



Right to Health and Its Financing in Africa: End
Epidemics and Strengthen Systems that
Uphold the Right to Health for All

Draft Study

Executive Summary

The African Union and its Member States subscribe to a robust normative legal framework on the right to health. At its core is the African Charter on Human and People's Rights, which holds that "Every individual shall have the right to enjoy the best attainable state of physical and mental health" and that States parties to the Charter "shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick." This right is buttressed by a set of individual and people's rights, and duties. It is also complemented by other regional instruments, including the African Charter on the Rights and Welfare of the Child, the Maputo Protocol on the Rights of Women in Africa, and the Protocol on the Rights of Older Persons in Africa.

Realizing the right to health depends on both the amount of health-care financing, its distribution between the public and private sectors, and the ways in which health care is financed. The interplay between health financing and the right to health in Africa has been relatively under-explored — even though that understanding is vital for identifying opportunities to enhance health financing and overcome at least some of the obstacles that stand in the way of realizing the right to health.

Over the past decade, Africa has made impressive progress towards Universal Health Coverage (UHC), gains that have been driven especially by significant financing for HIV and other epidemics, vaccines and childhood infectious diseases. Strong investments in HIV, TB malaria and maternal and child health, resulted in a gain of nine years of average life expectancy across sub-Saharan Africa in the period 2013-2016, with gains strongest where HIV has been most prevalent. Rights-based approaches that have emphasized the universal right to health and community-based responses have helped to drive the achievement of these gains.

The COVID-19 pandemic and its economic upheaval threaten to undo those achievements. The pandemic's impact in Africa has been especially severe for vulnerable populations. Africa is home to a disproportionate share of the more than half-billion people who have been pushed deeper into poverty by out-of-pocket health costs in the pandemic.

Two of the five countries globally with rates of catastrophic health spending and impoverishing health spending above corresponding global medians are in fragile and conflict-affected situations (South Sudan estimates for 2017 and Nigeria estimates for 2018). Many countries in Africa will face the multiple challenges of on-going HIV, TB, and Malaria epidemics, inequitable health care systems, poverty, and the impact of climate change through hurricanes or natural disasters.

Approx. 325 million people in AU (or 27% of the AU population) were further pushed into poverty due to out-of-pocket expenditure on health (population increase in poverty). Given the combined health and economic shock of COVID-19, this number will likely only grow. Those who are poor and more vulnerable will be deprived of their right to access services, or they will choose spending for essential goods or paying for health. Medicines and outpatient care were identified as the main determinants of household OOP health spending in 25 countries in Africa with a similar structure of OOP health spending for people with and without catastrophic health spending.

A marked lack of global solidarity has left the continent deprived of equitable access to protective equipment, vaccines and treatment—which, together, with shutdowns and other social restrictions disrupted disease programmes (notably for HIV, TB and malaria) and knock prevention efforts further off-track. Bringing the COVID-19 pandemic to an end, recovering from these setbacks and enabling a

sustained post-pandemic recovery will require close attention to health financing. It also requires strategies for avoiding fiscal austerity and widening fiscal space on the continent.

Annual spending on health averages at nearly 10% of GDP globally, but it is much lower in Africa: about 5.3% of GDP. Consequently, Africa accounts for only about 2% of global health spending, even though it has 16% of the world's population and 26% of the global disease burden. More than two decades ago, African governments pledged (in the 2001 Abuja Commitment) to allocate 15% of their national budgets to health; today, the average is still only 7%.

Africa is experiencing a more severe pandemic-induced economic contraction than other regions, with debt-to-GDP ratios increasing by 8 percentage points to 70% in 2020, and a corresponding drop in general government revenue. Countries with some of the worst economic growth prospects, where per capita GDP is predicted not to return to pre-COVID levels until at least 2026, are also home to half the total number of people living with HIV and TB in the African Union.

One third of health care services in Africa is financed from out-of-pocket expenditure, a relatively high proportion by global standards. Out-of-pocket expenditure is regressive – poorer households spend larger share of their income on health care than richer households – and it tends to further impoverish low-income households. It causes people to avoid or delay using health-care services. It also tends to be an inefficient forms of health care financing. There is abundant evidence that user fees worsen outcomes for HIV as well as for maternal and child health.

Social health insurance (that is tied to employment) is an important source of health financing globally, but it is problematic in the African context where more than 80% of the workforce is in the informal sector and is seldom included in workplace-based health insurance.

Public-private partnerships can fail to result in benefits for the broad public, especially when regulation is weak and policy dialogue with the public sector is absent. Greater success has been achieved by drawing on private-sector based innovations in service delivery. Indeed, the COVID-19 pandemic exposed many of the weaknesses of mixed public-private models in health care provision in Africa, with price-gouging, failure to admit patients, and system failures eventually requiring public sector intervention.

The failure to invest sufficiently in public health has is evident in health staff shortages, gaps in primary health care provision (especially in rural areas) and inequitable access to services. At the same time, community-based responses to the HIV epidemic and other diseases have strengthened health system resilience and have contributed cadres of community health workers who have been crucial for maintaining health services during to the COVID-19 pandemic.

The COVID-19 pandemic has imposed huge burdens on health systems, incurred additional costs and restricted economic growth. But it also has created the opportunity to fundamentally reassess health financing in Africa and find new ways to advance towards the full realization of the right to health.

Options include drawing on additional liquidity from international financial institutions, ensuring that health financing mixes advance equity (e.g. by accelerating the abolition of user fees), and debt relief and forgiveness.

A number of measures are available to broaden the revenue base in African Union countries in ways that can increase health financing. They include combating tax evasion, improving the terms and conditions on which countries obtain financing, and implementing debt relief and cancellation

policies. Arguably the most important policy challenge confronting the continent in the pandemic-recovery period will be to avoid the austerity trap that bedevilled previous crisis responses and inflicted great social harm. Civil society and other partners, especially those from community organizations and at local level, must be engaged in financing dialogues to support the right to health. They should also be mobilizing broad popular support for national policy-making that advances the right to health in tangible and fair ways.

The health financing choices of today will have direct consequences for the health and lives of tens of millions of people across the continent. They will also decide the progress African countries make against the ongoing HIV and TB epidemics and other life-robbing health threats.

In mid-2021, the United Nations General Assembly agreed on a new five-year global AIDS strategy with a set of ambitious but vital targets for 2025. Modelling indicates that, if those AIDS targets are met, about 185 000 will acquire HIV in African Union countries in 2030. But if programmes continue at their current levels of intensity and effectiveness and the targets are missed, that number will rise to over 600 000. The impact of a business-as-usual approach will be especially harsh on adolescent girls and young women. They are projected to represent 27% of the total of new infections in 2030, amounting to about 280 000 new infections, if the current state of affairs is maintained. But if the global targets are met, that number will be brought down to 90 000. To meet the global AIDS Strategy, it is estimated that approximately US\$ 10.9 billion is needed in 2022, with that amount rising to about US\$ 12.4 billion in 2025.

The fiscal space for overcoming the deficits in health financing are cramped in countries of the African Union. But the COVID-19 crisis has also brought opportunities for change. These opportunities must be seized, including through broad-based financing dialogues and problem-solving that services the people of Africa. This Study is intended as a support to these efforts.

Section 1. Introduction

1.1 PURPOSE AND STRUCTURE OF THE STUDY

Health is fundamental right. When health financing is grounded in the right to health, enables equal access to all, avoids user fees in public health services and reduces OOPs , it contributes to greater equity in health.

All states have obligations to respect, protect, promote and fulfil people's right to health. The African Charter on Human and Peoples' Rights specifically guarantees the right to enjoy the highest attainable state of physical and mental health (or 'the right to health').

This synthesis Study by UNAIDS and the African Commission on Human and Peoples’ Rights (ACPHR) examines the financing arrangements that are needed to realize the right to health. The aim is to enrich the Commission’s guidance and recommendations so that domestic and other resources for health can be increased and better allocated. The COVID-19 pandemic and earlier health crises such as Ebola and HIV have highlighted opportunities for securing the right to health for all in Africa. In particular, more than four decades of responding to the HIV epidemic has shown that safeguarding people's rights and achieving sufficient and sustainable health financing go hand-in-hand. Realizing the right to health in requires approaches that are inclusive and that tackle inequalities head-on.

Realizing the right to health requires tackling the underlying social determinants of health, as the African Commission has stated repeatedly. Those factors include harmful gender norms and gender inequalities, as well as other inequalities such as economic status, education etc. that lead to poorer health outcomes. Financing for Right to Health requires a whole-government approach and the contribution of several sectors, including health, social support, education, finance and others that will enable a high impact response for all components of the right to health (Fig 1).

This Study will focus on leveraging health financing for addressing HIV and other epidemics in the African Union.

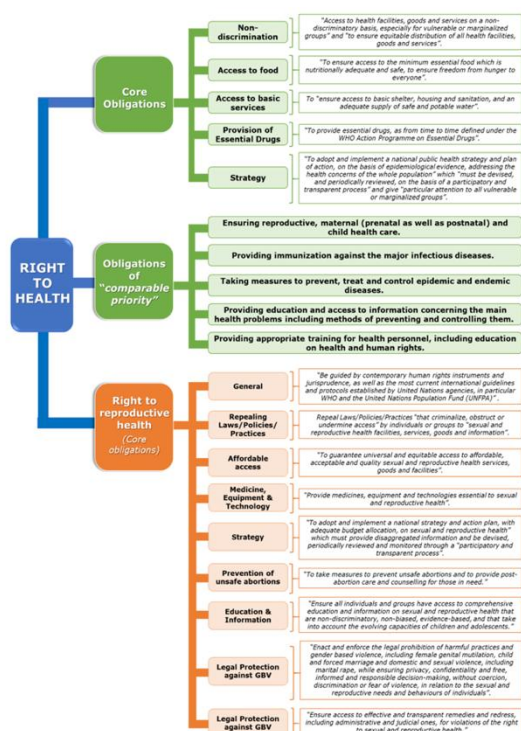
The Study provides a synthesis of the evidence concerning financing policies, spending and the ways in which increased domestic spending will better enable States to fulfil their core obligations in relation to the right to health. It identifies progressive financing policies that are directed at the

interdependent goals of health, rights and sustainability.

There are at least three overriding reasons for increasing domestic spending and budget allocations to health care: to strengthen the people-centred health systems that can uphold the right to health for all; to end the long-running HIV, TB and other epidemics that assail the people of Africa; and to build resilience to meet health needs in the future.

Certain policy and financing decisions, including the elimination of user fees for public services, can accelerate the realization of the right to health, increase financial protection and address inequalities. Spending shifts to increase efficiency and equity can enable health-care systems to be reimagined as people- and community-centred delivery systems that serve everyone's needs fairly. The right to health also provides a framework under which

partnerships can be expanded. Different stakeholders — including neglected and vulnerable communities — should have a say in planning financing strategies and mixes, and they have important roles in strengthening accountability and transparency.



