## 2.5 AFRICA

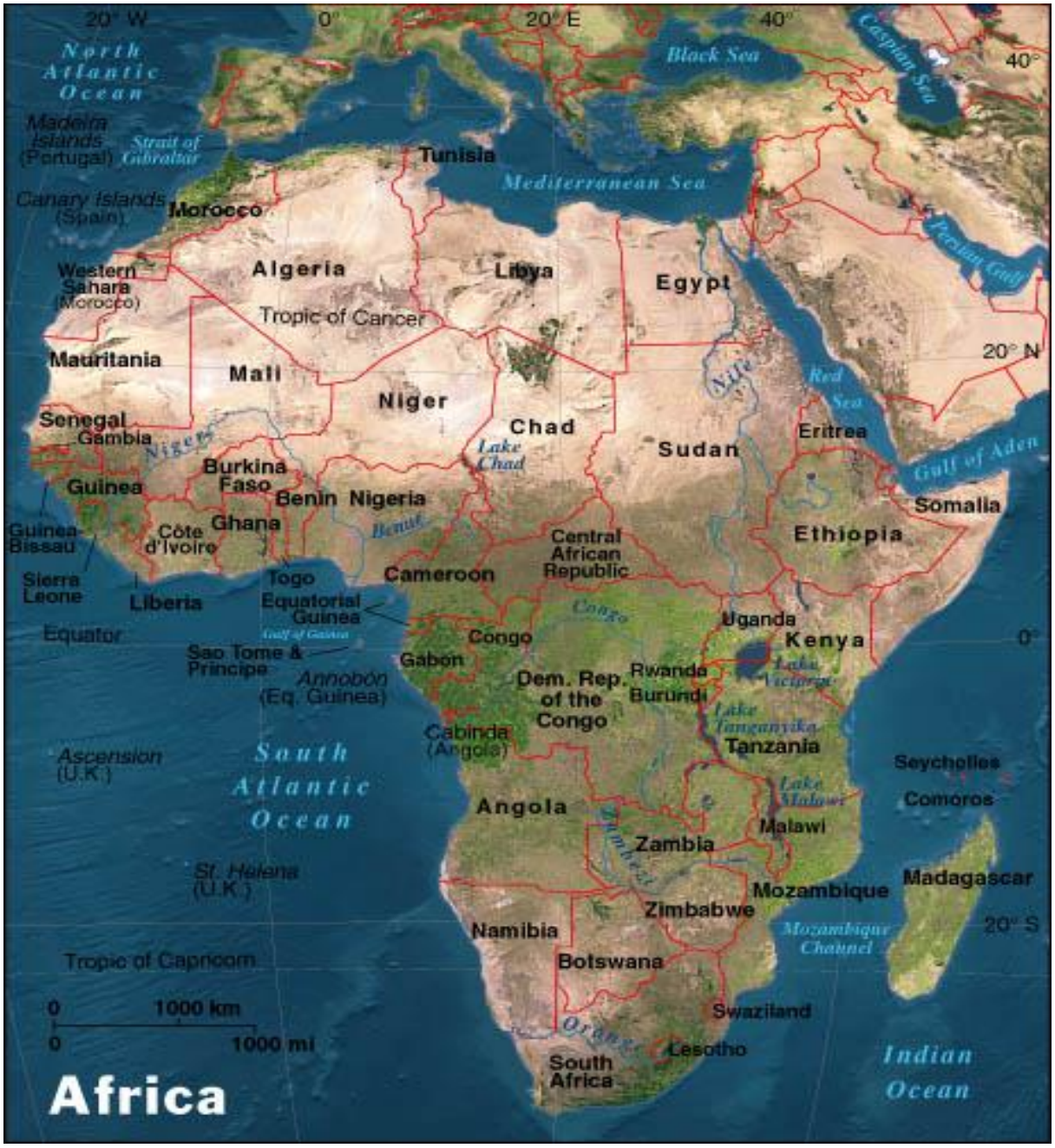



**Figure 2.7: Map of Africa**

**Source:** Google Images, 2011

Africa is classified as the poorest continent. During the last two decades about 80% of its countries experienced war. This generated many health problems. Lack of infrastructure, malnutrition and poor sanitation contributed to deprived immune systems, making people more susceptible to illnesses and even death.

This is the main reason why Africa receives a large amount of funding. Most countries are still recovering from recent wars and people are still suffering from health related issues.

Harsch (2005) stated that despite some hesitancy and half-steps, the US, UK, France, Belgium and numerous others have pledged not only to give significantly more aid to Africa in the coming years, but also to increasingly aim that assistance at the MDG's and other development goals identified by African countries themselves. It is also noted that a "big push" of aid will not be the sole answer, but must be accompanied by trade reform and other policies promoting private capital flows, technology transfers, security and environmental protection. Since the Millennium Summit in 2000, overall aid to Africa has been rising. Moreover, the continent's slice of the total aid pie has been growing. In 1997-98, sub-Saharan Africa received 35% of net ODA disbursements by DAC. By 2002-03, this share climbed to 41%, and Canada doubled its overall aid levels by 2010. These allocations would be focused on just 25 countries, chosen on the basis of poverty level, 14 countries of which is in Africa. Already in 2002-03 seven of the DAC was giving half or more of their overall aid to sub-Saharan Africa.

Donor countries may report debt relief as part of their aid disbursements. "At the time such loans are written off, they are counted at full face value," explains DAC Chairperson Richard Manning. "It does not reflect a real transfer of resources."

The OECD found that only 8.1% of total ODA, or 12.7% of aid disbursed to the health sector, went to those priorities in 2002. To build momentum for the MDG's in Africa, it is recommended to significantly "scale up" human development services such as education, health care, water and sanitation. With funding from both national governments and external sources, Africa will need to triple its current number of doctors, nurses and community health workers to make a significant impact in the health sector (Harsch, 2005).

