togo Ghana, Swaziland, Botswana, Senegal, Namibia, Comoros, Lesotho **(24 countries)**	Sierra Leone, Sao Tome and Principe, Burkina Faso, Guinea-Bissau, Mozambique, Uganda, Mali, Niger DRC, Benin, Kenya Eritrea, Zambia, Ethiopia **(14 countries)**	Gambia, Burundi, Rwanda, Tanzania, Liberia, Malawi **(6 countries)**

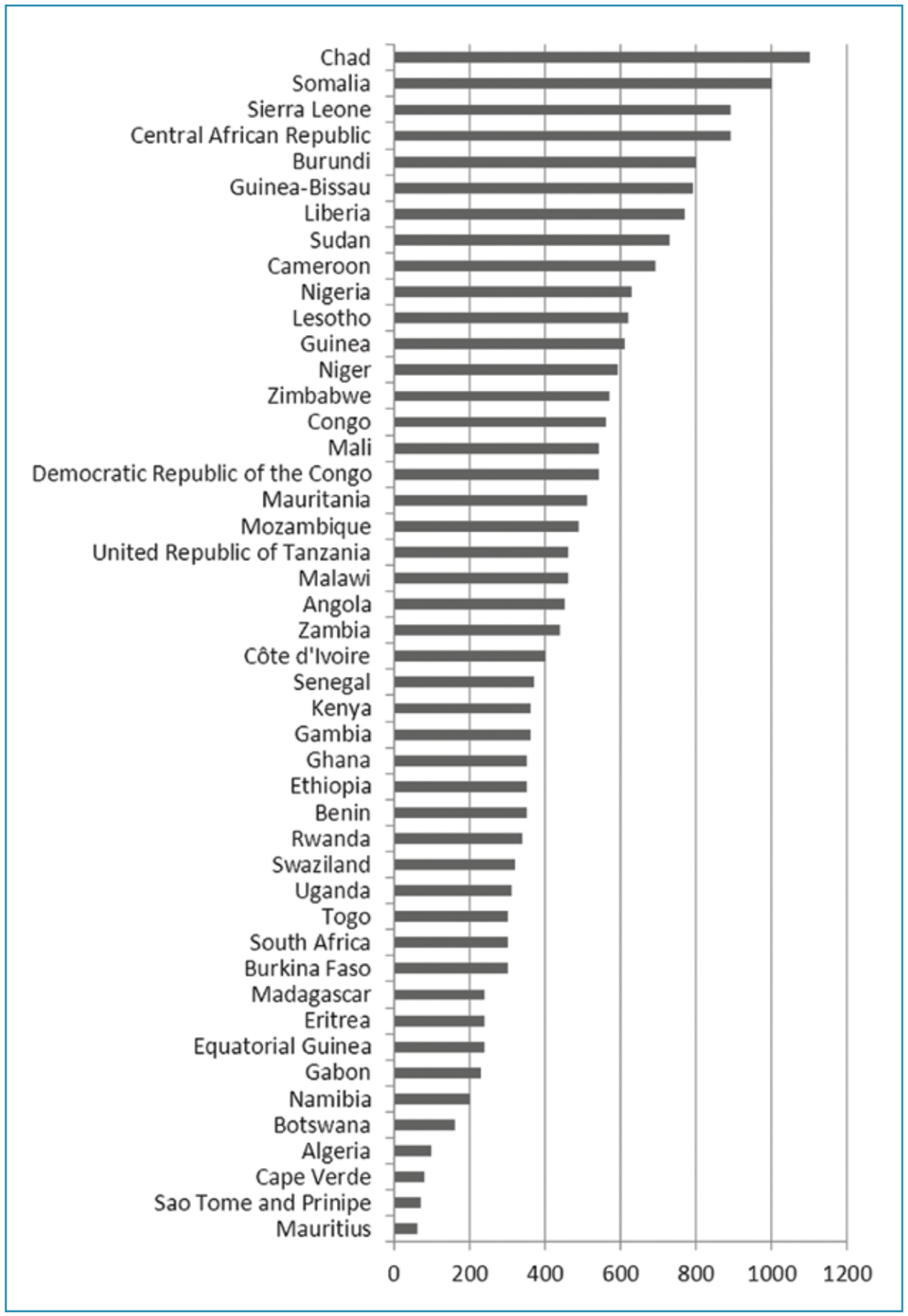
Annex IV: GGHE as a share of GGE for AFR countries

Countries	2001	2005	2010
Algeria	10	8	8
Angola	6	4	7
Benin	12	11	10
Botswana	10	17	17
Burkina Faso	10	19	13
Burundi	8	12	8
Cameroon	7	8	9
Cape Verde	12	10	10
Central African Republic	11	8	8
Chad	14	13	3
Comoros	5	11	13
Congo	4	6	5
Côte d'Ivoire	6	4	5
DRC	3	7	9
Equatorial Guinea	10	7	7
Eritrea	5	2	4
Ethiopia	10	10	13
Gabon	4	5	7
Gambia	7	11	11
Ghana	10	15	12
Guinea	6	4	2
Guinea-Bissau	2	4	4
Kenya	8	8	7
Lesotho	9	7	13
Liberia	11	11	11
Madagascar	15	12	15
Malawi	9	20	14
Mali	12	11	11
Mauritania	8	9	7
Mauritius	11	9	10
Mozambique	15	18	12
Namibia	10	13	12
Niger	10	15	11
Nigeria	3	6	4
Rwanda	10	16	20
Sao Tome and Principe	7	13	13
Senegal	8	12	12
Seychelles	8	9	9
Sierra Leone	7	8	6
South Africa	11	10	12
Swaziland	10	10	10
Togo	8	10	15
Uganda	10	11	12
United Republic of Tanzania	11	9	14
Zambia	11	15	16
Zimbabwe	9		