Source: International Commission of Jurists. Living Like People Who Die Slowly: The Need for Right to Health Compliant COVID-19 Responses.2020

The synthesis of evidence presented in this Study is intended to support better networking and communication across various policy and implementation communities. Policy-makers in finance ministries, programme managers in line ministries, the people delivering services in public and community sectors, and advocates at all levels often seem to frame and approach common challenges and objectives in incompatible ways. They tend to operate in isolation from one another and struggle to recognize how their goals and activities can be harmonized to mutual benefit. This Study is intended to help erect a bridge between the apparently distinct concerns of health provision, financing, and the right to health.

The core unifying message is that when health financing is grounded in the principles of the right to health, countries will proceed more rapidly along the path towards health equity.

The Study has been informed by a comprehensive desk review of documents concerning the HIV epidemic, health financing and the right to health. The literature review identified key documents concerning national experiences as well as those produced by global-level partners (WHO, the World Bank, African Union, UNAIDS, UNECA, and others). Based on a keyword search, over 400 articles were selected for secondary data analysis. Primary research was not conducted for the study.

For some priority issues, there exists extensive literature which merits consideration in its own right, but is beyond the scope of this Study. Those issues include the prevalence and impact of corruption, misuse of resources, and the misallocation of financial resources; litigation around the right to health; the enabling legal environment; and the elimination of discriminatory laws and practices that restrict the ability of individuals and groups to receive health care.

This first section of the Study sketches the current opportunities to link the right to health and health financing. Section 2 examines the financing policies of States and their practices regarding HIV, health financing and the impact on countries' abilities to fulfil their core obligations around the right to health. Section 3 maps risks and strategic opportunities and identifies high-impact actions to promote the right to health to catalyse transformative financing policy shifts and increased allocations.

1.2 A ROBUST NORMATIVE FRAMEWORK FOR THE RIGHT TO HEALTH

The normative framework for the right to health on the African continent is anchored in the African Charter on Human and Peoples' Rights, and is consistent with the right to health as set out in the International Covenant on Economic, Social and Cultural Rights. Complementary treaties and commitments agreed to by African States address the rights of children, women, and older persons, and health issues including HIV, sexual and reproductive health, and access to medicines.

The normative framework for the right to health on the African continent is anchored in the African Charter on Human and Peoples' Rights, which was adopted in 1981 and entered into force in 1986 (see Box 1). This charter complements international legal instruments, including the International Covenant on Economic, Social and Cultural Rights. Article 12 of the latter document establishes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. The charter also complements regional and international treaties that concern a range of rights relevant to health and with respect to particular populations, including women, children and older persons.

Key treaties that complement the African Charter on Human and Peoples' Rights include the African Charter on the Rights and Welfare of the Child, adopted in 1990. It recognizes that children require particular care with regard to their health and physical, mental, moral and social development. It established state obligations to reduce infant mortality, provide health care to all children, ensure the provision of adequate nutrition and safe drinking water, combat disease and malnutrition within the framework of primary health care and ensure the meaningful participation of nongovernmental organizations, local communities and the beneficiary population in the planning and management of basic service programmes for children. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), adopted in 2003, requires state parties to ensure that women's right to health, including sexual and reproductive health, is respected and promoted. The Protocol on the Rights of Older Persons in Africa commits State Parties to guarantee the rights of older persons to access health services that meet their specific needs. Most African states are also party to numerous international treaties that guarantee the right to health as well as other rights that are critical to the enjoyment of the right to health.ⁱ

In addition to these treaty obligations, key regional commitments to realize the right to health have been included in the Pretoria Declaration on Economic, Social and Cultural Rights in Africa in 2004, ACHPR Resolution 141 on access to health and needed medicines in Africa, and the 2001 Abuja Declaration on HIV/AIDS.

In combination with strong human rights norms that have been developed at the national level, these regional and international treaties and commitments provide a robust normative framework for realizing the right to health and for advancing the African Union's 2063 development agenda. **The prospects for realizing the right to health are closely tied to the financing policies and spending patterns that support health care and pandemic responses, including the HIV and TB responses. Financing policies and the ways in which funding is sourced and allocated can either enable or**

constrain the realization of the right to health. The better we understand this interplay, the easier it becomes to identify barriers that stand in the way of improved and more equitable health systems and outcomes.

Section 2. Challenges in the current financing landscape and implications for fulfilling the Right to Health

Compared with the rest of the world, Africa's health spending is low. Improvements in service coverage over the past decade have occurred off a very low base. The continent still lags behind other regions against key indicators, including access to health services, the size of the health workforce, and the burden on the population of out-of-pocket expenditure. These weaknesses are rooted largely in financial decisions and factors, including the failure to ensure financial protection and limited capacity to raise additional resources, all compromise the ability of African states to meet their obligations on the right to health.

2.1 HEALTH SPENDING ON THE AFRICAN CONTINENT

Health spending in Africa amounts to less than 6% of GDP on average, which is not sufficient resources to fund the infrastructure, human resources and medicines a well-functioning public health system requires. Health financing needs to be adequate and sustainable, it should support pooling to spread the financial risks of ill-health, and it should ensure that spending is efficient and equitable. Commitments by all the countries of the African Union to Universal Health Coverage have been undermined by the lack of sustained resource allocation. Health spending is unbalanced: there are shortfalls in spending on health workforces and infrastructure, while a great deal of spending goes towards imported medicines, supplies and equipment.

There is no universal formula to define the optimal level of health spending for securing the right to health. But it is clear across the African continent that the public health has not been a political priority and has not been sufficiently financed. Per capita health spending in high-income countries is 80 times larger than in low-income ones. Spending by African Union countries falls well short of the US\$ 86 per capita per year estimated as a minimum for achieving Universal Health Coverage.ⁱⁱ

For the past two decades, total spending (from all sources) on health care in Africa has ranged from 5% to 6% of GDP.] Africa accounts for less than 2% of total global spending on health, even though it has 16% of the global population and 26% of the global disease burden. The funding gap is reflected in inadequate infrastructure, limited human resources, poor equipment and facility maintenance, and gaps in access to medicines — all of which are critical requirements to realize the right to health.

The African Union in its Abuja Declaration of 2001 recommended that governments allocate 15% of their budgets to the health sector. Few countries at any income level (and in any region) have reached

and sustained that level of health spending.ⁱⁱⁱ Almost no African country has reached the target set in the Abuja Commitment: data for 2019 indicate that only Botswana and South Africa were the only African countries with health spending that level. Eighteen of 23 of the lower-middle-income countries in the African union invest less than 9% of their government budgets on health. [But commitment to health is not merely a function of income level. Among the countries that spend least of their budgets on health are both some lower-middle-income countries (e.g. Benin, Cameroon) and some upper-middle-income countries (Equatorial Guinea and Gabon).

*Limited UHC coverage and impoverishment is partially due to **lack of sustained resource allocation to health care and hesitant implementation of health financing reforms.***

Universal Health Coverage (UHC) represents the aspiration that everyone receives good-quality health services, when and where needed, without incurring financial hardship. The indicators that were crafted to monitor UHC provide a helpful snapshot of the state of health expenditure and a yardstick for measuring progress towards putting in place key elements of the right to health.

UHC is perhaps best understood as a guide for setting clear health care priorities that advance the principle of fairness.^{iv} The two pillars of UHC — that individuals and communities have access to essential health services without experiencing financial hardship — require comprehensive health financing policies ranging from budget allocation to taxation and social protection. According to the World Bank, UHC requires as a combination of adequate and sustainable financing, pooling to spread the financial risk of ill-health, and efficient and equitable spending.^v The rewards are formidable: in addition to supporting good health and well-being, UHC also contributes to social inclusion and resilience, gender equality, poverty eradication, human dignity, and economic growth.

The African Region is the only region that experienced a sharp improvement in health service coverage in the past decade. Globally, service coverage increased by 25% between 1990 and 2019. In sub-Saharan Africa, progress accelerated faster than in other regions in the period 2010 to 2018, with the annual increase in coverage running at 2.6%, double the rate in the previous decade. Driving those improvements were significant increases in the funding for —and prioritization of — HIV programmes, vaccination campaigns, and childhood infectious disease and maternal health programmes during the era of the Millennium Development Goals (MDG).^{vi}

The African Union has recognized that sustainable and equitable financing is crucial for reaching the goals of UHC and that it entails both increased mobilization of domestic resources for health together with progressive taxation measures.^{vii} Most African countries have integrated UHC into their national health strategies and are committed to broaden fiscal space and prioritize health in public spending.

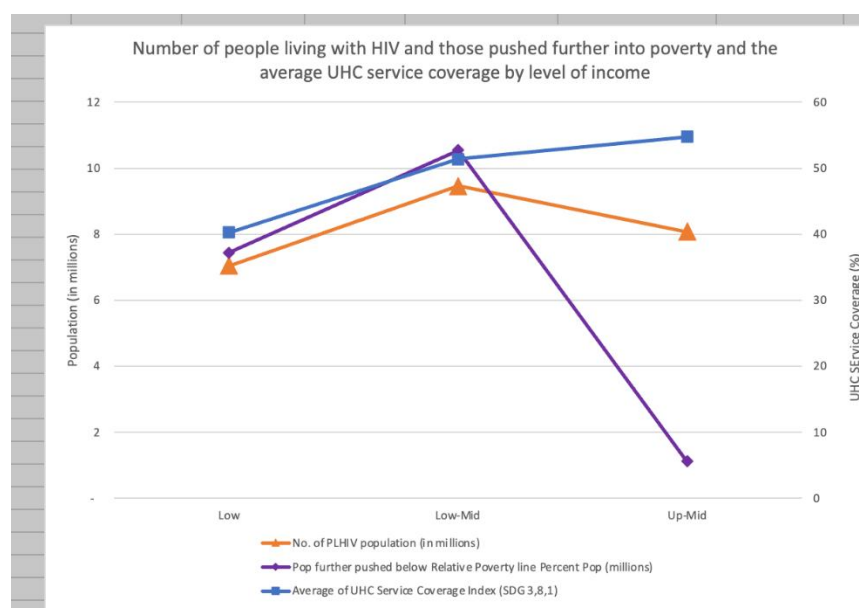
Many have adopted multisectoral approaches to finance health services, including HIV-related services. They have also stated their commitment to increase public financing by pooling resources, remove user fees and reduce out-of-pocket expenditures. However, **these commitments have been undermined by the lack of sustained resource allocation to health care and hesitant implementation of health financing reforms.**

Alongside the scale of investment needed for equitable health care are other important factors, including appropriate enabling policies, better targeting of resources to address needs, and health-system efficiency. This is one of the reasons why countries with similar levels of health expenditure achieve different levels of service coverage and results.

