Understanding and fixing West Africa’s Broken Health Systems

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Executive Summary

Health systems in West Africa are weakened and, in some cases, broken. Despite political declarations, West African governments’ reluctance to invest funds in the health sector has made it dependent on foreign aid and to the out of pocket money from poor and vulnerable people. This policy paper analyses trends related to public health system financing in the region and critical sources of funding. The paper also assesses the performance of health policies through selected health indicators, before trying to understand what accounts for the poor performance of sectoral health policy through descriptive and comparative analysis.

From this analysis, we can conclude that health financing and expenditure has always been a low priority for West African governments, which has undoubtedly led to weak health systems within the region. Citizens lack access to quality, affordable, effective, and efficient health care services, and the healthcare of citizens is usually traded for donor interests.

Despite increasing wealth creation through GDP, an increase in public budget over time, coupled with political declarations on universal health coverage, there is no government in West Africa which has succeeded in realizing its commitment to increase government spending on health care to 15%.

Health financing sources remaining divided. Except for Cabo Verde, Guinea Bissau and The Gambia, the health systems of other countries are predominantly funded by the domestic private sector (user fees), which is comprised of mostly of out-of-pocket funding and household investments.

Maternal, neonatal, and infant deaths have remained high and constant over the past three decades, with only Cabo Verde making meaningful progress in reducing deaths in these three categories. Although all countries are making significant progress in reducing neonatal and child mortality rates, the ratio remains high. The adult mortality rate remains high within the region, with male mortality rates being higher than female rates. The cause of death related to communicable diseases is high in the region but slowly decreasing all over time. The contraceptive prevalence ratio of West African countries is very low except for Cabo Verde, and the region has, overall, a low prevalence of HIV compared to other regions on the continent.

To conclude, it is unlikely that West African countries will meet Sustainable Development Goal 3 by 2030 unless governments commit to building infrastructure, investing in health financing, and promote health as a public good and human right.

Finally, the paper provides policy recommendations for ways in which to create and support a robust health care system and ensure quality healthcare services for all citizens as a public good and human right.
• Governments need to make further investments in health by increasing their public spending (in respect to commitments made in the Abuja Declaration), tackling corruption loopholes that impede funds from being invested in the healthcare system;
• Articulate national priorities to identify relevant sub-sectors where needs are, through wider public consultation including key stakeholders and minimize external influence when setting those priorities;
• Regional bodies can ensure better coordination and investments by harmonizing and strengthening the regional healthcare policy and mobilizing adequate resources for financing through regional mechanisms;
• Central and local governments improve citizen participation in decision-making processes and increasing demand for accountability through the inclusion of citizens’ input into local community development plans which can determine the national health plan and priorities;
• Increase national spending on health through the mobilization of domestic resources and the effective management of tax systems and natural resource revenues;
• Investments in other health components such as contraceptive methods, nutritional conditions and water, sanitation and hygiene instead of just treatment-based healthcare services;
• Invest in peer-learning avenues and information dissemination campaigns and platforms to ensure that citizens are better informed and can make educated decisions on their healthcare needs;
• Ensure that national priorities come before donor priorities;
• Amplify voices and provide alternative avenues to truly realize broad socio-economic rights for every West African;
• Invest in the education of medical personnel, while creating channels for retention of qualified staff.
Introduction

West African governments are great at signing protocols and international conventions, but less so in implementing them to deliver meaningful impact for their citizens’ wellbeing. External images and commitments are of higher importance than being accountable to their citizens. Despite political declarations, the significant number of protocols & conventions signed and the creation of institutions both at the national and regional levels, West African government places a low priority public health service delivery. Health sector financing is more dependent on foreign aid and more critically on poor and vulnerable user fees. The limited public resources allocated to the sector is oftentimes diverted into shady deals, and corrupt practices and citizens have limited understanding of these public budget allocations and policy formulation processes. The advancement of the population’s health was elevated to global agendas, with an emphasis on attaining universal health coverage since the Alma Ata Declaration of 1978. Furthermore, the World Health Organization (WHO) called for the attainment of “Health for All” by the year 2000, followed by the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs). However, making progress on universal health coverage entails all people having access to quality health care services without incurring financial hardship. What are the progress and the key challenges faced by West African countries in achieving this goal?