### 2.5.1 Kenya

- **Background to Kenya**

According to the CIA (2011), Kenya covers a total of 580.367 hundred thousand square kilometres. It has a population of 41 million people. There is a total annual growth of 2.46% (2011 estimate). The life expectancy at birth is 59.48 years, 58.91 years for males and 60.07 years for females. The infant mortality rate is stated at 52.29 deaths per 1 000 births, where the fertility rate is around 4.19 children born from a woman. The adult HIV/AIDS prevalence rate is 6.3% and 1.5 million people were living with AIDS (2009 estimates). These statistics would rank Kenya 5$^{th}$ in the world, when looking at Kenya's stats. The 2009 estimates stated that 80 000 Kenyans died annually of AIDS. Approximately 90.6% males and 79.7% of females (fifteen years and over) can read and write (2003 estimates).

- **Background to Kenya's health sector**

Briscombe, Sharma and Saunders (2010) found that between the 1970s and 2000, the share of Kenya's population classified as poor grew from 29% to about 57% of Kenya's eight provinces, the percentage of residents living below the poverty line in six provinces was above 50%; the remaining two provinces, Nairobi and Central Province, had slightly lower percentages.

A high level of poverty and poor health outcomes gives a clear correlation between infant mortality, child mortality, and fertility rates. Analysis of Demographic and Health Survey 2003 data indicates that poor health conditions can be paralleled with the least wealthy segments of society. High unemployment is one of the main reasons why the poverty levels are so high, affecting 37.9% of Kenyan women and 23% of men (2003).

The private sector in Kenya is one of the most developed and dynamic in sub-Saharan Africa. The leading causes of deaths in Kenya can be attributed to HIV/AIDS, acute respiratory infection (ARI), diarrhoeal diseases, and malaria (World Health Organization [WHO] 2004).