The progress made in the past decade in increasing health service coverage in Africa is both insufficient and fragile. Even before the COVID-19 pandemic, it was projected that gains in UHC globally would reach an additional 270 million people by 2023, well short of WHO’s target of an additional 1 billion people.^{viii} While the impact of COVID-19 is yet to be fully assessed, there is strong evidence that the pandemic has set back progress towards UHC to a significant degree, with major disruptions in services in 2020 which persisted into 2021. The global disparities in COVID-19 vaccine access will compound the shortfalls in people benefitting from UHC, as unvaccinated populations remain excessively susceptible to illness and health services continue to come under pressure.

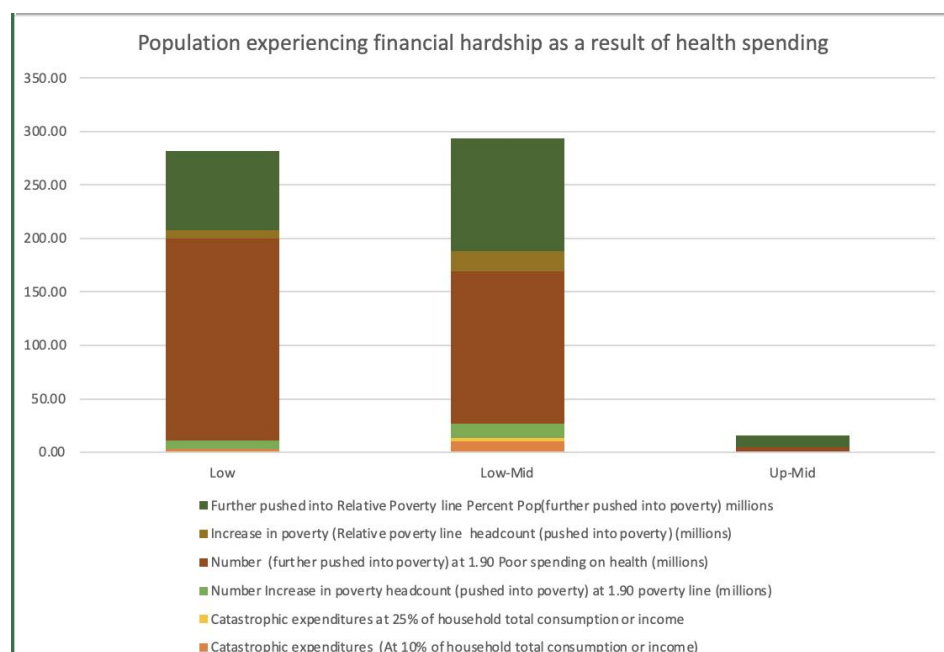
Financial protection

Despite higher levels of public spending, reductions in impoverishing health spending did not occur in high-income countries and overall, globally in 2017, half a billion people were pushed or further pushed into extreme poverty. Approx. 325 million people in AU (or 27% of the AU population) were further pushed into poverty due to out-of-pocket expenditure on health (population increase in poverty). Given the combined health and economic shock of COVID-19, this number will likely only grow. Those who are poor and more vulnerable will be deprived of their right to access services, or they will choose spending for essential goods or paying for health.



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Two of the five countries globally with rates of catastrophic health spending and impoverishing health spending above corresponding global medians are in fragile and conflict-affected situations (South Sudan estimates for 2017 and Nigeria estimates for 2018). Many countries in Africa will face the multiple challenges of inequitable health care systems, poverty, and the impact of climate change through hurricanes or natural disasters.



Access to health professionals and to medicines

A skilled, motivated and adequately supported health workforce is critical for fulfilling the right to accessible and quality health-care services. Safe workplace for health-care providers require, at a minimum, having sufficient numbers of skilled health workers. Many countries face significant deficiencies in both the quantity and quality of their health workforces.

Thirteen of the 47 African countries for which data are available had fewer than 5 per health professionals (including doctors, nurses and midwives) per 10 000 population; the global benchmark was 23 health professionals per 10 000 population.^{ix} **The chronic lack of investment in health drives a negative spiral, where insufficient numbers of skilled health workers cause system gaps and care failures which then require greater proportions of expenditure to be directed towards consumables (medical products), at the expense of investing in the health workforce and infrastructure.**

There are a number of structural imbalances that exacerbate the impact of the lack of health professionals in Africa. In some countries there is a chronic under-investment in education and training of health workers. There is a mismatch between education and employment strategies and population health needs. Rural and remote areas are underserved. Even when workforce supply levels have been maintained, budgetary constraints and austerity measures have limited the public sector's capacity to absorb new generations of trained health workers. In western Africa for example, almost half of all years with IMF programmes included reforms stipulating layoffs or caps on public-sector recruitment and limits to the wage bill between 1995 and 2014. This impeded countries' abilities to hire or retain health-care professionals. The paradoxical result is that, in some countries, health worker unemployment co-exists with major unmet health needs.^x

Among the initiatives to correct these imbalances is the African Union's 2017 goal to rapidly train and deploy 2 million community health workers.^{xi} As part of its response to COVID-19, the African

Union in 2022 (at its 35th summit) decided to establish a framework for (re)training Africa's human resources for health.^{xii} The emphasis on the community health workforce reflects the many strengths of this approach (including an almost 10:1 return on investment) and the need to cope with shortages of primary health-care workers at community level.^{xiii} Among the lessons of the HIV response is that investment needs to be shifted towards the community level with strong primary health care including community organizing and self-support groups which add immeasurably to the effectiveness of health service provision.

The failure to invest sufficiently in the health workforce reflects a major imbalance in health expenditure priorities in the region. Pre-COVID 19, it was estimated that an average 39% of health budgets in Africa were spent on medical products, while expenditure on health workforces (14%) and infrastructure (7%) was low. In contrast, countries with well performing health systems invest up to 40% on their health workforces and 33% on infrastructure.

Spending on medical products is inflated by the need to import these products. Even before COVID-19, African countries were manufacturing less than 2% of the medicines consumed on the continent. The lack of local production and the dependence on external markets also limits access to medicines, equipment and supplies. While the continent's pharmaceutical industry is evolving with at least 370 drug product manufacturers in Africa, it is clustered in only 9 countries, with limited production functions.

The COVID-19 pandemic has shown what happens when global supply chains come under pressure. Disruptions in the supply and distribution of medical products led to shortages of personal protective equipment across Africa and sent the costs of medicines and drugs soaring. The final cost of antiretroviral drugs sourced from manufacturers in India is estimated to have risen by 10-25% during the first year of the COVID-19 pandemic.^{xiv}

Higher costs and constrained supplies of essential medicines have several consequences. The market in traditional medicines has filled gaps in supply, but in an unregulated fashion that results in out-of-pocket health spending on remedies that are frequently ineffective. The most vulnerable populations tend to be worst affected by that trend. Similarly, the circulation and unregulated sale of counterfeit medications is a significant problem in Africa, as elsewhere,^{xv} as is the diversion of drug supplies for illicit purposes.

The establishment of **the African Medicines Agency marks a significant step towards addressing some of these challenges. The African Commission on Human and Peoples' Rights has a critical role to play in engaging with the Medicines Agency** to inform the design of pharmaceutical policies to make medicines more affordable and accessible. The Commission's 2008 Resolution on Access to Health and Needed Medicines in Africa called on States to take specific steps to ensure the availability and accessibility of essential medicines, including through the promotion of equity pricing and by implementing intellectual property policies that take full advantage of all flexibilities in the WTO TRIPS agreement.^{xvi} The Commission called for policies to support the establishment of scientifically sound pharmaceutical industries in Africa, with particular emphasis on local African production for greater self-reliance. It also called for parallel importation and compulsory licensing for medicines to be used where available and applicable.^{xvii}

1.3 HEALTH FINANCING IS CENTRAL TO REALIZING THE RIGHT TO HEALTH

State obligations allow for the progressive realization of the right to health, but they do require States to be non-discriminatory and to take deliberate steps to achieve that right. Epidemic crises such as HIV and COVID-19 have confirmed the need for rights-based approaches, but opportunities have been missed to use rights- and equity-based advocacy to support better financing for health more generally.

The amount of money spent on health, where sourcing of the funds come and their allocation are among the fundamental determinants of the right to health. The right to health establishes an obligation on States to ensure adequate availability of funds and to prioritize financing for health in budgets.^{xviii}

International law holds that, while the highest attainable standard of health may be achieved progressively and subject to available resources, there are nevertheless various obligations that are of immediate effect. For example, the right to health must be exercised without any discrimination, whether on the basis of sex, age, race, ethnicity, nationality, gender, sexual orientation, gender identity, disability, religious or other status. This obligation of non-discrimination has immediate effect. Countries are obliged to take deliberate, meaningful and targeted steps to achieve the goal. There is a general agreement that State Parties have a core obligation to “ensure the satisfaction of, at the very least, minimum essential levels of” the right to health. The Committee on Economic, Social and Cultural Rights has stated clearly that this core obligation includes, at the very least, the provision of essential primary health care. Even where resources are scarce, there remains an immediate and ongoing obligation to ensure the “widest possible enjoyment of the relevant rights under the prevailing circumstances”.^{xix} The African Commission has also made it clear in previously that the establishment of functioning health systems is a necessary element in protecting the Right to Life under the African Charter.^{xx}

Whatever the level of health care provision, the right to health entails that goods, services and facilities must be available, accessible (including affordable), acceptable and of good quality.^{xxi xxii xxiii}

In 2018 the African Commission stated that the minimum core obligations of the right to health include at least the following:

- a. Ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;*
- b. Ensure the provision of essential drugs to all those who need them, as periodically defined under the WHO Action Programme on Essential Drugs, and particularly antiretroviral drugs;*
- c. Ensure universal immunization against major infectious diseases;*
- d. Take measures to prevent, treat and control epidemic and endemic diseases; and*
- e. Provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them.*^{xxiv}

Human rights experts and mechanisms regionally^{xxv} and globally^{xxvi xxvii} have clarified that “appropriate means” to realize the right to health includes financing, with the Special Rapporteur on the Right to Health advising that the full realization of the right to health is contingent upon the availability of “adequate, equitable and sustainable financing for health at the domestic and international levels.”^{xxviii} The interrelation between the right to health and health financing is clearly recognized.

Rights-based approaches are increasingly prominent in the HIV response, in sexual and reproductive health and rights programmes, and in relation to marginalized and vulnerable populations. However, except for regarding access to medicines as an equity and rights issue, the link between financing and the right to health has been neglected in policy-making and programming circles. **There are opportunities to use equity- and rights-based advocacy to increase budgetary allocations to health, but they are not being used.**

It is only when health crises have struck, such as the HIV or COVID-19 pandemics, that the relationship between financing and the realization of the right to health has slipped into sharp focus. These health crises exposed how financing decisions — past and present, domestic and international — were depriving vast numbers of people of their right to health. A legacy of under-funding had constrained the capacity of States to manage, at great cost to societies and economies.