This paper is informed by the work the Open Society Initiative for West Africa (OSIWA) has been supporting in the space of health systems strengthening and governance. More importantly, my main motivation comes from seeing daily, the tragic conditions that my fellow citizens across the region face when trying to access basic services for themselves or their loved ones. Simultaneously we see countless state representatives and officials rush to seek a better-quality health services in Europe, the USA, Brazil or India, leaving the poor and vulnerable in their own country to fend for themselves.

The first section explores health financing in West Africa, before discussing selected health indicators and measuring progress. The second section provides a descriptive analysis of health status’ through selected indicators. Finally, the third section will focus on some health determinants. The paper ends with short concluding remarks and recommendations are made to improve the governance of health systems in West Africa.
I. Health system financing in West Africa

1.1 Health Expenditure as a share of GDP

West African governments have failed to meaningfully invest in their own health systems, which face significant budget deficits. In figure 1, between 2000 and 2016, the average health expenditure of West African countries except for Cote d'Ivoire, Guinea Bissau, Mali, Niger, and Sierra Leone, was less than 5% of GDP. The country exceptions did not necessarily perform better in this period. At least one main factor accounts for the numbers and this is the influx of external resources (foreign aid) with conditionalities and has the effects of distorting national priorities. Also, the domestic general government health expenditure as a share of GDP is far weaker.

The five exception countries whose overall spending exceeds 5% of the GDP, are also spending their own domestic resources: Cote d'Ivoire: 0.8% of GDP, Guinea Bissau: 3.4% of GDP, Mali: 1% of GDP, Niger: 1.5% of GDP and Sierra Leone: 2% of GDP. The remaining countries spent on average 1% of GDP or less, except Cabo Verde: 3.1% of GDP and Senegal: 1.5% of GDP. More worrying are the cases of Cote d'Ivoire: 0.8% of GDP, Guinea: 0.37% of GDP, Liberia: 0.74% of GDP, Nigeria: 0.53% of GDP and Togo: 0.39% of GDP. This means that less than 1% of GDP is allocated to public health services. Several factors account for this low prioritization of health funding, the major one being weak accountability mechanisms and social contracts between citizens and their governments (central and local). Citizens are not well informed and are excluded from participating in public resource collection and budget allocation processes.

Figure 1

![Health Expenditure % GDP between 2000 & 2016](image)

1 This measures the share of all wealth created in the national economy and allocated to health sector.
Figure 2 shows the current health expenditure per capita. Except Cabo Verde, where the average spending of health care between 2000 and 2016 was almost $130 USD per person per year, spending across the rest of the region averaged between $20 USD for a country like Niger and $65.1 USD for Nigeria during the same period. Over time, trends in health expenditures have remained the same including during periods of crisis, for example in the Mano River Union countries that experienced the Ebola outbreak, with the exception of Sierra Leone, where the elasticity of expenditure per capita increased between 2013 and 2016.

Source: World Bank - World Development Indicators

Based on domestic general government expenditure per capita, Cabo Verde seems to be making conscious efforts in allocating public resources to improve health systems (see Fig.3). For the other countries, not only is per capita expenditure low, but in many instances, it has decreased over time. Despite public discourses and widespread evidence of dysfunctional public health systems, West African governments fail to prioritize the development of accountability systems and adequate financing channels to address this.
1.2 Domestic general government health expenditure as a share of general government expenditure

African governments made commitments to their citizens to allocate at least 15% of total spending on health and have yet to follow through on these commitments. Three categories of countries can be identified (see figure 4): (i) countries with health budget allocations below the average rate of 5% (between 2000 and 2016), these are Benin, Cote d’Ivoire, Guinea, Liberia, Nigeria, and Togo; (ii) countries with average expenditure levels between 5% and 10%, these are Burkina Faso, Cabo Verde, The Gambia, Ghana, Mali, Niger, Senegal, and Sierra Leone and (iii) only one country with average public budget allocation during the targeted period above 10% which is Guinea Bissau. Despite an increase in GDP coupled with political declarations on universal healthcare access, the realities in the field are different.
1.3 The Structure of Health Expenditures by Funding Sources