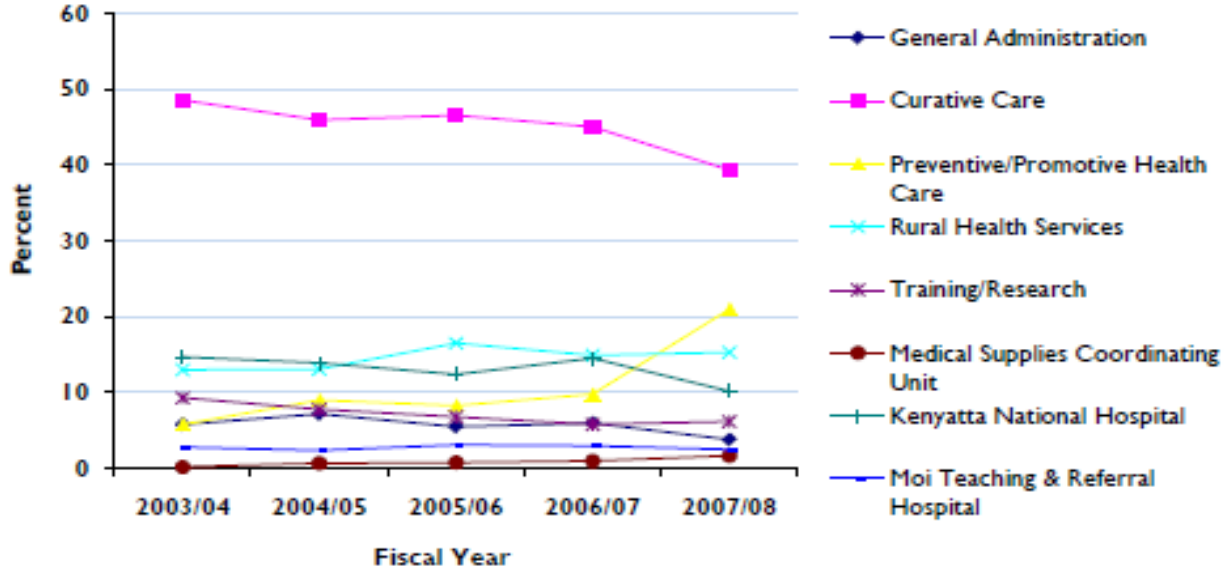


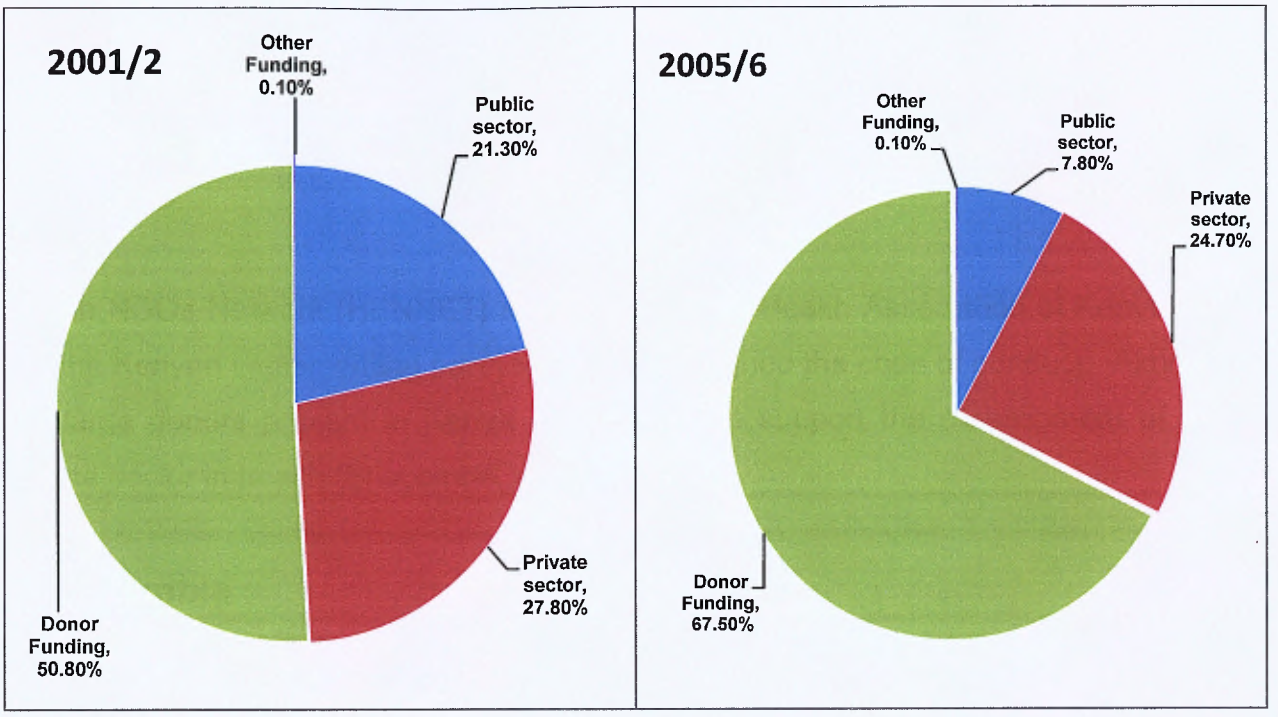

**Figure 2.8: Percentage Share of Health Resources from 2003/04 to 2007/08**

**Source:** Ministry of Medical Services, 2008

Briscombe, et al (2010) stated that as in most countries in sub-Saharan Africa, the burden of disease in Kenya is driven primarily by infectious and parasitic diseases including HIV/AIDS, TB, malaria, diarrhea diseases, and childhood vaccine preventable diseases. Maternal morbidity and mortality, injuries, and cardiovascular disease are also major contributors to the burden of diseases. With HIV prevalence rate of 6.3%, and approximately 1.5 million Kenyan adults living with HIV/AIDS (2007), the disease is a significant burden to the health system and society in general.

## ➢ Funding towards Kenya's health sector

Financing sources towards the health sector, specifically towards HIV/AIDS in the 2005/06 period are illustrated below.




**Graph 2.10: Financing sources for 2005 - 2006**

**Source**: NHA, 2006

The international donor community is another central stakeholder in the health sector. It is very large and active in Kenya, and the donors work closely together. They have formed a working committee called Development Partners in Health in Kenya (DPHK). The position of chairperson of this standing committee rotates annually.

In 2005, a representative of USAID was the chairperson. The group is committed to co-ordination and has developed a code of conduct, including high level officials from the Government of Kenya (GOK), donors, and implementing partners as signatories. To date, the following countries and multilateral organisations have signed the code of conduct:

- Denmark,
- European Union,
- Germany,
- Japan,

- United Kingdom,
- UNAIDS,
- UNFPA,
- UNICEF,
- United States,
- World Bank Group,
- WHO.

Health NGOs Network (HENNET) and the Christian Health Association of Kenya (CHAK) are the Kenyan implementing partners that have signed the code of conduct. Almost all of the large donors present in Kenya are working to support the development of the for-private sector in health (Briscombe, et al, 2010).

### 2.5.2 Zambia

#### ➢ Background to Zambia

According to the CIA (2011), Zambia covers 752.618 thousand square kilometres. It has a population of 13.881 million people and a growth rate each year of 3.06% (2011 estimates). The life expectancy at birth is 52.36 years, 51.13 years for males and 53.63 years for woman. The fertility rate of Zambia is 5.98 children per woman and the HIV/AIDS adult prevalence rate is 13.5% (2009 estimate). People living with AIDS were 980 000 in 2009 and approximately 45 000 add to this number each year. These figures rank Zambia 11$^{th}$ in the world. Approximately 86.8% of males and 74.8% of females (age fifteen and over) can read and write (2003 estimates).

#### ➢ Background to Zambia's health sector

Because of its substantial mineral deposits Zambia was one of wealthiest countries in the sub-Saharan African region in the 1960s. Since the 1990's it has declined to have the highest level of income poverty and the fourth highest level of human poverty among Southern African Development Co-operation countries. Nutrition was identified as a major factor contributing to the high levels of morbidity and mortality within Zambia, thus the health status in Zambia is poor.

The latest MDG Progress Report shows that Zambia is making progress, but not fast enough to meet the MDG targets. Providing basic health services to most of the population remains a challenge (Pereira, 2009).

Health services in Zambia are provided through a network of public facilities, complemented (largely, although there is still some duplication) by mission facilities in the rural areas and in urban areas, by a growing private sector. Primary health care in the public sector is provided by health centres, either in urban areas which are intended to service a catchment population of between 30 000 and 50 000, or rural areas with a designated catchment area of 29km and an estimated catchment population of 10 000. Some areas also have health posts, which offer a more limited range of services to a smaller number of people (Lakes, 2004).

## ➢ Funding towards Zambia's health sector

According to Pereira (2009), the latest available figures are from 2007. The figures indicate that the major donors to the health sector are: the Global Fund (US$23 million), the Netherlands (US$21 million), Sweden (US$19 million), Canada (US$14 million) and the US (US$14 million). Furthermore, The US President's Emergency Plan for AIDS Relief (PEPFAR) was the single biggest donor with US$269 million in 2008, though not all this money is recorded as contributing to the health sector, around 90% of all funds are allocated to disease-specific programmes (mainly HIV/AIDS), while the remaining 10% supports the government's efforts to strengthen health systems. In 2007, PEPFAR and the Global Fund provided almost US$340 million, while the total funding from Organization for Economic Co-operation and Development - Development Assistance Committee (OECD-DAC) countries to the health sector amounted to US$51 million. This figure excludes budget support, but it also includes contributions from the Organization for Economic Cooperation and Development-Development Assistance Committee (OECD-DAC) countries to HIV/AIDS, tuberculosis and malaria.

The Ministry of Health formulated a policy and strategic plan in the year 2001. This was implemented under the sector-wide approach (SWAp) framework. The key priority programmes outlined in the policy and strategic plan were:

- HIV/AIDS,
- Tuberculosis,
- Malaria,
- Reproductive Health,
- Child Health,
- Oral Health,
- Mental Health and
- Environmental Health.

