FACTS Reports

Field Actions Science Reports

Special Issue 4 (2012)
Fighting Poverty, between market and gift

Dominique Kerouedan

Health in Africa: what can France and Europe do about it?

Electronic reference
Dominique Kerouedan, « Health in Africa: what can France and Europe do about it? », *Field Actions Science Reports* [Online], Special Issue 4 | 2012, Online since 10 June 2012, Connection on 10 October 2012. URL : http://factsreports.revues.org/1564

Publisher: Institut Veolia Environnement
http://factsreports.revues.org
http://www.revues.org

Document available online on: http://factsreports.revues.org/1564
This document is a facsimile of the print edition.

http://factsreports.revues.org/1564
Published 31 May 2012

FACTS
Reports

D- Health in Africa: what can France and Europe do about it?

Dominique Kerouedan[1]

Lecturer at Sciences-Po

Abstract. Africa is the continent where the social and health situation is of greatest concern, and where progress on the Millennium Development Goals is the slowest. Access to global assistance for health is complex, as it is channeled through new funding mechanisms: global public-private partnerships or "innovative" financing. The aim of this paper is to demonstrate that the effectiveness of this aid, which is growing in volume, depends on a more equitable distribution between different countries on the same continent, or among patients with different pathologies, on financial resources as well as technical expertise, and on a evidence-based allocation of funding, using objective criteria such as epidemiological data, the efficacy of the chosen treatments, the population profile, the effectiveness and efficiency of selected interventions, etc. It is our opinion that food insecurity, including in urban areas, and unequal access to global health aid–combined with Africa's unprecedented demographic growth and with the global financial and economic crisis effects–threaten the African continent political stability, particularly in the French-speaking Africa. To avoid the situation deteriorating still further, France and Europe, who have a historic responsibility towards this part of the world, must ensure that the human and financial resources allocated to global initiatives–channels these institutions favour to the detriment of bilateral aid–also benefit the most deprived populations living in French-speaking African countries.

France's role in promoting better health in Africa continues the colonial legacy of the French Army Medical Corps and the bilateral system put in place by the Ministry of French Technical Cooperation from the early days of independence up until the end of the 1990s. France built and equipped hospitals and clinics, trained health personnel, helped combat major endemics, sent French doctors and technical assistants in every specialist field, conducted clinical research and social science projects… all of these activities were keenly awaited and much appreciated both by the populations and health authorities throughout that period. By sending out its men and women, with front-line experience in the practice of Tropical Medicine or Health Sector Administration, France cultivated–for four decades–the mutual institutional collaboration so essential in reinforcing the national capacities of the public sector and civil society. Since the early 2000s, the reform of France's international cooperation policy has been accompanied by a sharp decline in bilateral aid, including technical assistance, and the redirection of government funds toward global initiatives with programs that are managed remotely, mostly from Geneva.

Meeting in Okinawa in 2000, the year of the Millennium Declaration, and pursuing the initiative the following year in Genoa, under the helmsmanship of the African United Nations Secretary General, Kofi Annan, G8 Leaders answered the call to address the three pandemics that, alltogether, kill six million people a year: the G8 decided to set up a Global Fund to fight AIDS, Tuberculosis and Malaria. That same year, a United Nations General Assembly Special Session (UNGASS) declared AIDS a global security threat, while the Heads of States of the Organization of the African Union, meeting in Abuja, again in 2001, undertook, by signing the Abuja Declaration, to devote 15% of their national budgets to health.

Ten years later, it is more vital than ever to meet those challenges: the population of the continent is set to double by 2050, and food security issues are not the only ones. Africa represents 25% of the world's disease burden, 3% of its health personnel, and 1% of its economic resources. A number of reports have announced strong growth in Africa by 2015. Maybe so, but Africa remains on the sidelines of globalization; the Millennium Development Goals will not be met here. Who will reap the benefits of this growth? How can one prevent the huge inequalities that accompany growth and instead seize the opportunity to lay down the foundations of social protection? Has Michelle Bachelet's Social Protection Advisory Group addressed some of these issues at the G20 held in November 2011?