Health funding sources are composed mainly of public and private sector funding, which includes domestic and external resources. Except for Cabo Verde, whose expenditure comes primarily from public funding and, to a lesser extent, the same situation for The Gambia and Guinea Bissau, all other countries’ health systems are predominantly funded through user fees. The most emblematic cases of this are Cote d’Ivoire, Nigeria, and Togo where user fees account for more than 70% of financing for health services. Contrary to popular belief, foreign aid or other funding streams are not the main sources of funding for health systems in West Africa. In a few instances, external health expenditure is significant and higher than domestic general government expenditure. This is the case in Burkina Faso, Guinea and Liberia where it was respectively 31.7%, 37% and 18% of health expenditure between 2000 and 2016 (See Fig.5). This funding model has its limitations for many reasons:

- In this context, private funding comes in the form of user fees. This means that only households that have the resources can afford healthcare services. In the context of mass poverty, which is characteristic of the majority of West African countries, poor and vulnerable citizens are routinely excluded from accessing affordable and quality healthcare services. To realize access to universal health coverage in West Africa, this will require a sustainable increase in public spending on health and the reduced reliance on out-of-pocket financing;

- Limited domestic general government expenditure is typically allocated to operational costs rather than investments. This limits the supply of health services particularly to poor and vulnerable citizens;
- Notwithstanding the limits of external health expenditure, foreign aid is always tied with conditionalities and can distort public health policy to benefit donor interests.

Figure 5

Structure of health expenditure: Sum of 2003 by Country Name and Series Name

Source: World Bank - World Development Indicators

II. Health indicators

2.1 Number of maternal\(^2\), neonatal\(^3\) and infant\(^4\) deaths

Health systems in West Africa are far from homogenous. During the past three decades, there has been little progress in containing the number of deaths in different categories.

- **Category 1**: Only Cabo Verde has made meaningful progress in reducing maternal, neonatal, and infant deaths.
- **Category 2**: Countries that have not made any progress in decreasing maternal, neonatal, and infant deaths over the past three decades are Benin and The Gambia. In Benin, between 1990 and 2017, the number of maternal deaths went from 1300 to 1600, while the number of neonatal deaths went from 10,635 to 13,391, and the number of infant deaths went from 23,945 to 25,561.

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\(^2\) Maternal death refers to the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

\(^3\) Neonatal death refers to number of neonates dying before reaching 28 days of age.

\(^4\) Child mortality refers to number of infants dying before reaching one year of age.
- **Category 3:** Countries like Cote d'Ivoire, Ghana, Mali, Niger, and Togo have failed to make progress in one or two categories. Cote d'Ivoire and Niger have not made any progress in maternal and neonatal deaths. While Ghana, Mali and Togo have regressed in maternal deaths and in neonatal deaths.

- **Category 4:** Countries that have registered high number of deaths, particularly from 1990 to 2005, but started making positive and significant progress between 2006 and 2017.

Source: World Bank - World Development Indicators
2.2 Mortality rate, adult, female & male (per 1000 adults)

Overall, the adult mortality rate remains high in the region. The male mortality rate is higher than the female mortality rate across all the countries. Countries with the highest adult mortality rates are Sierra Leone, Nigeria, Liberia, Cote d'Ivoire, Guinea Bissau, and Burkina Faso. While a country-specific context can explain these facts, common determinants among these countries can be attributed to poor governance and weak accountability systems. (See Fig.8)

Figure 8

![Mortality rate, adult, female and male (per 1000 adults) - Sum of 1990 by Country and Series](image)

Source: World Bank - World Development Indicators

2.3 Mortality rate, infant, neonatal & under 5 (per 1000 live births)

Across the region, the mortality rate under five years of age (per 1,000 live births) is higher than the infant and neonatal mortality rate. Niger registered the highest ratio, followed by Sierra Leone, Liberia, Mali, Guinea, Nigeria, and Burkina Faso.