Annex V: Out-of-pocket paymentss as a share of THE for the African Region

	Less than 20%	20–40%	More than 40%
2001	Namibia, Botswana, Mozambique, South Africa, Angola, Seychelles, Madagascar, Swaziland **(8 countries)**	Algeria, Rwanda, Malawi Cape Verde, Ghana, Lesotho, Zambia, Gambia, Ethiopia, Liberia, Equatorial Guinea, Mauritius, Uganda, Mauritania, **(14 countries)**	Sao Tome and Principe, Niger, Kenya, Congo, Tanzania, Eritrea, Burundi, Guinea-Bissau, Benin, Comoros, Mali, Senegal, Chad, Gabon, Central African Republic, Burkina Faso, Nigeria, Togo, DRC, Cameroon, Côte d'Ivoire, Guinea, Sierra Leone **(23 countries)**
2005	Namibia, Seychelles, Botswana, Malawi, Mozambique, Swaziland, Rwanda, South Africa **(8 countries)**	Madagascar, Ghana, Gambia, Cape Verde, Angola, Algeria, Zambia, Ethiopia, Lesotho, Senegal, Liberia, Sao Tome and Principe, Mauritania, Equatorial Guinea, Tanzania, Burkina Faso, Comoros, Burundi **(18 countries)**	Congo, Mauritius, Kenya, Uganda, Niger, Benin, Guinea-Bissau, DRC, Mali, Eritrea, Chad, Gabon, Togo, Central African Republic, Nigeria, Cameroon, Sierra Leone, Côte d'Ivoire, Guinea **(19 countries)**
2010	Seychelles, Namibia, Botswana, Malawi, Tanzania, Mozambique, Swaziland, Lesotho, South Africa, Angola **(10 Countries)**	Algeria, Rwanda, Equatorial Guinea, Gambia, Cape Verde, Zambia, Ghana, Madagascar, Comoros, Senegal, Liberia, DRC, Burkina Faso, Ethiopia, Burundi **(15 countries)**	Niger, Kenya, Mauritania, Benin, Togo, Gabon, Uganda, Mauritius, Eritrea, Mali, Congo, Sao Tome and Principe, Nigeria, Central African Republic, Guinea-Bissau, Cameroon, Chad, Côte d'Ivoire, Sierra Leone, Guinea **(20 countries)**

Annex VI: Maternal mortality ratio for AFR countries (2010)



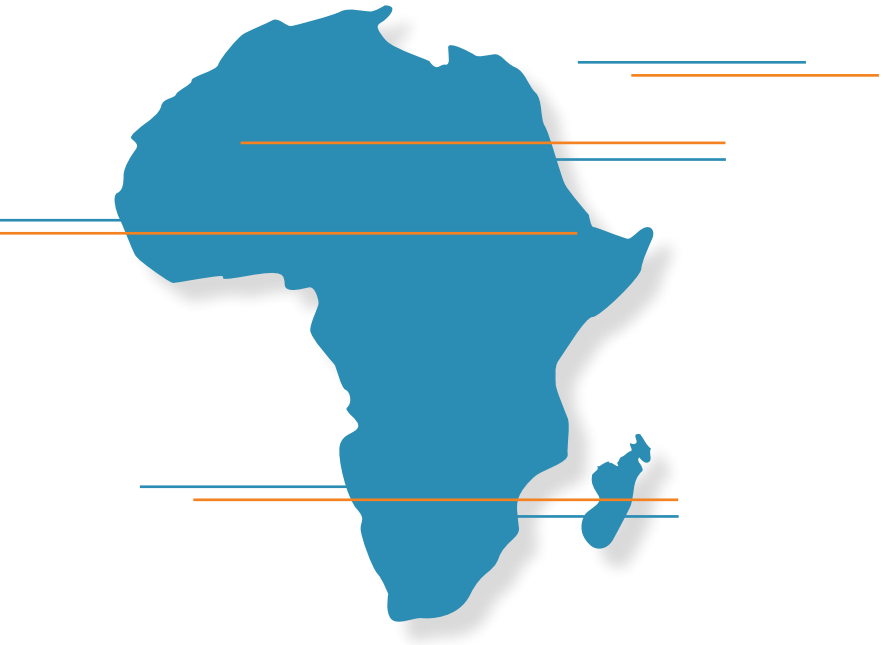
Endnotes:

[i] Until 2004, there were taxes on tobacco and alcohol, and the Ministry of health received part of the funds collected. However, these taxes disappeared with the introduction of VAT. The issue of innovative mechanisms of financing should be included as part of the revision of the health financing strategy, which should start soon.

[ii] In the Comoros, the innovative mechanism developed is a tax of 20% on tobacco and alcohol. This tax is put in a public common basket, but a specific account for health "Fund of development health (FDS)" was opened in the Central Bank of the Comoros in 2004 for this matter.

[iii] The pilot model "to work together" developed by USAID in Guinea aims to improve local governance by strengthening the capacity of the urban communes and community rural development institutions in mobilization and management of financial resources. Fifteen percent of these resources are allocated to the local health sector. This model was developed in the regions of Faranah, Kankan and N'zerekore.

[iv] The country has introduced a compulsory AIDS levy for all formally employed persons which goes to the National Aids Trust Fund for the care of HIV infected persons and for HIV prevention services.



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