Africa's health situation can be summed up as follows: almost 70% of the world's people living with HIV/AIDS, more than 90% of AIDS orphans, and, more importantly in terms

[1] Founder of the Concentration in Global Health at the Paris School of International Affairs (www.psia.sciences-po.fr). Lecturer at Sciences-Po. Editor of *Santé internationale: Les enjeux de santé au Sud*, Les Presses de Sciences Po, January 2011. 592 pp.

of the dynamics and spread of the disease, it is in Africa that 70% of new HIV infections arise. The global incidence of tuberculosis continues to rise–due to the increase in the number of new cases in Africa. It is in Africa, again, that more than 80% of the world's cases of malaria occur, and where malaria kills the largest number of children under five years old and pregnant women. Africa that has 50% of maternal and infantile deaths: mortality in pregnancy or childbirth beats all records, and abortion-related mortality is higher here than anywhere else. It doesn't stop there. Respiratory and cardiovascular diseases, diabetes, and cancer challenge governments and the governed–the vast majority of whom have no health cover–to cut health spending, while rampant urbanization spawns a rise in high-risk behaviors (sedentary lifestyles, smoking, alcoholism, etc.). The shortage of health workers is more acute than elsewhere: according to WHO, of the 4 million extra health workers the world badly needs, at least 1 million are needed in Africa alone.

Unprecedented demographic growth, the world's highest maternal and infantile mortality rates, infectious diseases, chronic illnesses, mental health problems, road accidents, no health insurance or social protection for most people, shortage of health workers, and the effects of the global economic and financial crisis: what response can there be to these complex and intricate issues that have such a devastating impact on the well-being and economic and social development of an entire continent?

The various national, French and European responses–in place or in preparation–are modest: only six of the continent's 53 states have met the Abuja target, ten years on. For several years now, France has been turning away from traditional bilateral aid in favor of funding global public-private partnerships and contributing to the development of innovative financing mechanisms that are managed a long way from the field, which calls for a certain number of precautions, discussed later in this paper. As the European Court of Auditors lamented in 2009, the share of the European Development Fund allotted to the health sector declined between 2000 and 2010. About 3% of the 10th EDF goes to the health sector of Africa, the Caribbean and the Pacific States under the Cotonou Agreement, the very countries (in the case of Africa) that are showing the slowest progress on the health-related MDGs. The European Commission was not able to show that general budget support–for ten years, the preferred instrument of development funding–helps to improve health sector performance in the ACP countries, or in fact does anything to reinforce their health systems, even when the disbursement mechanisms offer strong incentives. It is the United Kingdom which, through funding, operations, and balanced bilateral and multilateral expertise, demonstrates a clear political will to support health development… in English-speaking Africa.

At the global scale, it is true that the volume of health aid has risen in absolute terms in recent years, due to the spectacular contribution of the United States, via the Bill and Melinda Gates Foundation and PEPFAR (the President's Emergency Plan for AIDS Relief), which aim to finance, respectively, vaccines and AIDS treatment programs (with a limited amount for prevention the 5-y PEPFAR evaluation says). Ten years after it was created, the Global Fund has committed nearly 22 billion dollars in spending, in the form of 600 subsidies in 150 different countries. If aid from the European Commission is added to aid from EU Member States, the European Union is the largest donor to the Global Fund. And by injecting 360 million euros a year, France is one of the Fund's leading backers. At the G8 Summit in Muskoka in 2010, where UN Secretary General Ban Ki Moon launched the Global Strategy on Women's and Children's Health, France announced a contribution of 500 million euros over the next five years.

To meet the challenges described above, and the growing needs of tomorrow's world, in a context of global financial crisis, where aid will be cut back–"less money, more needs"–it is more vital than ever to guarantee the effectiveness and impact of aid funding.