Almost all countries are making meaningful progress in reducing neonatal mortality, but the ratio remains high. Consistent efforts need to be made to meet the SDG target of 12 per 1,000 live births by 2030. On the other hand, if the current trends are maintained, it will be impossible to meet the SDG target of 25 per 1000 live births by 2030 on the under-5 mortality ratio.
2.4 Maternal mortality ratio\(^5\) (per 100,000 live births)

Over the past three decades, the maternal mortality ratio has remained very high in West Africa. Except for Cabo Verde (see Fig. 10), which is below the SDG 2030 target, other countries are far from the goal and likely will not meet the 2030 goal. Even if the ratio is declining, it remains high. For instance, Sierra Leone has the highest maternal mortality ratio, followed by Liberia and Nigeria. Between 1990 and 2015, the ratio slightly decreased in Sierra Leone from 2630 to 1360, Liberia from 1500 to 725, and in Nigeria from 1350 to 814. However, during a period of over 26 years, from 1990 to 2015, progress remains very low.

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\(^5\) Maternal mortality ratio is the number of women who die from pregnancy-related causes while pregnant or within 42 days of pregnancy termination per 100,000 live births
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Source: World Bank - World Development Indicators

Despite the worrying level of this ratio at the regional level, these statistics are only the tip of the iceberg. There are thousands of women in West Africa who suffer from morbidity and disability-related diseases such as hypertension, diabetes, and fistula following pregnancy. This is the result of weak infrastructures, the lack of human and financial resources, socio-cultural barriers, lack of awareness, stigma and illiteracy.
III. Explanatory factors of poor health indicators performance

3.1 Cause of death, by communicable diseases and maternal, prenatal and nutritional conditions (% of total)

The cause of death refers to the share of all deaths for all ages by underlying causes. Communicable diseases, maternal, prenatal and nutritional conditions include infectious and parasitic diseases, respiratory infections, and dietary deficiencies such as underweight and stunting.

The cause of death related to communicable diseases as per the above definition is high in the region, but we are seeing general decreases. Countries with a high level of deaths related to communicable diseases, with an average rate above 60% are: Burkina Faso, Guinea, Guinea Bissau, Liberia, Mali, Niger, Nigeria and Sierra Leone.

The second category of countries with an average rate between 50% to 60% is: Côte d’Ivoire, Benin, Ghana, Senegal, The Gambia and Togo. The country with the lowest rate of deaths related to communicable diseases is Cabo Verde, with an average rate of 23%.

Figure 11

Source: World Bank - World Development Indicators
3.2 Cause of death, by non-communicable diseases\(^6\) (% of total)

The goal by 2030 is to reduce by one third, premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.

Non-communicable diseases such as cancer, diabetes, mellitus and cardiovascular, are increasingly rising in the region. Almost 70\% of the deaths in Cabo Verde are related to non-communicable diseases, making it the highest rate in the region. In countries like Benin, Burkina Faso, Cote d’Ivoire, Ghana, Guinea, Senegal, Sierra Leone, The Gambia and Togo, almost 30\% - 40\% of deaths are related to non-communicable diseases. There are also countries where the level is low between 20\% to 30\% but an increasing trend.

Figure 12

![Cause of death by non-communicable deseases (% total)](image)

Source: World Bank - World Development Indicators

3.3 Contraceptive\(^7\) prevalence, any methods (% of women ages 15-49) and Fertility\(^8\) rate, total (births per woman) in West Africa

There is ample evidence that birth control and management are critically important in the public health sector. Beyond the demographic aspect of controlling the fertility rate, birth management can significantly improve maternal and infant mortality rates with a more significant economic

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\(^6\) Cause of death refers to the share of all deaths for all ages by underlying causes. Non-communicable diseases include cancer, diabetes mellitus, cardiovascular diseases.

\(^7\) Contraceptive prevalence rate is the percentage of women who are practicing, or whose sexual partners are practicing, any form of contraception. It is usually measured for women ages 15-49 who are married or in union.

\(^8\) Total fertility rate represents the number of children that would be born to a woman if she were to live to the end of her childbearing years and bear children in accordance with age-specific fertility rates of the specified year.
impact of reducing household health expenditure and providing more productive and leisure time for women. Therefore, contraceptive methods can be a powerful determinant factor of health indicators. Despite the limited and scattered data on the issue in the region, it appears that the use of contraceptive methods remains low in West Africa with the diversity of cases.