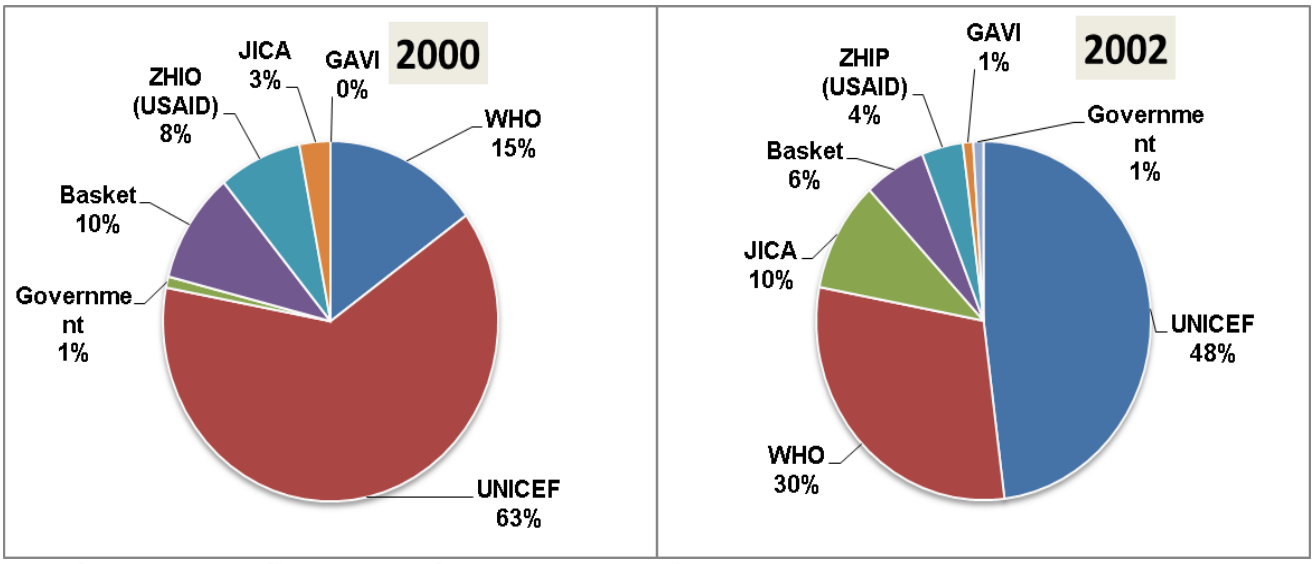
**Table 2.1: Annual Funding Situation for Zambia EPI Programme 2003-2012**

2003 - 2012 **All amounts are in US $**

| | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|---|---|
| Secure Funding | 5,836,919 | 5,184,312 | 7,010,001 | 5,224,697 | 4,960,629 | 5,051,900 | 5,090,638 | 4,432,941 | 2,119,299 | 1,464,885 |
| Probable funding | 0 | 2,511,978 | 2,608,579 | 2,261,385 | 6,734,940 | 2,969,109 | 2,367,104 | 2,472,710 | 6,749,514 | 2,067,308 |
| Funding gap | 147,897 | 938,716 | 884,568 | 1,235,330 | 930,166 | 977,091 | 1,098,056 | 1,784,076 | 4,366,935 | 5,645,217 |

**Source:** Health Sector Background Zambia, 2012

Zambia depends significantly on external financing to meet expenditure plans formulated in the budget. From Table 2.1 it is clear that the gap of funding given and the actual funding needed are increasing each year, making it difficult for Zambia to reach its health goals and ensure a more sustainable growth towards ensuring everyone receives basic health care.




**Graph 2.11: Funding from Different Donors in 2000 - 2002**

**Source:** Health Sector Background Zambia

As seen in Graph 2.11, the funding given by different donors stayed more or less the same over a two year period, except for UNICEF, WHO and JICA, whose funding decreased.

### 2.5.3 Sierra Leone

#### ➢ Background on Sierra Leone

According to the CIA (2011), Sierra Leone is a small country on the West coast of Africa that covers 71 hundred thousand square kilometers. The population is around 5.363 million people with a population growth of 2.25% per year (2011 estimates). The life expectancy is 56.13 years, 53.69 years for males and 58.65 years for females. The infant mortality rate is around 78 deaths per 1 000 births, where the total fertility rate is 4.94 children per woman. The adult HIV/AIDS prevalence rate of Sierra Leone is 1.6% while 49 000 people are living with AIDS and 2 800 people die each year (2009 estimates). These figures rank Sierra Leone 59$^{th}$ in the world. Approximately 46.9% of males and 24.4% of females (age fifteen and over) can read and write.

## ➢ Background on Sierra Leone's health sector

From September 1992, Sierra Leone embarked on major reform of its health sector. The reform had three broad objectives:

1. To make a realistic assessment of its health care delivery system.
2. To develop a sector policy that would set out long- and short-term goals and objectives.
3. To develop an action plan that would map out specific pathways through which the policy objectives could be achieved.

Prior to 1992, Sierra Leone made various attempts at developing strategies for health as part of broader development plans, they are as follows:

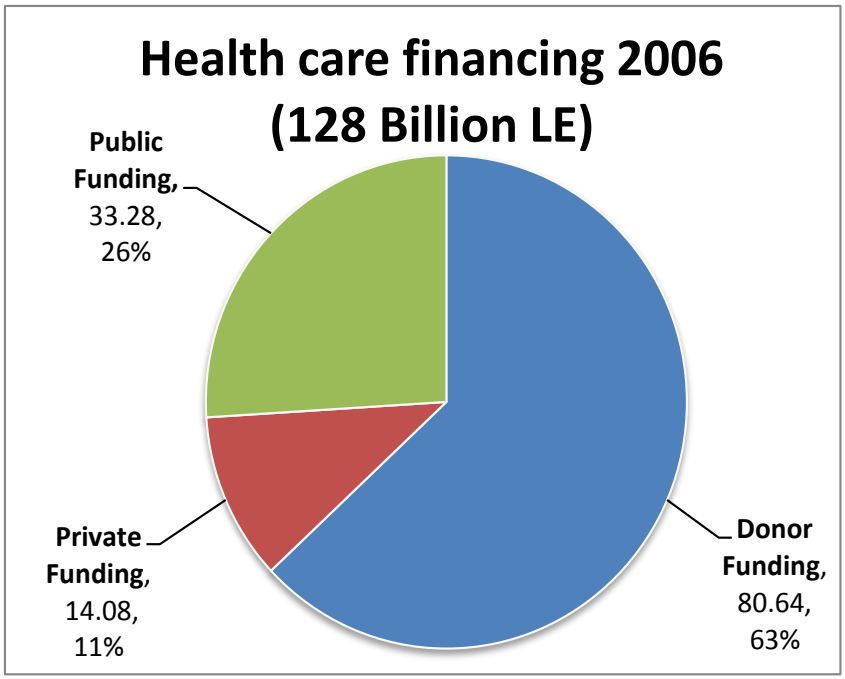
1. The National Five Year Development Plan (1974-79).
2. The Three Year Public Investment Plan (1980-83).
3. The Three Year National Development Plan (1983-86).
4. The Sierra Leone Programme for Rehabilitation and Development (1985-88).