1.4 WHY NOW? THE CONTINENT IS AT A CROSSROADS MOMENT

The COVID-19 and HIV pandemics lay bare the case for a transformative approach to health financing in Africa. They reveal systemic vulnerabilities but also prove that sustained investment can turn epidemics around, as the HIV response has shown. COVID-19 continues to expose the limited global solidarity for ensuring equitable access to health supplies and resources, but it is also strengthening Africa's resolve to achieve greater self-reliance, especially in relation to the supply of medicines and vaccines.

The COVID-19 pandemic is having a devastating impact on the lives and livelihoods across the world, with the greatest burden befalling the most vulnerable populations. Women are bearing a triple burden of care work, income insecurity and compromised access to health services. Gender-based violence has escalated. Migrant and refugee populations have been locked out of essential health access. Young people have lost schooling and employment opportunities, with the crisis exacerbating pre-existing educational disparities. Workers in the informal sector have been left without social protection. People living with HIV and other chronic health conditions found health services disrupted, especially in the first six months of the COVID-19 pandemic.

Exacerbating these impacts has been the striking lack of solidarity shown by high-income countries, whose initial reaction to global shortages of protective and other essential equipment and medicines was to hoard supplies and leave fragile supply chains susceptible to price gouging. The rapid development of safe and effective COVID-19 vaccines has been an unprecedented scientific achievement, but the failure to ensure equitable global access has been a catastrophic moral failure, confirming Paul Farmer’s prediction, made two decades ago, that “excellence without equity looms as the chief human-rights dilemma of health care in the 21st century”.^{xxix} Only six African countries reached the WHO minimum target of having 40% of the population vaccinated before the end of 2021.

At mid-June 2022, only 19% of people on the African continent were fully vaccinated, and 13 countries had vaccinated less than 10% of their populations.^{xxx} Meanwhile, 75% of the population of high-income countries had been fully vaccinated and 53% had received booster doses.^{xxxi}

In many African countries, the initial responses to the COVID-19 pandemic were among the quickest in the world. Early alert and response measures were introduced and activated, and contact tracing systems were rushed into operation. In western Africa, especially, countries drew on their recent experiences with Ebola outbreaks. There and elsewhere on the continent, countries harnessed the community and social infrastructure built as part of their HIV responses. But as the COVID-19 pandemic spread and its global impact escalated, many countries found themselves facing formidable structural vulnerabilities. These included limited and disrupted access to medical supplies and equipment, small and overstretched health workforces, the punishing economic costs of the pandemic, especially for workers in the informal sector, and a lack of social protection systems capable of protecting people from precarity.

The COVID-19 and HIV pandemics exposed these vulnerabilities and make it all the more urgent to end AIDS. Despite the achievements of the past two decades against AIDS, progress was not on track to end the pandemic. That goal has been put under even greater strain by COVID-19. In 2020 there were 890,000 new HIV infections in the countries of the African Union, and 460,000 deaths from AIDS. Every week, 5000 young women aged 15 to 24 become infected with HIV. Six in seven new infections in adolescents 15-19 in sub-Saharan Africa are among girls, and young women 15-24 are twice as likely to be living with HIV than young men. In the countries of the African Union there are twenty-five million people living with HIV, 76% of whom are on life-long treatment.

More than two years after the COVID-19 pandemic, its cumulative impact is weighing on countries. Public accounts are under severe strain, hemmed in by slow economic recovery, shrunken fiscal revenues and ballooning debt obligations. **This is placing health and social spending — already highly rationed — under even greater pressure.** It is vital that public policy responses avoid the disastrous fiscal austerity and social spending cuts that so often become the reflex response in times of crisis, swelling the ranks and heaping further misery on those who are left behind.

[A HUGE opportunity for positive change](#)

While the COVID-19 crisis has added enormous pressures on health systems, it has also brought opportunities for positive change. Public awareness about the importance of a rights-based approach to health is growing, as people experience and witness the devastating effects of health inequities and underinvestment in health. Political concern and public support for a shift in health financing can be harnessed to drive ambitious and long-overdue reforms that can boost resilience and sustainability.

Using these opportunities well will require drawing the right lessons from the pandemic and countries' responses. That includes understanding why such major gaps in essential service access occurred and why vulnerable populations were left in the lurch so badly. The gaps stem from the neglect of public health systems, entrenched during past structural adjustment policies and prolonged by the austerity measures that were introduced after the global financial crisis of 2008-2009. Discrimination against vulnerable and ostracized populations, and the ongoing use of user fees, left them especially exposed to effects. Include human resources for health

A resilient recovery requires undoing entrenched inequalities by continuing to invest in ending the epidemic threats that stalk Africa and introducing transformative health-care reforms to build

publicly-financed, people-centred health-care systems that reach everyone in need with quality services.

Advocacy for the right to health and a rights-based approach to health, including addressing the social determinants of health, is essential. Building equitable health systems requires dismantling the systemic and structural barriers that create health inequalities. That responsibility extends across sectors, including the sectors that decide and manage macroeconomic policy. Significant funding increases are needed to overcome the harm done by converging epidemic threats and socioeconomic inequalities.^{xxxii} The right to health framework can serve as a valuable compass for decision-making.

History offers inspiring examples of how crisis sometimes opens the doors of opportunity. A quarter of a century ago, a rampant HIV pandemic was devastating communities across the continent, even as newly-discovered (but very costly) combination antiretroviral therapy was saving lives in high-income countries. Received wisdom at the time held that these therapies were too expensive for mass use in developing countries and that those countries' health systems were also too weak to support large-scale treatment. A powerful transnational movement of activists, legal experts, academics, NGOs and multilateral institutions campaigned against the *status quo* and mobilized a groundswell of demands that drove down drug prices, prompted funding increases and brought affected communities to the centre of health care decision-making.^{xxxiii} Within a few years, saw HIV treatment — often free of charge — was reaching remote communities across Africa.

The HIV epidemic is not the only example of crises inviting innovation and renewal. Brazil's commitment to Universal Health Coverage (UHC) took shape amid faltering economic growth and acquired impetus during a period of social and political upheaval. Thailand also committed to its Universal Coverage Scheme in 2001, right after the 1998 Asian financial crisis and with economy still struggling to recover.

Converging crises, the potential to overcome and soon end major pandemics, and the growing insistence that health is not a privilege but a right — all this is generating a new clarity about the need for decisions and actions that will safeguard people's health and wellbeing across the African continent. National economies are under intense pressure and decision-makers are being urged to steady public finances with austerity policies. That route has been travelled before, with calamitous results. The social infrastructure and health systems that should sustain societies were dismembered. The lessons of those mistakes must be heeded. The choices African countries take in the next couple of years will have lasting consequences.

Inequities in health service coverage and high levels of associated financial hardship persist across the continent.

Section 2. Financing Policies and their impact on financial protection.

A disproportionate share of health financing in Africa come from out-of-pocket payments, which place a heavy burden on low-income earners. Despite the knowledge that user fees in public health services are regressive and deter people from seeking health care, they continue to be imposed. Two-thirds of African countries still charge these fees at all levels of care. An abundance of evidence points to the health and economic benefits of doing away with user fees.

Member States have an obligation to make use of the maximum available resources to realize the right to health, including by taking all necessary steps to raise adequate revenue.^{xxxiv} Health services are financed through various mechanisms in many countries, (i) government health spending (general government budgets and social health insurance); (ii) out-of-pocket (OOP) payments; (iii) development assistance for health; and (iv) prepaid private spending, which includes private insurance.

However, it is not just a matter of raising funds: how the money is raised has great bearing on the right to health. Health-care financing is equitable when it occurs in ways that protect individuals and households from adverse impacts on their livelihoods and health. In addition, financing health services affects income inequality because these services are financed (whether through taxes, insurance premiums or out-of-pocket payments) from household income.

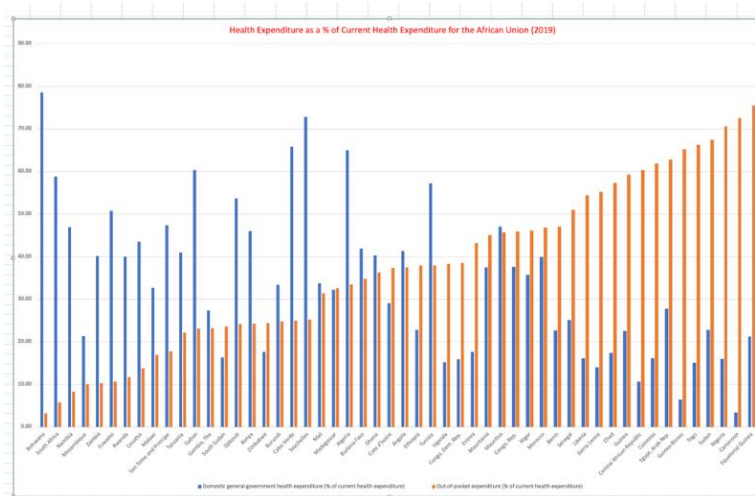
Out of pocket payments are spending on health directly out of pocket by households. They include access fees and charges for essential services.

Affordable access to quality health care is a basic human right and a foundation for the realization of other rights and for social and economic development. Africa has a relatively high proportion of OOP expenditure: on average, 36.3% of health care in Africa is financed from domestic public resources, 33.3% through OOP expenditure, and 12.6% from external resources. In countries such as Cameroon, Equatorial Guinea, Nigeria and Sudan, OOP health spending exceeded 70% of current health expenditure (CHE) in 2017. In Malawi and Mozambique, for example, donor funding accounts for more than 60% of CHE. Donor funding is predominantly allocated to addressing the HIV, malaria, tuberculosis epidemics and maternal and child health.

There is a strong negative relationship between the public financing share of health vs Out-Of-Pocket expenditures. Where government spending on health is too low, *the costs of healthcare are transferred mostly to households for whom high out-of-pocket payments are often a cause of impoverishment and an important barrier for accessing quality health care.*

OOP payments for health deepen impoverishment are deeply regressive, since they absorb larger proportions of low-income earners' finances compared with people in higher income brackets. OOP payments, including user fees, are detrimental to the right to health. They create significant barriers to accessing health services and their impact is discriminatory. They burden individuals and households of low socioeconomic status the most. Decades of experience have shown that these financial charges, even when relatively small, deter people, especially poorer people, from using the health services they need, worsen health outcomes, and push people into poverty.^{xxxv xxxvi xxxvii xxxviii}

Countries charge **user fees** for publicly provided services and drugs as an instrument to finance health care in their country. This policy yields an unstable flow of financial resources and constitutes an access barrier that impede or



delays care and makes it more expensive for both patients and the system. It has a relatively greater

impact on the poor, as even the smallest payment can represent a substantial portion of their budget and impoverish them further.