- **Burkina Faso**: In 1993, the contraceptive prevalence was 24.9%, this level decreased over time, in 1999 it was 11.9%, in 2010 it was 16.2% before increasing steadily and reaching the highest level of 31.6% in 2018. The average fertility rate between 1990 and 2017 was 6.7.

- **Benin**: The contraceptive prevalence was 16.4% in 1996 and declined over time or at best remained constant and reached 15.5% in 2018. The average fertility rate between 1990 and 2017 was 6.2.

- **Cabo Verde**: Has made the most progress with an average rate of contraceptive prevalence of over 60% during the past decade. The average fertility rate between 1990 and 2017 was 3.7.

- **Cote d’Ivoire**: The contraceptive prevalence was 15% in 1999 and reached the level of 23.3% in 2018. The average fertility rate between 1990 and 2017 was 6.1.

- **The Gambia**: Registered a very low level of contraceptive prevalence. It was at 11.8% in 1990 and passed to 9.5% in 2000 and increased slightly in 2010, reaching the level of 13.3% before dropping at the level of 9% in 2013. The average fertility rate between 1990 and 2017 was 6.2.

- **Ghana**: The contraceptive prevalence was 20.3% in 1993, dropped at 15% in 1999 before reaching the highest level of 34.7% in 2011 and 30.8% in 2017. The average fertility rate between 1990 and 2017 was 6.2.

- **Guinea**: Has the lowest contraceptive prevalence ration in the region. The ratio was lower than 1.7% in 1993, 6.2% in 1999, and 5.6% in 2012. The average fertility rate between 1990 and 2017 was 5.

- **Guinea Bissau**: The contraceptive prevalence ratio was 7.6% in 2000, 14.2% in 2010, before reaching the level of 16% in 2014. The average fertility rate between 1990 and 2017 was 6.

- **Liberia**: The contraceptive prevalence ratio was 10% in 2000, and 20.2% in 2013 before reaching the level of 31.2% in 2016. The average fertility rate between 1990 and 2017 was 5.9.

- **Mali**: The contraceptive prevalence was 8.1% in 2001, 9.4% in 2010 and 15.6% in 2015. The average fertility rate between 1990 and 2017 was 7.2.

- **Niger**: The contraceptive prevalence ratio was 4.4% in 1992, 14% in 2000, 18% in 2010 before declining at the level of 16.9% in 2016. The average fertility rate between 1990 and 2017 was 8.1.

- **Nigeria**: The contraceptive prevalence ratio was 6% in 1990, 15.3% in 1999, 14.1% in 2011 before increasing steadily, and reached the level of 27.5% in 2018. The average fertility rate between 1990 and 2017 was 6.4.

- **Senegal**: The contraceptive prevalence ratio was 7.4% in 1993, 10.5% in 1999, 13.1% in 2011, and reached the level of 27.8% in 2017. The average fertility rate between 1990 and 2017 was 5.8.
- **Sierra Leone**: Has a contraceptive prevalence ratio of 2.6% in 1992, 4.3% in 2000, 11% in 2010 before reaching the level 22.5% in 2017. The average fertility rate between 1990 and 2017 was 6.2.
- **Togo**: The contraceptive prevalence level was 25.7% in 2000 but declined to 15.2% in 2010 and slightly increased at 20% in 2014. The average fertility rate between 1990 and 2017 was 5.6.

Overall, the contraceptive prevalence ratio of West African countries is very low except for in Cabo Verde. This has proven to be another key challenge that is being faced by countries in the region, particularly to ensure universal access to sexual and reproductive health-care services, including family planning, information and education.

### 3.4 Prevalence of HIV, total (% of population ages 15-49)

Overall, the prevalence of HIV in West Africa is low compared to other regions on the continent. However, efforts still need to be made to contain and eliminate this pandemic by 2030. In West Africa, Côte d’Ivoire has the highest rate, followed by Liberia, Guinea Bissau, Nigeria, Togo, and Burkina Faso (see Fig.13). While the rate is decreasing throughout each country and in the worst-case stagnant, it is worrying to note that the prevalence of HIV has increased over time in Guinea Bissau, Niger, Senegal, and Cabo Verde have the lowest prevalence rate of HIV in the region below 1%.