Looking beyond initial appearances, a certain number of issues have to be addressed:

1 Health is not a priority for development policies

Don't be fooled. Health is not a priority, either for African governments or for the international development organizations. Some forty of the continent's governments spend less than 40 dollars per capita on health, whereas Jeffrey Sachs, chairman of the WHO Commission on Macroeconomics and Health, proposed a threshold of 40 to 50 dollars' health spending per capita, to ensure minimum healthcare provision; and that was back in 2001. Turning to the international community, the treatment of AIDS sufferers has captured the attention of donors, as have vaccination programs for children, although–do we need reminding?–not all eligible patients and children benefit from these programs. Meanwhile, the health systems, including the procurement and distribution of drugs, the training and career management of health workers, the quality of health data and information management, etc. have not enjoyed the same attention, thus generating an imbalance between diseases and systems, and above all, although less is said about it, an imbalance between patients that is extremely worrying from an ethical point of view: nowadays, it is better to have AIDS or tuberculosis than meningitis or typhoid fever. And don't even mention cancer.

More generally, apart from the risk of epidemics, seen as a genuine threat, health is of no real interest to the politicians: when invited to a "sector focus meeting" to plan cooperation agreements with their African partners, the ambassadors of France and the European Union do not, most of the time, choose to discuss the health sector. Seen as opaque, health is a difficult area to achieve demonstrable results, doctors are not the easiest of people to work with, resources are slow to trickle down, managerial capacities are weak, and so on. Nor is there much insistence on the part of local finance ministers.

Political will is measured not only in financial terms, but by the yardstick of expertise trained and mobilized. Money, without expertise, offers no potential for effective action. Particularly so in health, where the outcomes and the quality of health care go hand in hand. And yet in the 2000s, the French government and the European Commission decided to stop recruiting technical expertise directly for the development sector,

and to substantially cut back on the budgets allocated to expertise in general. In the agencies that represent their respective institutions on the ground–interacting with each country's health authorities at national, regional or more local level, or with the decision-makers of the main international organizations–French health and development expertise is almost entirely absent. It has become scarce, rendered almost obsolete by the major changes in the architecture of international aid over the last ten years. Where is French and European expertise trained? Who is preparing young people to contribute to the health development of the South in the near and long-term future? From the French point of view, it seems, "international" stops at the equator. Are the French and other Europeans giving development issues the attention they deserve? In the land of Descartes, Montesquieu and Montaigne, what are we doing to reflect on the major global challenges of the day and of the future, along the lines of the "think tanks" found in English-speaking countries?

Public interest can be cultivated, and political will can be built up over time, through parental education, through classroom teaching or talks from the earliest years at school, as well as through awareness training for future policy-makers (universities, the grandes écoles, ENA) in France and elsewhere. This is part of a broader project for society, preparing for greater openness to the world. Getting away from the ghost of the colonial past, distinguishing the goals, rationale and theoretical backgrounds of development and migration policies, reducing distance and disconnection, encouraging a closer encounter between our peoples, fostering mutual exchange about our realities and experiences, putting young people to work and funding solidarity travel, in both directions, and giving a voice to civil society in Africa… these offer a more effective way to build societies that can learn how to understand, support and integrate with each other. Are we doing anything like it? Are our representatives in elected for a addressing these issues, these society fundamentals? Political will is sustained by the aspirations of the people. The young are ready: but there are no mechanisms to channel their curiosity, energy and skills towards a partnership with their peers in Africa. It is easier to lift customs barriers on goods than it is to remove the many obstacles to the circulation of people between our countries, whether from South to North (visas) or from North to South (no institutional arrangement or funding). The result is a lack of trust and of ground-level understanding that can only stifle the inspiration behind development policies, in France and at the European Commission, which is currently preparing its development policy for 2014-2020.