Despite commitment to UHC, policy support and robust evidence of the benefits of doing away with user fees, health care financing reforms in Africa has progressed at slow pace, progress towards removing them has been slow and inconsistent.^{xxxix} Two thirds of African countries were charging user fees at all levels of care in 2017, according to the World Bank, and another 15% of countries had eliminated user fees at primary care level (Low-income countries were most likely to be charging these fees at all levels of care. (Figure 1).¹

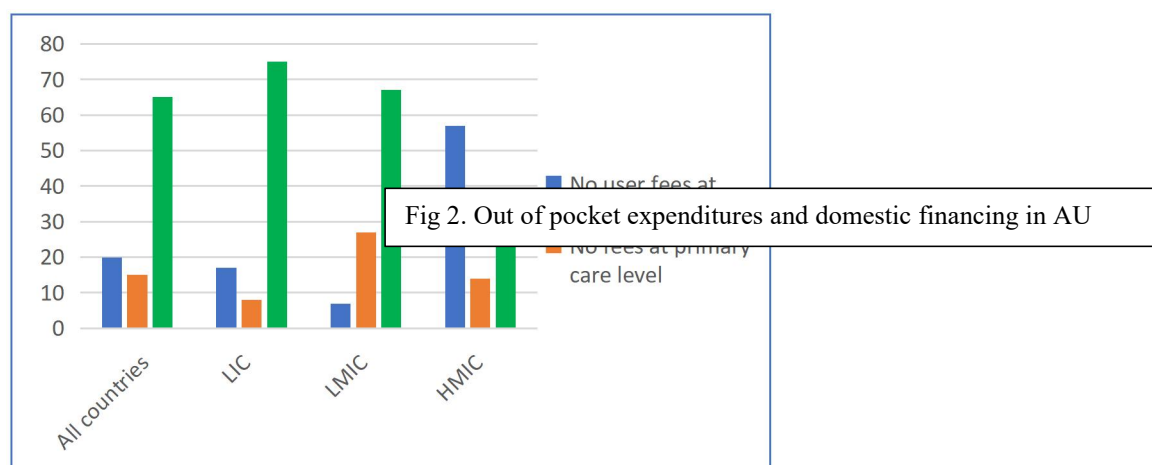


Figure 2. Countries charging user fees in public clinics and hospitals in sub-Saharan Africa, 2017

User fees also entrench and deepen health inequities. A Cochrane review of studies with longitudinal data has shown that the use or increase of user fees was associated with significant decreases in the use of public health services (Lagarde 2008). In Malawi, user fee introduced to general outpatient visits in health centres that provided free HIV treatment, attendance fell by 68% and with reduced opportunities to conduct HIV tests, HIV diagnoses among adults fell by 48%.^{xi} Similar negative effects on AIDS treatment adherence and testing uptake were observed in Cameroon, the Democratic Republic of Congo, Nigeria and Senegal.

In some cases, particularly in low middle income countries, people are detained in health facilities against their will for non-payment of bills or user fees — a clear violation of human rights — or the remains of deceased patients are withheld^{xli}. WHO stipulates that no person should be detained in a hospital against their will. Data on hospital detention is not systematically collected, but some estimates are that hundreds of thousands of people could be affected every year (Yates, Brookes & Whitaker) with detention periods ranging from days to months. These practices are against the right to health principles and require immediate policy and regulatory action by Member States.

The COVID-19 pandemic prompted many countries to remove user fees and co-payment at point of service in a bid to increase access to services and facilitate effective disease control. In many cases, COVID-19-related services freely available to the entire population. Countries adopting this strategy included Ethiopia, Indonesia, Papua New Guinea, and Tajikistan. Other countries are expanding their safety nets, targeting households with high health risks (World Bank, 2021).

¹ Cotlear D & Rosemberg M. Going Universal in Africa: How 46 African Countries Reformed User Fees and Implemented Health Care Priorities. Universal Health Coverage Study Series No. 26. Washington DC: World Bank; 2018.

Global association with increased public spending

Increased health spending is necessary but insufficient on its own to improve UHC effective coverage². Substantially increasing total health spending could be one avenue for elevating UHC effective coverage performance; however, many countries still have high out-of-pocket spending relative to their total spending³. How the revenues are managed through pre-paid pooling financing mechanisms and channelled to the population determines who has access to health care.

Section 2.

Incomplete health financing strategies, weak regulatory frameworks and a legacy of under-funding have resulted in fragmented health financing on the African continent. The pooling risk through health insurance schemes often benefits mainly the wealthiest sections of society who have access to employment-related social health insurance. The COVID-19 pandemic has reminded of the perils of relying on private sector health-care providers to the health needs of the wider public.

Financing arrangements across the continent include social health insurance (SHI), donor funding, and other forms of insurance, such as community-based health insurance (CBHI) and private voluntary health insurance (VHI). SHI, a compulsory system that deducts contribution payments directly from employee payroll taxes, is established in approximately sixteen African countries and provides benefits through national health insurance funds, national social security, and related branches.

Despite the limited contribution of health insurance schemes to current health expenditures in Africa, a critical review of the current characteristics of the financial arrangements is relevant to the ongoing efforts of many African countries considering this form of financing.

Limited coverage and impact

Health insurance mechanisms have increased the likelihood of people using health services and improving the financial protection of the insured in several contributing countries, including Ethiopia, Kenya, Ghana, and others. Exemptions for those most vulnerable have contributed to equity and social justice in Rwanda by enabling poor people and people living in extreme poverty to have access to primary health services. Ghanaian health insurance has significantly increased access to prenatal care and deliveries in health facilities for the most disadvantaged classes (Sanogo, 2019). These results, though, are limited in scope and coverage.

Despite several years of reform, only three countries – Gabon (40.5%), Ghana (40%), and Rwanda (74%) – have achieved a population coverage level of above 20%. Overall coverage is low and has stagnated in many countries, including Kenya, Nigeria (5%), and other countries. In several cases, inadequate public funding for health remains a key issue.[1]

Inequities in coverage, access, and enrolment at the detriment of the poor

Social health insurance schemes that seek to cover both formal and informal workers face some challenges. The potential for health insurance mechanisms to deepen rather than alleviate inequality is aggravated when healthcare financing and entitlements link to employment. In Ghana, although 80%

² www.thelancet.com Vol 391 May 5, 2018

³ Lancet 2020; 396: 1250–84

of the national workforce is in the informal sector, it accounts for only about one-third of national insurance membership. In Kenya, the major health insurance provider covers 89% of the insured (about 20% of the total population), mainly those working in the formal sector; contributions by the informal sector are low, with high dropout rates.[2]

Meanwhile, despite their goal of covering the informal workers and the poor, the inequities of enrolment, access, and financial protection are more pronounced for informal workers; self-employed, rural residents, men, those with lower educational attainment, and the migrant and the poor were less likely to be covered by health insurance schemes [3][4] (Erlangga, Suhrcke et al. 2019).

Social health insurance schemes can also exacerbate gender inequalities, such as when employment-related gender disparities translate into unequal access to health care. Generally, females were more likely to be covered by SHI schemes in Ghana and Kenya, but females in formal sectors are less likely to be covered than their male counterparts.[5] Women are less likely to be formally employed than men, with 90% of employed African women working in the informal sector, where incomes tend to be unpredictable and low, and they are less able to make regular contributions to maintain their insurance coverage.

High fragmentation increases inequities

Many insurance schemes' coverage is limited to primary health care and often to the geographic area of enrolment, and the individual will not be covered outside of the residence. This increases inequities, and it is likely to affect treatment quality for those with chronic diseases. In many other countries, coverage is limited to primary care and the enrolment locality.

Limited and differential financial protection

Despite the goal of protection from the financial burden of accessing services, evidence suggests that the current schemes lead to and entrench differential financial protection and health-service access across socioeconomic groups, and the poorest tend to remain without financial protection. Across the countries with SHI, CBHI, and private insurance, the out-of-pocket expenditures have not significantly reduced.

Private health insurance plays a limited role as enrolment is limited.

South Africa, Namibia, and Zimbabwe are exceptions with respect to their voluntary private health insurance schemes, but these serve to finance health services that are restricted to small, wealth sections of their societies. For example, 42% of South Africa's total health expenditure goes to voluntary private health insurance – the highest percentage in the world – but it benefits only 20% of the population, and in highly segmenting ways.^{xlii xliii} People who can afford to pay elevated fees and premiums can access care more quickly and obtain services that are otherwise unavailable or prone to long delays. In addition, participants are subject to losing access to the scheme if they are unable to maintain their contributions.

For most low- and middle-income countries, the choice remains whether funding should flow through compulsory insurance, direct government service provision, or a mix of the two.^{xliv}

Public-sector models require strong political leadership, and the support of technical assistance, capacity development and development assistance. **Countries that have expanded coverage at a low cost have built political commitment through strong leadership taking advantage of windows of opportunity and stable and effective institutions.** These success stories have been marked by sustained investment in training, infrastructure and management. They parallel the record

of high-performing health systems in high-income countries which are characterized by near universal coverage and at the very least protection against excessive medical costs in the form of caps for out-of-pocket spending, as well as full coverage for preventive services, primary care, and chronic conditions. Pooled and prefinanced health insurance which mitigates the financial risk of ill-health is a fundamental element of the social contract between governments as duty bearers and populations as rights holders.

THE ROLE OF THE PRIVATE SECTOR IN HEALTH FINANCING

The private sector is often promoted as a potential source of substantial additional resources for the health sector, but there is limited evidence that greater private sector engagement will result in healthier financing for the sector. This is especially the case in settings where legal and regulatory frameworks are incomplete and poorly enforced.^{xlv}

Almost no health system is entirely dominated by either the public or private sector. The relationship between the public and private elements is critical to health system performance and the realization of the right to health. (Sekhri and Savedoff, 2006) [WHO defines private sector engagement as the meaningful inclusion of private providers for service delivery in mixed health systems. It vests in the state the ultimate responsibility for governance of the overall health system — both private and public — including ensure quality of care and financial protection for patients, regardless of where they seek care.^{xlvi} These conditions are unlikely to be met where private sector engagement is not regulated and held to clear standards and obligations. **Lack of government provision of services and gaps in regulatory capacity have led low- and middle-income countries, including in the African Union, to become dependent on external actors for financing health goods and services. That tendency was by compounded by structural adjustment programmes** beginning in the 1980s, which saw many donors impose constraints on public health systems that constricted the role of the state in the provision of health care (Sparke, 2020).

In Africa, 26% of health care is sought from the formal private sector (e.g. privately-run medical clinics and nursing homes), with an additional 10% sought from informal providers. The private sector is itself composed of actors of different types — some are for-profit enterprises, often multinational, while others are not-for-profit.