(ANON, The processes of health sector reform in Sierra Leone)

## ➢ Funding towards Sierra Leone's health sector

According to "IDA at Work Sierra Leone: On the Path of Full Return to Development", Sierra Leone joined the World Bank in 1962, just one year after the country's independence. The IDA provided reliable development aid between 1996 and 2002; this was during the country's emergency period. It provided funding to over 3 000 war affected communities, totalling $240 million US dollars of resources for restoration of infrastructure, services, economic growth, institutional reforms, decentralised service delivery and governance. IDA also supported more than fifteen projects since the war ended in 2002.

In Sierra Leone, it was not possible to determine if there was a transitional funding gap due to the difficulty of obtaining reliable information. Sierra Leone has witnessed a downsizing of humanitarian support to health services following the peace agreement in 2002, while key informants report that development funds are slow to arrive. According to Canavan, Vergeer, Bornemisza, Hughes and Ezard (2008), the exit of a number of international NGOs, suggests that there may have been a funding gap.




**Graph 2.12: Health Care Financing 2006**

**Source:** World Bank data based on Ministry of Finance Budget Data.

In the last part of this chapter an overview will be taken at South Africa.

## 2.6 SOUTH AFRICA


**Figure 2.9: Map of South Africa**

**Source:** Google Images, 2011

### ➢ Background to South Africa

According to the CIA (2011), South Africa covers a total of 1.219 million square kilometers and has a population of 49 million people with a growth rate of -0.38% each year (2009 estimates). The life expectancy at birth is 49.33 years, 50.24 years for males and 48.39 years for females, where the infant mortality rate is around 43.2 deaths for every 1 000 births. The fertility rate is 2.3 children per woman and the HIV/AIDS adult prevalence is 17.8%. In 2009, 5.6 million South Africans were living with AIDS and 310 000 people died each year, which ranks South Africa 2nd in the world when looking at HIV/AIDS figures.

## ➢ Background to the health sector in South Africa

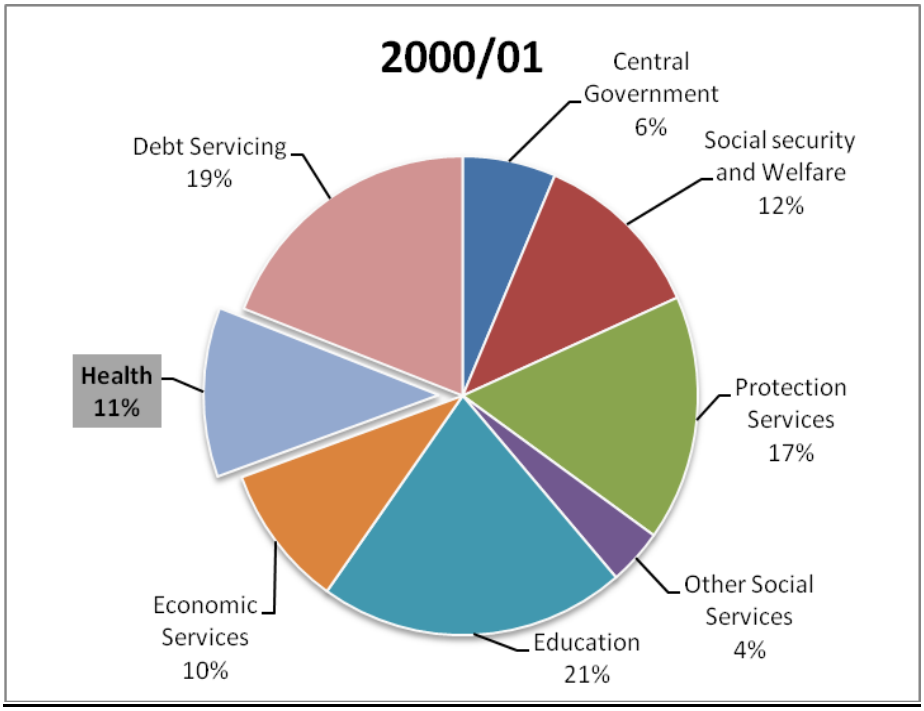
According to the Department of Health (DoH), South Africa's health system was built on apartheid, ideology and racism before 1994. Black, white and coloured people weren't treated the same and the fourteen Departments of Health existing then, were all functioning with their own objectives. Doctors and medicines were scarce at most rural hospitals, placing those with few resources at the bottom of the chain when it came to healthcare. "A faltering pulse" (2005), found that the health sector was being hit hard by the impact of HIV/AIDS, with an estimated 100 000 patients a year seeking treatment, for AIDS-related illnesses.

According to Harrison (2009), South Africa has a poor healthcare system, weak management and low staff morale. He also states that HIV/AIDS will still dominate for the next decade, unless financing can be sustained for the prevention of HIV/AIDS. The improvement of service efficiency and the quality of healthcare given to individuals will also play a big role in improving South Africa's health system.