2 Just how relevant is innovative financing?

Since the Millennium Declaration, in response to the pressure to fulfill the MDGs, and to the inability of OECD countries to meet their ODA commitments, innovative mechanisms have been devised to fund development. Their effectiveness has been compromised, not so much by the misappropriation of funds, which has been relatively limited, as by a lack of strategic vision, nationally or internationally, on how best to use the funds–the question faced by the political and administrative authorities on the ground. It is easier to comment on sporadic acts of corruption than to examine how efficiently and how appropriately the resources as a whole are used. The risk of misappropriation is inherent to the field of development for a whole series of reasons, Paul Collier tells us, notably because–I would add–cooperation inevitably implies mutual trust. And we build trust knowing eachother face to face. This is not to say that corruption should be tolerated; simply that there is no such thing as zero risk in this area. Above all, this debate must not get in the way of far more important topics around effectiveness and expected long-term impact. To cite just one example, do we not have at least as pressing a moral duty to examine the strategic effectiveness and impact of the 22 billions dollars mobilized by the Global Fund, as to denounce the misdirected use of a few million dollars in a handful of countries? When we place the Global Fund under such pressure, it is the recipient countries that feel the heat. In so doing, we perpetuate the financial and managerial vision of development, while continuing to overlook the need for a strategic analysis, based on research and on local dynamics, that would enable us to select effective interventions and attain the goal of "zero HIV infection", "zero tuberculosis", and "zero malaria deaths". According to UNAIDS, for every 2 people we put on antiretrovirals, 5 new HIV infections occur: thirty years after the start of the AIDS pandemic, we are still struggling to cope. Let us face the facts and agree to rethink our approach, so that we can move forward.

Apart from purchases (of drugs, vaccines, infrastructure, equipment and expertise) what can we do to ensure the efficacy of funded health interventions? AIDS prevention is a case in point, as is any intervention that seeks to improve health by changing behaviors. The complexity of the question is universal. In a landscape increasingly dominated by chronic diseases, the question of changing behaviors and everything that shapes those behaviors is crucial. But this is probably one of the most thankless tasks in public health, and one of the least well documented: what have we learnt from thirty years of failure in preventing the sexual transmission of AIDS in Africa? What have we retained from all those years of education in women and children's health, if not that the most powerful determinant of children's health is their mother's level of education and empowerment? What have we learnt from the anti-smoking campaigns in Europe? What are we doing about young people's widespread acceptance and practice of behaviors that lead them straight into alcohol addiction? What works in these areas? How are the thousands of experiments in Latin America transposed to Asia and Africa? And above all, how is all this transmitted, synthesized, and utilized by policy-makers?

The practice of evaluation has greatly evolved over the last ten years. In itself, evaluation has two sort of missions: accounting for the use of (usually public) funds, and drawing lessons from experience. There have been many studies and evaluations of French and European health aid policies and operations. And how, exactly, are they used by policy-makers, or by administrators, or even by health professionals? In France it is almost as if the government commissions studies or reports as a way of sweeping issues under the carpet. And the turnover of politicians doesn't help: new leaders are not

interested in the issues their predecessors dealth with, although they still face the same ones.

The failure to capitalize on knowledge and past achievements, and to properly value experience, contributes to a loss of institutional and professional memory: young people are taking up, not where we left off, but back where we started. Here, no doubt–alongside the lack of political will and the scarcity of expertise–lies one of the keys to understanding the ineffectiveness, if not the widely-decried failure, of development policies. We must give up on the current "poverty reduction" development paradigm, move on from a financial approach to development towards an effective and actionable strategic approach, the most logical course of action in a context of crisis where different candidates for aid are competing for global funding. In evaluating these innovative mechanisms, we must not mix up performance with effectiveness: operators can perform very well while implementing ineffective strategies, in the sense that despite all that is done and produced, they will have very little impact on morbidity and mortality rates and on the well-being of local populations.

3 Giving Africa equal access to funding for global health initiatives

Not only have the promises made by the G8 at Gleneagles in 2005 to double aid to Africa not been kept, ODA has since increased across the board–except for Africa. In the field of health, what has happened to all the money mobilized from around the world, with the amount of aid being multiplied by 4 between 1990 and 2007? A study by the Seattle-based Institute for Health Metrics and Evaluation[2] confirms the observations above by demonstrating, unsurprisingly, that the allocation of development assistance for health is a long way from following objective criteria such as epidemiological data, population data, burden of disease, or the cost-effectiveness of the funded interventions. It is clear that the aid priorities of rich countries are based more on political, geopolitical, economic or security criteria, and sometimes not even on these. It seems fair, then, to deduce that it is, by nature, inequitable. Is that acceptable? Is it efficient from the viewpoint of preventing and managing health risks on a global scale? Can we afford, in Africa, the luxury of development assistance that has no real foundation?