The proportion of health care that is sought from private providers is even larger for out-patient care: 35% from the for-profit private sector, and 17% seek care at shops faith healers and other informal providers. The greatest proportion of private sector care seeking occurs in Nigeria (52%), while in Cameroon, Uganda and Benin more than 40% of care is sought in the private sector.

The COVID-19 pandemic exposed many weaknesses in private sector provision of health care in Africa and elsewhere. While the **demands triggered by the pandemic shed light on the capacities of public health systems, it also was clear that a poorly regulated, parallel private health system was unable to fill the gaps in the national pandemic response.**^{xlvii}

The result was a crisis of service provision and pricing. Services were rationed and made accessible based on patients' ability to pay. Up-front deposits were often imposed on people seeking admission for COVID-19 treatment. In Zimbabwe, for example, some hospitals reportedly were demanded up to US\$ 5,000 for admission (Muchetu, 2020). Some private providers resorted to price gouging, charging well above market rates for goods or services for which demand is usually highly inelastic, such as hospital beds.^{xlviii} Some private providers refused to admit COVID-19 patients or engaged in brinkmanship on the price per patient to be paid by public health systems that desperately needed

access to beds in private facilities. **In some instances, state authorities had to intervene and impound beds, cap prices or threaten providers with legal sanction.**

Despite a reputation for efficiency, the private health care sector [IN AFRICA?] was often found to be under-resourced and lacking in capacity to manage large-scale, complex undertakings such as vaccination roll-outs and track-and-trace processes or to handle the sudden influx of patients to hospitals.

Long-standing mistrust between public and private health sector actors, coupled with the practices of many private sector actors during the pandemic have stoked tensions in many regions of the world. Some countries sought to impose limits on how much private providers could charge for COVID-19 services. Thailand, for example, introduced legislation in April 2020 to prevent private providers from charging COVID-19 patient user fees (Boonbandit, 2020), [REF] while Malaysia, the Philippines, and Indonesia set prices for COVID-19 treatment and fixed the government subsidized rates (Antara, 2020; Loo, 2020; Tiglao, 2020). In other cases, the private sector used its market power to resist government action, including by threatening to close services.

In South Africa, where three large corporations dominate the private hospital market, in mid-June, 2020 they were able to obtain prices per patient of ZAR 16 000 (US\$ 950) per day after extended negotiation with the Government.^{xlix} In other cases, governments have had to bailout private providers, or nationalize their private providers. In Egypt, for example, emergency powers were passed in April 2020 in effect to sequester private hospitals for the pandemic response (Reuters, 2020).

Whether or not public-private partnership initiatives indeed contribute positively to health-care financing depends on governments' capacities to establish and enforce regulatory standards and frameworks; and to then negotiate, implement, and manage contracts and collaborative initiatives that serve health strategies. **Weak or ambiguous overarching frameworks, coupled with poor enforcement and limited public sector capacities can result in private sector engagement undermining rather advancing the realization of the right to health.**

This is especially evident in the wake of financial or pandemic crises, when public spending cuts and the increased commercialization of health care are often promoted as solutions for financial deficits, typically to the detriment of progress towards achieving the right to health. **From a rights perspective, the commercialization of health care (including through privatization of services and functions) can pose significant risks to the availability, accessibility and quality of health facilities and services. It can lead to greater reliance on out-of-pocket payments, disproportionate investment in secondary and tertiary services to the detriment of primary health care, and increased concentration of services in urban areas.¹ The effects tends to weight heaviest on impoverished and other vulnerable and marginalized groups.** In 2018, the United Nations Special Rapporteur on extreme poverty criticized the extent to which the World Bank, the International Monetary Fund and the UN had promoted privatization of basic services, without regard for the human rights implications or consequences for low-income households.^{li}

Similarly, the African Commission on Human and Peoples' Rights has expressed concern that the growth of the involvement of private actors in health services "often happens without the consideration of human rights, resulting in growing discrimination in access to health services, a decrease in transparency and accountability, which negatively impact the enjoyment of the right(s) to health". It has called on States to act on their obligations to realize the right to health. The proposed steps include adopting legislative and policy frameworks for regulating private actors and ensuring

that their involvement conforms with regional and international human rights standards. Steps are also needed to ensure the protection of access to health care and needed medicines and to consider carefully the risks which public-private partnerships may pose to the realization of the right to health. The Commission urged States to ensure that the involvement of private actors in the provision of health services does not adversely affect human rights.^{lii}

[1] Atim C, Bhushan I, Blecher M, Gandham R, Rajan V, Davén J, Adeyi O. Health financing reforms for Universal Health Coverage in five emerging economies. *J Glob Health* 2021;11:16004.

[2] Atim C, Bhushan I, Blecher M, Gandham R, Rajan V, Davén J, Adeyi O. Health financing reforms for Universal Health Coverage in five emerging economies. *J Glob Health* 2021;11:16004.

[3] Anjorin, S. S., Ayorinde, A. A., Abba, M. S., Mensah, D., Okolie, E. A., Uthman, O. A., & Oyeboode, O. O. (2021). Equity of national publicly funded health insurance schemes under the universal health coverage agenda: a systematic review of studies conducted in Africa. *Journal of Public Health*. doi:10.1093/pubmed/fdab316.

[4] Fenny, Ama Pokuaa, Robert Yates, and Rachel Thompson. 2018. 'Social health insurance schemes in Africa leave out the poor', *International health*, 10: 1–3.

[5] Anjorin, S. S., Ayorinde, A. A., Abba, M. S., Mensah, D., Okolie, E. A., Uthman, O. A., & Oyeboode, O. O. (2021). Equity of national publicly funded health insurance schemes under the universal health coverage agenda: a systematic review of studies conducted in Africa. *Journal of Public Health*. doi:10.1093/

2.4 OVERCOMING INEFFICIENCIES IN HEALTH FINANCING IN AFRICA

A clear mismatch between health spending and population needs is evident across African Union countries. This is most obvious in the under-investment in primary health care. Allocative and spending inequities and inefficiencies are a major reason for health systems' slow progress towards realizing the right to health.

Across Africa there has been under-investment in human resources for health care, including for primary health care and especially in rural areas. The latter is a cornerstone for realizing the right to health. Hence, international and regional human rights norms and standards typically include minimum core obligations of universal, non-discriminatory access to quality primary health care.^{liii liv}
^{lv} For example, the African Charter on the Rights and Welfare of the Child specifically calls on countries to combat disease and malnutrition within the framework of primary health care.

In reality, though, resource allocation is skewed toward hospitals and urban populations that tend to be comparatively better-serviced. Average public expenditure in the WHO Africa Region on non-primary health care (hospitals and specialist care) is up to three times higher than spending on primary health care and prevention (WB, PHC). Inefficient health spending is also reflected in the unequal rural/urban distribution of health-care workforces and infrastructure, which significantly contributes to rural-urban disparities. Globally, 56% of the global rural population lacks health coverage as compared to 22% of

Differentiated approaches that strategically identify and serve subgroups with higher disease burdens and lower access to essential services have been a core feature of efforts to end the AIDS, TB and malaria epidemics. These approaches can extend the coverage of health programme, enhance their equity, and make them more efficient and effective (by reaching the people that need them the most).

There is compelling evidence that community health workers and mid-level cadres can effectively deliver a range of quality health services, including the management of common childhood illnesses; the promotion of antenatal care and breastfeeding and support for the prevention and treatment of TB, malaria, and HIV. However, despite the evidence of effectiveness, these efforts are under-funded. Reasons include institutional inertia, the influence of patterns of prestige and interest groups which favour tertiary care and physicians over community health workers.

With financing and other support, community-led and -based organizations are able to bring vital services to ostracized populations — including migrants, sex workers, people who inject drugs, transgender people, and gay men and other men who have sex with men — who are at heightened risk of HIV and other life-threatening infections. Punitive laws, stigma and discrimination often deter these populations from using standard public health services. Community-led responses are successful at countering disinformation, ensuring the continuity of health services, improving equity, and protecting the rights and livelihoods of vulnerable populations. The important roles of community-led and -based organizations as catalysts for rights-based and evidence-informed responses to HIV has been recognized by the Human Rights Council. It has urged countries to empower communities of persons living with, at risk of or affected by HIV, including community-led organizations, to take leadership roles in the HIV response and be included in planning, implementing and monitoring of the response, and that they are provided with sufficient financial support.^{lvi}

The resilience and impact of community-led and -based services was demonstrated early in the COVID-19 pandemic when they rapidly adjusted to deal with disruptions and maintain essential services for marginalized and vulnerable sections of society. To take one of many examples, in Uganda, a combination of community-centred approaches was used, including multi-month dispensing of antiretroviral medicines, community drug pick-up points, and communal drug collection (where people form small groups and alternate collecting everyone's antiretroviral medicine). In western and central Africa, Nigeria's Antiretroviral Therapy Surge initiative succeeded in boosting HIV treatment coverage and quality despite COVID-19 disruptions. Also being recognized is the value of community-led monitoring capturing local, action-oriented data that can be used to advocate for improvements, enhance health services, and promote greater accountability among service providers.

Financing for community responses is modest and is sourced chiefly from international donors. In many countries, legal frameworks hamper the effective operation of the community sector by making it difficult for community-led organizations to register and receive funding. In prioritizing health in their budgets, governments should heed their positive obligation to facilitate the active participation of individuals and communities in the formulation, implementation and monitoring and evaluation of health budgets.^{lvii}

3.1 PATHWAYS FOR TRANSFORMING HEALTH FINANCING TO REALIZE THE RIGHT TO HEALTH

Increased domestic resource mobilization is fundamentally important for realizing the right to health is. Even though fiscal space is constricted, there are opportunities to boost public spending on health, including by tapping into new funding mechanisms that become available during the COVID-19 pandemic. Beyond that, the deficiencies of the current health financing system must be addressed. Right-to-health advocacy should aim at increasing the share of total public spending that is devoted to health, with a focus on removing inequalities in health spending and closing the gap to reach epidemic control for HIV, TB and malaria.

There is a genuine prospect of ending the AIDS epidemic as a public threat in Africa in the next decade, a feat that will far-reaching benefits for the health of entire societies and the health systems they rely on.

3.1. Bold Policy decisions to overcome the Macroeconomic Challenges

Advocating for financing for the right to health is ever more important in the current context of deteriorating global economic conditions following the Russian Federation's invasion of Ukraine combined with increasing inflation, and fears of debt distress in poor countries estimated by the World Bank in the recent 2022 "Double Shock Double Recovery" Analysis.