## ➢ Funding towards South Africa's health sector

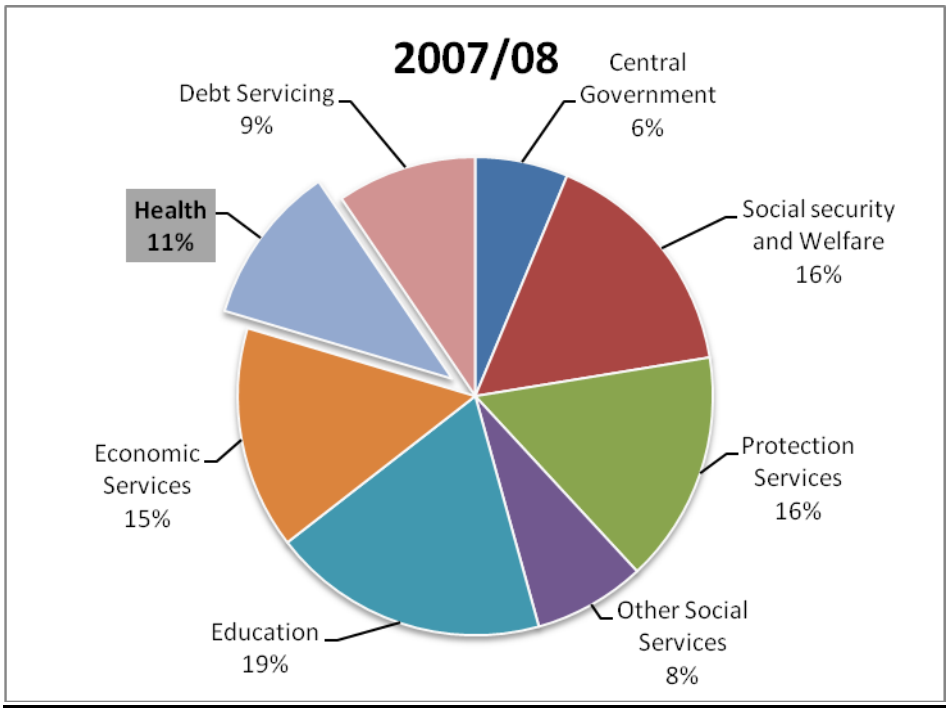
According to the website of Media Club South Africa (2010), "over R8-billion was added to specific health service interventions, laying the foundations for National Health Insurance. This included:

- R1.2-billion to introduce family health care teams
- R2.9-billion to improve quality in health facilities, medical equipment and hospital systems
- R1.4-billion for improved district-based maternal and child health services
- A new office of standards compliance to inspect and certify hospitals
- Funding for the Department of Health to lead the necessary institutional and management reforms, revitalising health infrastructure, including a new infrastructure grant for provinces
- Expanding capacity to train medical doctors and nurses."




**Graph 2.13: Government Expenditure share 2000/01 (functional classification)**

**Source:** National Treasury, 2009

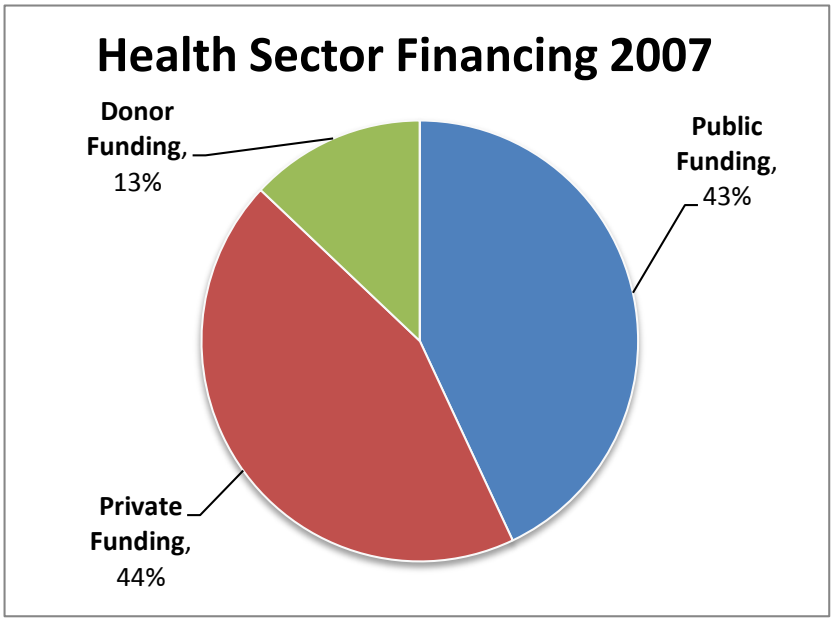



**Graph 2.14: Government Expenditure Share 2007/08 (functional classification)**

**Source:** National Treasury, 2009

Graph 2.13 and Graph 2.14 show that the percentage of funding allocated towards health from 2001 until 2008 stayed constant at 11%. The percentage for debt servicing more than doubled (from 9% to 19%), as well as the percentage towards other social services (from 4% to 8%).

In 2005 funding towards the health sector was contributed as follows:




**Graph 2.15: Health Sector Financing South Africa 2007**

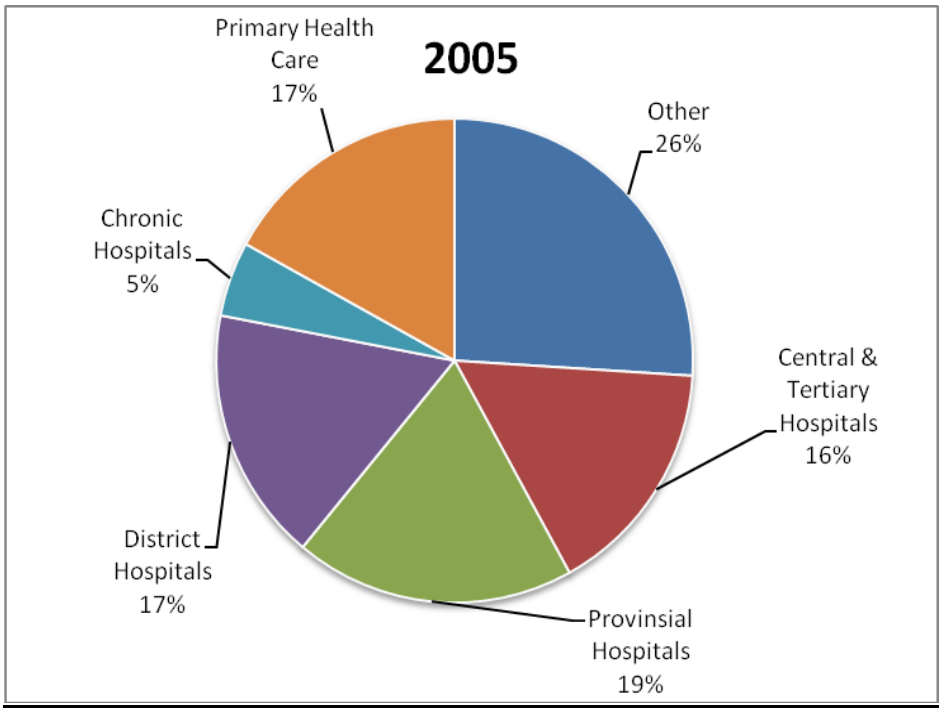
**Source:** Health care financing in South Africa, 2010