Looking at existing analyses of how official development assistance is allocated, it would appear that, over the last ten years, the health sectors of the countries of French-speaking Africa–and particularly the poorest, in the Sahel region–have not benefited equally and equitably from aid from the European Development Fund or the Global Fund, both of which receive a substantial inflow of French taxpayers' money, and both of which are supposed, officially, according to their policies, to help the poorest. This hypothesis merits closer scrutiny, if health outcomes depend in part on the efficiency and volume of funding allocated, as observed in several countries of Eastern and Southern Africa, where the United Kingdom, the United States, and American Philanthropic Foundations combine their massive health aid monies, while at the same time putting numerous experts on the ground, building capacity with the result that health indicators are improving.

It would be useful to conduct a study specifically on the Sahel countries, where bilateral aid from France, Germany and the EU has been gradually pulled back over the last ten years, without governments or alternative financing solutions stepping in to shore up the health systems. The issue is all the more critical in that this inequality is likely to be made even worse by insecurity.

No less worryingly, there is an inequality of access to knowledge, for two reasons: firstly, the exchange of knowledge is facilitated at the global scale (between Brussels, Geneva and Washington, for example). It is much harder to find funding for North-South or South-South training courses, conferences or scientific conventions. What is the point of discussing the problems facing the actors of the South, between ourselves at the global level, in absentia, as it were–something that occurs increasingly frequently between parties that know neither the sector nor the geographical area under discussion? Secondly, the vast majority of the knowledge, information, guidelines, online debates, e-learning courses, evaluation reports, etc. is available exclusively in English. Those of us who speak English, along with some in the capital cities of West and Central Africa, have gained much from reading these sources, and from the two-way exchange between the scientific community and the ground-level actors; so why do we withhold this knowledge from a large part of humanity, already the poorest and most deprived, when it might help them to gain some control over their own destiny?

We should ask ourselves this important question: to what extent might the international community's apparent "disinterest" in the health sector of West Africa be a contributing factor, alongside food insecurity, in the region's growing political instability? It is at least plausible, after all–even if it remains to be objectified and measured–that its economic development has been impacted by a social and health situation that is both disastrous and unfair.

Effective health aid needs to be strategic, technical, qualitative and financial. All of the above–and equitable, too. We believe that the French authorities have a responsibility to ensure that the funding mechanisms that they choose henceforth to prioritize genuinely help to roll back pandemics and to reinforce health systems, disseminate knowledge, train national and international experts, develop national capabilities and expertise, and ultimately contribute to improving medical and health coverage, health indicators, and the health status and well-being of the population. All of these things are factors in conflict prevention and stability.

In the words of WHO Director General Margaret Chan: *"I doubt whether public opinion will ever have the power to change the way the world works. But I maintain that we cannot have a dynamic economy and a stable society without equitable access to health care and greater equity in terms of health outcomes. In fact, I would go further: these outcomes should be regarded as a key measure of how we, as a civilized society, are making progress. Today, millions of people continue to die because they cannot obtain the medicines,*

[2] C. Murray *et al.* Development assistance for health : trends and prospects. 2011. http://www.healthmetricsandevaluation.org/

vaccines and other public health resources that they need. The reasons for this failure are not medical: the real causes are economic, social and political"[3].

The topic is surely worth a little of our attention. As Paul Collier reminds us, development aid cannot act in isolation. Trade and governance are just as essential. Africa is not like other continents of the South. What is happening in West Africa, in medical, social and demographic terms, challenges the values of France, Europe and the entire world. Peace hangs in the balance.

[3] Margaret Chan. *La santé publique dans un monde interdépendant. Santé: le grand défi*. Revue Politique International. Dossier spécial hiver, 2010-2011. http://www.politiqueinternationale.com/revue/article.php?id_revue=130&id=967&content=synopsis