**Figure 13**

![Prevalence of HIV, total (% population ages 15 - 49)](chart)

Source: World Bank - World Development Indicators
3.5 Prevalence of undernourishment (% of the population)

Population below minimum level of dietary energy needs (also referred to as prevalence of undernourishment) shows the percentage of the population whose food intake is insufficient to meet dietary energy requirements continuously.

Three categories of countries can be identified in the region.

- Countries with a low level of undernourishment, between 0 to 10%: Ghana, Mali, and Nigeria;
- Countries with a medium level of undernourishment, between 10 to 15%: Benin, Cabo Verde, Niger, and The Gambia;
- Countries with a high level of malnutrition above 15%: Burkina Faso, Cote d'Ivoire, Guinea Bissau, Guinea, Liberia, Senegal, Sierra Leone, and Togo.

It is worth noting that except for Burkina Faso and Senegal, none of the countries in the Sahel region have high levels of undernourishment. However, populations in the Mano River Union countries experience high levels of undernourishment. Based on these figures, there is no direct correlation between the level of malnutrition and mortality rate (maternal, infant, neonatal, and under 5) (See Fig.14).

**Figure 14**

![Graph showing prevalence of undernourishment across various countries](source-url)

Source: World Bank - World Development Indicators
Conclusions

From this analysis, we can conclude that health financing and expenditure has always been a low priority for West African governments, which has undoubtedly led to weak health systems within the region. Citizens lack access to quality, affordable, effective and efficient health care services and the healthcare of citizens is usually traded for donor interests.

Despite increasing wealth creation through GDP, an increase in public budget over time, coupled with political declarations on universal health coverage, there is no government in West Africa which has succeeded in realizing its commitment to increase government spending on health care to 15%.

Health financing sources remaining divided. Except for Cabo Verde, Guinea Bissau and The Gambia, the health systems of other countries, comprised of mostly of out-of-pocket funding and household investments, are predominantly funded by the domestic private sector (user fees).

Maternal, neonatal and infant deaths have remained high and constant over the past three decades, with only Cabo Verde making meaningful progress in reducing deaths in these three categories. Although all countries are making meaningful progress in reducing neonatal and child mortality rates, the ratio remains high. The adult mortality rate remains high within the region, with male mortality rates being higher than female rates. The cause of death related to communicable diseases is high in the region but slowly decreasing all over time. The contraceptive prevalence ratio of West African countries is very low except for Cabo Verde and the region has, overall, a low prevalence of HIV compared to other regions on the continent.

To conclude, it is unlikely that West African countries will meet Sustainable Development Goal 3 by 2030 unless governments commit to building infrastructure, investing in health financing and promote health as a public good and human right.

Policy Recommendations

- Governments need to make further investments in health by increasing their public spending (in respect to commitments made in the Abuja Declaration), tackling corruption loopholes that impede funds from being invested in the healthcare system;
- Articulate national priorities to identify relevant sub-sectors where needs are, through more extensive public consultation including crucial stakeholders and minimize external influence when setting those priorities;
- Regional bodies can ensure better coordination and investments by harmonizing and strengthening the regional healthcare policy and mobilizing adequate resources for financing through regional mechanisms;
• Central and local governments improve citizen participation in decision-making processes and increased demand for accountability through the inclusion of citizens' input into local community development plans which can determine the national health plan and priorities;
• Increase national spending on health through the mobilization of domestic resources and the effective management of tax systems and natural resource revenues;
• Investments in other health components such as contraceptive methods, nutritional conditions, and water, sanitation and hygiene instead of just treatment-based healthcare services;
• Invest in peer-learning avenues and information dissemination campaigns and platforms to ensure that citizens are better informed and can make educated decisions on their healthcare needs;
• Ensure that national priorities come before that of donors;
• Amplify voices and provide alternative avenues to truly realize broad socio-economic rights for every West African;
• Invest in the education of medical personnel, while creating channels for retention of qualified staff.