Graph 2.15 illustrates that South Africa's contribution from public and private funds are approximately equal, with 43% publicly generated and 44% privately generated. Donor funds do not seem to play an immense role in South Africa's health sector.

These funds can be analysed further by considering distribution to the different categories within the health sector.

The more funding that is given to research, the lesser the burden of diseases will be.

- Unknown




**Graph 2.16: Distribution of Total Government Health Care Expenditure**

**Source:** National Treasury, 2009

Graph 2.16 shows that the distribution of total government health care expenditure is almost evenly distributed towards each sector, except for Chronic Hospitals that received only 5% of the total funding. The other four sectors (primary health care, district hospitals, and provincial hospitals, central & tertiary hospitals) received between 16%-19% of the total funding per sector, 69% of the total funding.

## 2.7 CHAPTER SUMMARY

After taking a look at the background of different countries, it is much easier to put the need for funding into perspective and consider the funding given to a specific country. To summarise, Third World countries, especially those who endured violent warfare just over two decades ago, are the countries with the greatest need for funding. Because of the lack of infrastructure, caused mostly by war, sanitary facilities are not even basic in most of these countries. This reality, as well as poor nutrition, is probably the cause of most of these countries' health problems. These countries also have the highest HIV and child mortality figures worldwide.

Without funding, therefore, these countries and their people have limited opportunities for life.