It is estimated that the public debt will further reduce spending capacities. Interest per capita payments are projected to rise on average in all country income groups through 2027, thereby increasing liabilities that are set aside before the remaining funds can be allocated to other priorities, including health. interest payments are expected to substantially restrict government capacities to spend on health. For example, in the contraction low-income countries (LICs), despite being the only subset of countries where per capita interest payments on public debt are expected to fall, they will, assuming no change in the priority given to health in budget decisions, still curtail potential per capita government spending on health, on average, by 4.4 percent (US\$0.8) in 2027

The Russian invasion of Ukraine and its destabilizing shocks, inflation and rising interest payments on public debt will further negatively impact those most vulnerable and bold policy decisions are required to raise government revenues as a share of GDP, increase the share of health in government budgets, and improve the efficiency and equity of health spending.

CATALYZE INCREASED RESOURCE MOBILIZATION FROM DOMESTIC SOURCES AND DONOR FUNDING

To ensure that every person enjoys the right to health, political leaders have to make appropriate economic, financial and social choices in increasing spending for health and ending HIV, COVID 19 and epidemics. If not, the impact of the COVID-19 pandemic, of the Ukraine war on global markets, and the volatile global financial landscape on health-care financing, increases the risk that the gap between the demands for health spending and available public resources will widen. This will require concerted efforts, evidence-driven advocacy, and partnerships to place financing for the right to health in the financing dialogues and fiscal decisions leveraging the various emerging opportunities. Key strategic directions include:

- ❖ *Promote the right to health in financing dialogues to advocate for removing macro-economic barriers, debt relief, tax evasion, and increasing domestic resource mobilization for HIV, Health and social spending.*

The historic approval by the Bretton Woods Institutions of the general allocation of Special Drawing Rights equivalent to US\$650 billion out of which US\$275 billion of the new allocation will go to emerging markets and developing countries, provided a unique opportunity to improve liquidity in countries and create space for substantive investments in inclusive recovery. Potential magnitude and reallocation can provide a massive overhaul to development and health financing. The majority of the allocation, over \$400bn, will go to high income economies, and there is a clear demand for a transfer of a portion of those to African countries. Some countries such as the US or France have already committed to transfer via loan 20% of their share. High income countries should consider reallocating the highest possible portion to support health financing and other recovery related efforts of developing countries. Allocations to developing countries and health fall significantly short of the developing country needs and increased efforts are required to tap into the new funding made available at macro-level in countries.

Fulfilling people's right to health requires financing reforms — at national and transnational levels — that strengthen fiscal systems and social spending for equitable and resilient recovery. They include tangible shifts towards more sustainable and equitable international financing assistance, including overhauled tax, lending and debt servicing policies for Africa. The Special Rapporteur on the Right to Health in 2012 noted that “widespread corruption, tax loopholes and weak tax administration, characterized by high rates of tax evasion often diminish States' capacity to raise revenues and allocate adequate public funds towards health.”^{lviii}

Quick debt relief and cancellation policies will open up additional fiscal space for African economies, approximately half of which were at high risk or in debt distress in mid-2022. The IMF has called for an effective “common framework for debt treatment”, in response to the disappointing and slow implementation of the G20 Debt Service Suspension Initiative and similar mechanisms.

- ❖ *Advocate against austerity measures that reduce public spending.*

Financing the right to health and ending epidemics requires significant resource increases and sound policies and investment. Austerity measures — imposing cuts on health and other social service spending — undermine progress towards realizing the right to health. The independent expert on foreign debt and other related international financial obligations of States on the full enjoyment of all human rights, particularly economic, social and cultural rights has pointed out that austerity measures,

when they lead to cuts to healthcare spending also have a gendered aspect with disproportionate impact on women including cuts to women-specific health services.^{lix} International financing support is often made conditional on countries introducing "spending reforms" which, in the past, have included cuts in spending on social services and subsidies. This had done great harm to the health and welfare of poor communities, and it has eroded labour, civil and political rights. Under international human rights law, any conditions attached to a loan that would imply an obligation on the State to adopt retrogressive measures in the areas of economic, social and cultural rights that are unjustifiable would be a violation of their human rights obligations.^{lx} The Human Rights Council's Guiding Principles on Foreign Debt and Human Rights and its Guiding Principles on Extreme Poverty and Human Rights both call for human rights impact assessments of conditionalities that are attached to loans or of measures which create a foreseeable risk of impairing the enjoyment of human rights by persons living in poverty beyond their national territory.

- ❖ *Advocate for increasing the share of total public spending devoted to health and social spending, fund the gap to reach epidemic control for HIV, TB and Malaria, and address inequalities*

In 2021, there were 890,000 new HIV infections in the countries of the African Union, and 460,000 deaths from AIDS. The distribution of these new infections and AIDS deaths tells the story of where there are programmatic gaps and the inequities that structure and 460,000 deaths from AIDS. The distribution of these new infections and AIDS deaths tells the story of where there are programmatic gaps and the inequities that structure the pandemic.

New infections in women and girls aged 15 and over outnumber those in men and boys by almost 2 to 1. Eighty-two percent of women (15+) were on antiretroviral therapy, compared to 70% of men, and as a result men outnumber women in AIDS deaths (200,000 adult men and 180,000 women died of AIDS in AU countries in 2020). An estimated 68% of people living with HIV in African Union countries are virally suppressed, three-quarters of people living with HIV in the AU are on antiretroviral therapy, but only 51% of those under 14, as programmes fail to reach and sustain therapy in infants and children.

The colliding COVID-19 and HIV pandemics make it all the more urgent to end AIDS. Progress against the AIDS pandemic, which was already off track, is now under even greater strain in the current context of fiscal constraints and competing priorities. If the global AIDS targets are met, then modelling projects there will be 185,000 new HIV infections in African Union countries in 2030. If the targets are not met, and programmes continue at their current level of intensity, then that level of new infections will be 606,000, affecting young women and girls, and increasing fiscal pressure on health budgets. Ending the ongoing epidemic is critical for realizing the right to health.

- ❖ Maintaining global solidarity and international resources will be critical to support countries in the phase of recovery, facilitating equitable access to health services and improving financial protection for all populations.

3.1.1. Mitigate the detrimental effects of user fees as a platform to remove financial barriers for realizing the Right to Health

Addressing the current fragmentation of financing arrangements will be critical to the realization of the Right to Health.

- ***Promote removal of user fees in public health facilities and replace lost revenue and meet rising demand for services with higher levels of public financing.***

User fee removal increases both coverage and equity by reducing financial barriers by enabling all those in need to access the services regardless of their ability to pay. Robust evidence suggest that user fee removal has resulted in increased access to services and improved health outcomes, particularly for reproductive health, the poor, and children.^{lxi, lxiilxiii} In Burkina Faso, the risk of incurring catastrophic health expenditures dropped by two thirds and the average expenditure each time a young child became ill decreased from USD 11 to less than USD 2 following the abolition of user fees in two health districts.^{lxiv} Benefits are broader: People no longer need to sell assets or borrow money to meet health payments, the sick and poor maintain, improve their health and do not forego care, and increase their earnings. This contributes to reducing poverty and inequities while spurring economic growth.

While a comprehensive approach for long term results requires health financing reforms, countries have adopted short term solutions to address the negative effect of user fees, particularly regarding maternal care and for infectious diseases, given the negative effect of foregoing care is amplified at social level. Removing barriers to access improves adherence for people living with HIV, contributing to reducing viral load and preventing new HIV infections, as well as improving quality of life and productivity. Critical features of the policy change are to increase revenues or redirect resources to offset the user fee loss at facility level and to support the impact of the policy change by addressing other factors that block access to services.

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There is significant policy support for the removal of user fees, and substantial evidence of the benefits of doing so. Many national governments, aid agencies, and multilateral organizations including WHO, UNAIDS, other UN agencies, the World Bank, and the Global Fund regard the removal of user fees, alongside the reduction in OOP payments generally, as a necessary step towards realizing the right to health, increasing health equity, and improving health outcomes.

For the same reason, but also to facilitate disease control, several countries have offered free COVID-19 services to the entire population⁴. Countries adopting this strategy include Ethiopia, Indonesia, Papua New Guinea, and Tajikistan. Other countries are expanding their safety nets, targeting households with high health risks (World Bank, 2021). It will be critical to build on this momentum and avoid returning to providing health based on the ability to pay – against the core principle of the Right to Health.

- ***ENGAGE WITH MEMBER STATES, POLICYMAKERS, AND PARTNERS TO END HOSPITAL DETENTION FOR NON-PAYMENT OF BILLS.***

A comprehensive review of laws, regulations, and practices that result in hospital detention or other related measures with inform country tailored actions and advocacy to establish legal measures prohibiting the practice of detention related to user fee payments or otherwise render them illegal. Drawing on AU country experiences, accountability and monitoring instruments will be proposed to be implemented in collaboration with community organizations to document and promulgate positive practices and/or draw attention when such practices continue.

⁴ <https://www.chathamhouse.org/2020/05/covid-19-era-healthcare-should-be-universal-and-free>

3.2. ADOPT THE RIGHT-TO-HEALTH FRAMEWORK TO PROMOTE A GOVERNMENT-WIDE VISION FOR LEVERAGING EQUITABLE FINANCING TO END EPIDEMICS, PROMOTE HEALTH CARE FINANCING REFORM TOWARDS UNIVERSAL HEALTH COVERAGE AND TACKLE INEQUALITIES.

While removing user fees at public-sector health facilities has assisted in reducing financial barriers, this policy is of little value if public facilities remain underfunded and of poor quality. COVID-19 has shown that returning to the *status quo* is not an acceptable solution. The slow and inefficient implementation of previous financing reforms will further weaken the health care system, hinder AIDS response progress, and increase inequalities.

Resilient recovery and fulfilling the Right to Health obligations depends on collective ability to catalyse transformative financing reforms that truly accelerate equitable financing to end the epidemics, get back on track and accelerate progress towards UCH, and address inequalities. This will include advancing towards sustainable and equitable international financing patterns, including tax, lending and debt treatment policies for Africa.

3.3.2. *Progressive financing policies, pre-paid pooling and equitable distribution for resilient recovery*

Only through a fundamental shift to financing strategies relying on predominantly public funding and distribution of pooled resources according to needs will it be possible to disrupt the enduring patterns of financing-related inequalities and turn financing into an accelerator for realizing the right to health^{lxv lxvi lxvii lxviii}. The evidence shows that while each country will choose a context-tailored solution, no country has made significant progress towards the Right to Health and UHC without relying on a dominant share of public funds to finance health.^{lxix} While the change of pace will be determined by country context, equitable health care financing reforms must commit to establishing a mix of resource-generation instruments that assure equitable funding flows and allow for subsequent pooling to cover universally guaranteed health services and rights. The implementation will require sustained international partners' support to enabler countries with constrained fiscal space to implement comprehensive equitable health care financing reforms that make significant strides towards the realization of the right to health, including equitable access to quality services, and financial protection for those most vulnerable, marginalized populations, and people living with HIV.

