Africa in the Wider World

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3 | The Unfinished Health Agenda in Africa

J. Stephen Morrison and Talia Dubovi

Some of the United States' most vital and impactful relationships with African nations are in the health sector. In the past decade, over $50 billion has been committed to addressing HIV/AIDS through the President's Emergency Plan for AIDS Relief (PEPFAR),[1] and the investment of significant additional resources has led to dramatic advances in the prevention and treatment of infectious disease; improvements in maternal, newborn, and child health; better training of health workers and management of health systems; and progress on outbreak control. This expansive, historic engagement has earned the United States considerable good will, and it has prompted partner governments, international institutions, foundations, and other donors to increase their own commitments to health. It has also put a spotlight on the considerable unfinished health agenda in Africa and the need for the United States and others to look for new and innovative ways to expand affordable, equitable health services on the continent, including better leveraging the potential of the private sector to achieve future substantial gains in health in Africa.

The tenor of recent discourse in U.S. policy circles regarding the future of U.S. development assistance—and health in particular—might give the impression that a transition to African countries taking predominant responsibility for managing, financing, and delivering health services is imminent, and that the United States will soon be able to substantially draw down its investments in the health sector. However, this proposition is mistaken and misses one critical question: will African states realistically acquire the capacity in the near to medium term to take ownership of their health systems? In a very few instances—South Africa, Botswana, Namibia—there is reason to be hopeful; in the majority of cases, there is much more work to be done, and a true transition to country ownership remains a distant aspiration.

The question of capacity has many facets. The first and most obvious is funding. While levels of U.S. and international development assistance for health have been resilient—and have in fact grown slightly between 2011 and 2013 in spite of the global financial crisis and austerity measures—there is general consensus that future aid budgets will be flat at best.[2] Expansion of services—to reach more people, address additional diseases, improve infrastructure and technology, and expand training—will have to come from increased efficiencies, enhanced private-sector participation, and higher budgetary commitments by national governments. Economic growth on the continent is promising, but it is not universal. And even in countries that have experienced 3–6 percent growth

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[1] U.S. President's Emergency Plan for AIDS Relief (PEPFAR), "Shared Responsibility-Strengthening Results For An AIDS-Free Generation: Latest PEPFAR Funding," June 2014, http://www.pepfar.gov/documents/organization/189671.pdf.

[2] Institute for Health Metrics and Evaluation (IHME), *Financing Global Health 2013: Transition in an Age of Austerity* (Seattle, WA: IHME, 2014), http://www.healthdata.org/sites/default/files/files/policy_report/2014/FGH2013/IHME_FGH2013_Full_Report.pdf.

over the past decade, there has not been in most cases a commensurate expansion of health budgets.[3] Former prime minister Raila Odinga of Kenya recently highlighted how African leaders must always balance health needs with other competing priorities, from infrastructure and transportation to public safety and education.[4] The United States and other international donors cannot assume that economic growth will automatically lead to robust investments in health systems.

In the meantime, African nations also face the growing economic and health burden of noncommunicable diseases (NCDs), such as diabetes, hypertension, respiratory ailments, and cancer. Dr. Thomas Frieden, director of the U.S. Centers for Disease Control and Prevention, has called NCDs the “unstarted agenda”—a formidable challenge that has yet to be addressed meaningfully by national governments or international donors.[5] Driven by obesity, dietary and lifestyle changes, tobacco and alcohol use, and environmental contamination, NCDs have the potential to derail economic gains while dramatically increasing the demands on health systems. Transitioning to country ownership will thus require not only assuming responsibility for managing the infectious disease and maternal, newborn, and child health infrastructure created by international donors but also expanding systems to be able to prevent, diagnose, and treat NCDs. It requires changing public behavior, and better engaging the private sector to address chronic illnesses.

A second facet is human capacity. The World Health Organization estimates that there is a global shortage of 7.2 million health care workers who are needed to adequately address the health needs of the population.[6] Countries that have tried to address this gap through voluntary health worker programs face serious questions about how long volunteers can be expected to stay on the job, and paid programs, such as Ethiopia’s Health Extension Program, face equally serious questions about how long funding can be sustained. In addition, health workers need to be educated and trained, and countries must address longstanding problems with the quality of work environments that threaten retention rates. Building the necessary workforce will require serious political dedication along with significant budgetary commitments.

Third, a lack of adequate infrastructure limits many countries’ health-sector capacity. This shortfall takes two forms: the need for physical infrastructure, including roads, electricity, and water, and a lack of public health infrastructure. Power Africa, the Obama administration’s major development initiative on the continent, was created because two-thirds of sub-Saharan Africans lack reliable electricity supplies.[7] Basic reporting and surveillance systems that allow for decisionmaking, health monitoring, evaluation, and accountability are severely lacking.[8] Combined, these gaps in infrastructure pose significant challenges to building sustainable health systems.

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[3] Ibid.

[4] Raila Odinga, keynote speech at “Health in Africa: The Unfinished Agenda,” conference hosted by CSIS, CARE, and World Affairs Council of Atlanta, Atlanta, May 19, 2014.

[5] Thomas Frieden, keynote speech at “Health in Africa: The Unfinished Agenda,” conference hosted by CSIS, CARE, and World Affairs Council of Atlanta, Atlanta, May 19, 2014.

[6] World Health Organization (WHO), *A Universal Truth: No Health Without a Workforce* (Geneva: WHO, November 2013), http://www.who.int/workforcealliance/knowledge/resources/GHWA_AUniversalTruthReport.pdf.

[7] White House Office of the Press Secretary, "FACT SHEET: Power Africa," June 30, 2013, http://www.whitehouse.gov/the-press-office/2013/06/30/fact-sheet-power-africa.

[8] Frieden, keynote speech at “Health in Africa.”

Finally, governance and leadership are the ultimate arbiters of the future. When corruption siphons health dollars into off-shore accounts,[9] when laws against homosexuality impede access and threaten the safety of entire populations,[10] and when failures in governance lead to governments that are not responsive to the needs of their citizens, health outcomes suffer.[11]

This is not to undermine the real and important gains that have been made or the potential of countries across the continent to eventually take full ownership of their health systems. But prematurely transitioning to country ownership threatens to roll back the important health gains that have been achieved in the last decade.

The United States and the international community can and should play a role in addressing these barriers and helping African governments develop the capacity to assume the cost and management of providing health care to their citizens. The Obama administration should use the occasion of this summit to emphasize the role that the private sector can play in health, and to push hard for corporate leaders to engage more fully to find new ways to bring affordable, quality services on an equitable basis to all African citizens.

Most importantly, it is the African leaders gathering in Washington who must decide if they have the political will to advance the health agenda. Without their commitment—to expand budgets, end corruption, engage the private sector, build and sustain community-level primary health care delivery, improve conditions for health workers, and delegitimize homophobia and human rights violations—countries cannot progress toward sustainable health systems. The future of health in Africa is in their hands.

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[9] Odinga, keynote speech at "Health in Africa."
[10] Richard Downie, *Revitalizing the Fight against Homophobia in Africa* (Washington, DC: CSIS, May 2014), http://csis.org/files/publication/140506_Downie_HomophobiaAfrica_Web.pdf.
[11] Odinga, keynote speech at "Health in Africa."