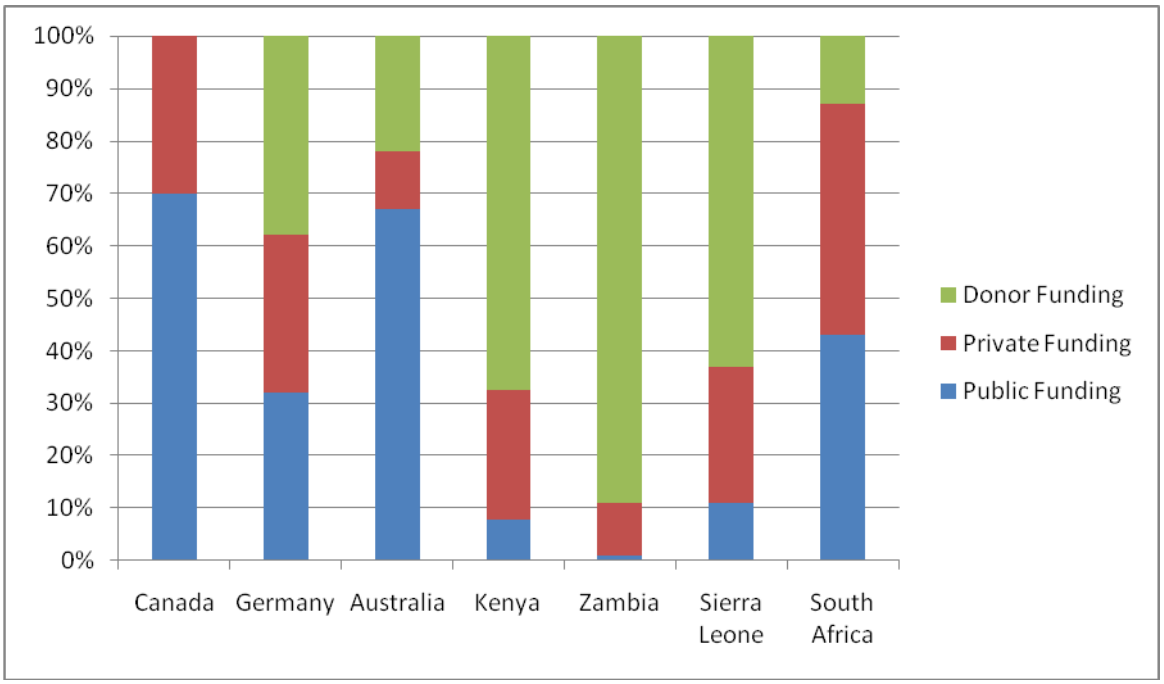


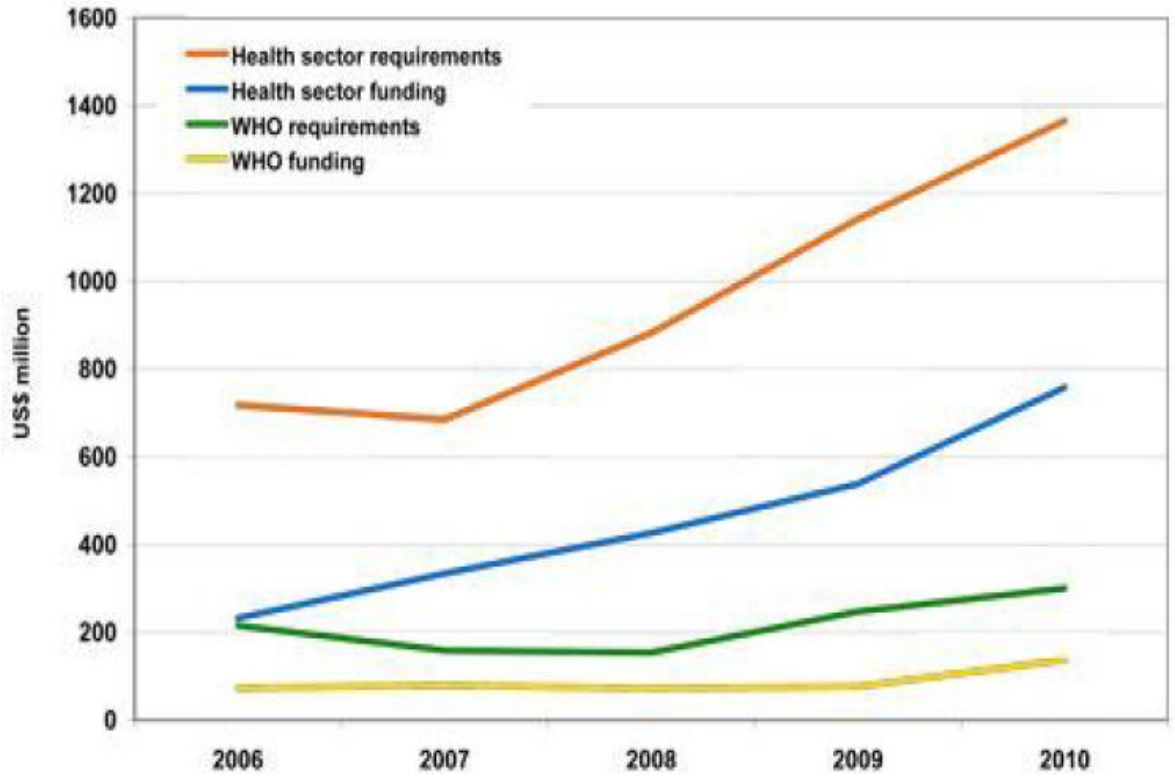

**Figure 2.10: Summary of Funding towards Health Sector**

**Source:** Own research

From Figure 2.10 it is clear that First World countries, like Canada and Australia, don't make much use of donor funding, while Third World countries like Kenya, Zambia and Sierra Leone are dependent on donor funding to sustain their health sectors. In South Africa, health sector funding is almost equally distributed between public and private input, with a small percentage (13%) from donor funds.

When looking at the large sums these African countries receive, one must ask the questions:

- Does the large amount of funding really make a difference to the health sector?
- Would the health sector be worse off without these large amounts of funding?
- Are these funds allocated correctly and distributed towards the greatest need?




**Graph 2.17: Health Requirements and Funding for 2006 - 2010**

**Source:** WHO, 2011

Graph 2.17 illustrates that the health sector requirements in the world are much higher than the funding given each year. Even the WHO health sector requirements aren't met annually. This raises the question whether our health sector requirements will ever be met, or do we need to adjust our annual goal so that it would be in line with the funding that we can generate?

## 2.7.1 Evaluate African countries health sector growth

Because training programmes are poorly funded and because there is a shortage of equipment and reference materials, most African countries do not have a good educational system and suitably trained individuals. Poorly trained people produce deficient health care professionals, which in turn impacts on health care provision (The Health Sector Human Resource Crisis in Africa, 2003).

Basic sanitation, clean water and adequate nutrition are identified as many African countries' biggest problems. The onset of diseases that are interconnected to one another makes it difficult to deal with the arrival of killer diseases in the health sector. To make matters even worse, most of these countries suffer from fragmented distribution channels for medical equipment and pharmaceutical products. Shortages of medicine and supplies are common in these countries.

A report from the Economist Intelligence Unit, found that chronic diseases will overtake infectious diseases by 2030 (WHO Report 2012). WHO also predicted that the main causes of death will be cardiovascular and respiratory diseases, such as asthma and chronic obstructive diseases (COPD), both of which are related to fuel-burning for cooking or smoking. "It's very difficult to go from a health service focused on treating diarrheal diseases, TB and providing vaccinations for children to one that is focused on promoting healthy lifestyles and changing behavior," says Stefano Lazzari, Tunisia's WHO representative. Information Technology (IT) needs to play a more dominant role in improving health in Africa. Africa has 600 million mobile-phone subscribers out of a total population of 900 million, which amounts to 67% of the total population. (WHO Report, 2012)

In recent years donor funding from governments and multilateral organisations made a significant difference to improving health and diminishing mortality rates. Yet in 2010, WHO noted that we aren't even close to reaching the MDG's objectives. "Improvements in access to safe drinking water and sanitation have also stalled in Africa, making it difficult to combat stubbornly high levels of water borne illnesses." North Africa has shown the greatest progress in reaching MDG 1 and MDG 2.

Some analysts criticised the dependence that donor funding has created in some countries, as it creates an insufficient solution during a global economic crisis period. "The opposite of sustainability is dependence and what we've done in most cases is create dependence," says Keith McAdam, a member of the board of directors of the American Medical Research Foundation (AMREF).

For the near future donor funding will remain one of the dominant sources of financing for the health sector in Africa. For two reasons this poses a problem.

- Firstly, donor funding is short-term and funded from foreign governments and multilateral organisations, who suffer from the global economic crisis being faced at the moment.
- Secondly, "donor funding has traditionally been focused on single ailments or conditions, rather than on multi-condition, comprehensive healthcare systems that Africa will require in the future." Dr Tedros, the Ethiopian Health Minister stated that, "The more efficient healthcare systems – that focuses on disease prevention and health promotion, and can pool funds from different sources to address funding gaps flexibility – the more proficiently it can offset the impacts of any declines in external funding flows." (WHO report, 2012)

There is a need to have a collaborative approach by private and public sectors to ensure sustainable improvements in the health sector. A conclusion is made, as stated by Harsch (2005), (previously stated in this chapter):

"A "big push" of aid will not be the sole answer, but must be accompanied by trade reform and other policies promoting private capital flows, technology transfers, security and environmental protection. With funding from both national governments and external sources, Africa will need to triple its current number of doctors, nurses and community health workers to make a significant impact in the health sector."