3.3.3. Direct spending to reimagine a people/community-centred equity driven delivery system.

Realizing the right to health requires effective spending that strengthen people-centred systems as well as holistically enhance public health capacities to reimagine primary health care and community-led delivery into robust systems that uphold the right to health for all, accelerate ending HIV and other epidemics in Africa, and are resilient to future shocks and pandemics.

There is also a need to invest in local production and reduce dependency on external market: building on the commitments the African Union has made. Recent African leadership Covid-19 vaccine access has increased the political momentum behind local production and emerging interim solutions suggest steps that can be further built upon, to equitably bridge demand across high, middle, and low-income countries, as for example in the Benefit-Based Advance Market Commitment that the Vaccine Alliance has been deploying to pool purchasing power and market potential in lower-income countries.

Prioritize and increase investments on PHC and community response

Implementing the people- and community-centered model of care requires greater efficiency through the priority increased allocation of new resources to the first level of care and networks to increase the availability of quality services and speedily address unmet health needs. In addition to increasing funding, it is critical to shift the PHC financing from private sources and household budgets, towards financing PHC services free at the point of care through general government revenue.

The lessons learnt from scaling up antiretroviral therapy to more than 25 million people, including those with limited access to health care, regardless of age, sexual orientation, gender, or ability to pay, are relevant to shifting resource utilization toward a system that addresses structural and systemic inequities and resource allocation disparities. HIV is not alone in this regard: underlying inequalities are at the heart of the unequal impacts of COVID-19, tuberculosis, malaria, Ebola, cholera and other infectious diseases.

Reimagining the delivery system will further benefit from leveraging capacity, policy changes, and programme infrastructure built by AIDS financing that can be used to address other health conditions and increasing efficiency and equity. For example, accessible, rapid point-of-care diagnostics were developed to increase uptake of HIV testing and shift to a model of self-testing and community-led programmes. These technologies are allowing for rapid implementation of diagnostic capacity for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) PCR testing in low-income and middle-income countries (LMICs).

With HIV treatment simplified over the last decade (e.g. one pill, once daily), care became increasingly decentralized. Delivered by nurses authorized to prescribe HIV medicines and lay health workers to assist in dispensing the medicines, decentralized delivery has contributed to rapid increases in the coverage of HIV treatment since the mid-2000s. It enabled successful integration with primary-care health services in some settings, including antenatal care, maternal and child health, sexual and reproductive health, and tuberculosis and primary care at the point of care, which are critical for sustained effective HIV programmes and expanded PHC.

The financing of community-led and community-based responses has enhanced the realization of the right to health for the most vulnerable and marginalized populations that have been unable to access health systems. This is not a short-term remedy and long-term commitment of governments is required in order to lead to equal health outcomes. There is need to institutionalize and integrate public financing^{lxx} of community-led responses in the national policies and systems to reach marginalized and other populations, increase coverage, and equity.

3.4. STRENGTHEN LEADERSHIP AND COLLABORATION AND MULTI-STAKEHOLDER PARTICIPATION IN FINANCING DIALOGUES TO INFLUENCE POLICIES AND DECISIONS TOWARDS FULFILLING THE RIGHT TO HEALTH.

Partnership and multistakeholder coordination are critical for the progressive realization of the right to health. Financing dialogues should be inclusive and need to draw in partners from all relevant sectors and at all levels, from global summit to local participatory accountability efforts. The HIV response offers good examples of incorporating community modalities for delivering basic health services.

This can be achieved through a multipronged approach that builds political momentum around a shared vision, leverages the right to health framework at country and continental levels, and employs a variety of tactics to increase participation of partners and communities in financing dialogues, budgetary discussions, and inserts human rights and equality in the discussion around health financing.

Partnerships should be fostered with the Ministry of Health, Finance, parliamentarians, community organizations and international partners to overcome political barriers, and influence shifts towards equitable financing strategies and increased allocations to strengthen people-centred systems that uphold the right to health.

A common framework across countries would enable assessment of implications of financing decisions and policies on fulfilling the core obligations of the Right to Health and equity.

There is a need to generate data regarding the financing policies, budgets and funding trends and the right to health to catalyse early action and promote changes that support progress towards the realization of the Right to Health. Lessons learned on participation, mitigation, leveraging partnerships and collaborations with Ministry of Health, Finance, and other critical partners should be documented along with intercountry exchanges to establish country experiences and evidence on the impact and influence of the Right to Health framework on effective and equitable financing decisions. Collaboration with partners to invest on expanding evidence and fill the gaps on the Right to Health and Financing, learn from experiences, and address areas of controversy (e.g. private sector's role in health care financing) can be strengthened.

There is a need to promote the participation of civil society and other partners in financing dialogues to support the Right to Health. The different mechanisms and opportunities for such a dialogue need to be identified and will assist in increasing the transparency of financing decision and accountability. Engaging civil society organizations and the public in decision-making and feedback can help to craft policies and services that are appropriate and reach the people most in need. Multisectoral support is essential for reducing health inequities since some factors influencing disease burdens and barriers to access lie outside the reach of the health sector. Multisectoral involvement and coordination should be integrated in national health plans and policies^{lxxi}.

Health financing dialogues should be complemented by an increased appreciation, in particular among the health financing community, of the necessary legal, social, cultural, judicial and other measures that are required to realise the right to health, including removal of stigma and discrimination in health care, the creation of an enabling legal environment and removal of discriminatory laws that create barriers to health services, increase in gender equality and removal of harmful gender norms.^{lxxii}

Section 4. RECOMMENDATIONS

4.1 Concerted action to end epidemics and pandemics

Advances in ending the epidemics of HIV, TB and malaria, to respond rapidly to new outbreaks of Ebola virus disease, and to address the growing burden of non-communicable diseases on the continent should be maintained and accelerated. The experience of the COVID-19 pandemic has imparted both positive and negative lessons for what is needed in ongoing pandemic preparedness and response, and the ways in which system-wide transformation can be achieved.

4.1.1 RECOMMENDATIONS TO THE MEMBER STATES

4.1.1.1 States should initiate comprehensive intra-action and after-action reviews of the COVID-19 response to draw lessons learned for pandemic preparedness and response explicitly linked to prior epidemic and other relevant experience.

4.1.1.2 Resource mobilization from domestic and international sources sufficient to meet global targets to end the epidemics of HIV, TB and malaria should be sustained.

4.1.2.3 Capacity and programme infrastructure built by the AIDS response together with the responses to TB, malaria and other diseases should be leveraged to address other health conditions.

4.1.2. RECOMMENDATIONS FOR COMMUNITY ORGANIZATIONS AND CIVIL SOCIETY

4.1.2.1 The network of community organizations mobilized in the COVID-19 pandemic and community organizations responding to the HIV epidemic should undertake joint assessments of lessons learnt and use these to inform concerted capacity building of a community response infrastructure.

4.1.2.2 Building on positive examples in the HIV and COVID-19 responses, community health workforces should be expanded and equitably financed, in support of the AU target of 2 million community health workers available across the continent.

4.1.3. RECOMMENDATIONS TO REGIONAL ENTITIES

4.1.3.1 Local production of medicines with a goal of continental self-sufficiency in medicines production for essential and pandemic and epidemic vaccines, therapeutics and diagnostics should be supported through the African Medicines Agency and technology transfer initiatives.

4.1.4. RECOMMENDATIONS FOR DONORS AND INTERNATIONAL PARTNERS

4.1.4.1 International Financial Institutions should provide support for a sustainable and equitable recovery from the COVID-19 pandemic through the mobilization of bonds and other revenue streams and explicit financial settings to support expanded fiscal space and against austerity responses.

4.1.4.2 Initiatives in the WTO TRIPS Council to develop a platform for patent rights to be overridden in order to diversify the production of COVID-19 vaccines, therapeutics and diagnostics should be brought to a rapid conclusion.

4.1.4.3 International financing should be mobilized to augment domestic resource mobilization to ensure countries are on track to end AIDS by 2030, in line with global commitments.

4.2 Reinforce efficient, people-centred and transformative health financing to realize the right to health

4.2.1. RECOMMENDATIONS TO MEMBER STATES

4.2.1.1 States should aim to rebalance and increase the efficiency of their health budgets to:

- achieve global benchmarks in allocation to health workforces and infrastructure,
- reduce the budget share on medicines purchase including by support for local production,
- increase budget allocations to primary health care, and
- overcome rural/urban disparities.

4.2.1.2 States should progressively increase public health expenditure with the aim of reducing out-of-pocket expenditure from current levels across the Continent of 30% of total health expenditure to meet the global average of 18%.

4.2.1.3 In the post-COVID-19 period health expenditure budgets should be expanded including if necessary though deficit financing.

4.2.1.4 Political leadership and capacity building should be deployed to support strong public regulatory frameworks for health including clear rules-of-the-game for public-private partnerships and the regulation of private actors. Legislative and policy frameworks should be adopted to ensure the involvement of private actors is in conformity with regional and international human rights standards.

4.2.1.5 Pooling and pre-payment mechanisms for health expenditure (health insurance) should be expanded to create large, unfragmented and compulsory pools as the core of health expenditure financing.

4.2.1.6 In keeping with AU commitments including the Addis Ababa Declaration on Health Financing of 2019, States should progressively ensure the abolition of user fees in health, ensuring that implementation is orderly with removal accompanied by compensatory government financial support.

4.2.1.7 States should ensure there are remedies entrenched in legislation to eliminate detention for non-payment of health fees.

4.2.2. RECOMMENDATIONS TO COMMUNITY ORGANIZATIONS AND CIVIL SOCIETY

4.2.2.1 Partnerships should be fostered with the Ministry of Health, Finance, parliamentarians, community organizations and international partners to overcome political barriers, and influence shifts towards equitable financing strategies and increased allocations to strengthen people-centred systems that uphold the right to health.

4.2.2.2 Community based organizations should be capacitated and empowered to join national dialogues to identify alternative macro-fiscal policies that address the austerity measures, fiscal policy, the need for job and income security, and human rights.

4.2.2.3 Community organizations should develop and use checklists of financial accountability for health that support the realization of the right to health.

4.2.3. RECOMMENDATIONS FOR REGIONAL ENTITIES

4.2.3.1 Regional benchmarks should be established for high performance health financing including targets for public expenditure on health, taking into account Continental experience in relation to the Abuja targets on the proportion of national budgets to be spent on health.

4.2.3.2 African Charter Article 62 reporting mechanisms should systematically examine State progress to the realization of the right to health and synthesise key information on barriers and opportunities.

4.2.3.3 The Commission should conduct a comprehensive review of laws, regulations, and practices that result in hospital detention or other related measures and develop model legislation to prohibit the practice of detention related to user fee payments.

4.2.4. RECOMMENDATIONS TO DONORS AND INTERNATIONAL PARTNERS

4.2.4.1 International Financial Institutions should ensure that conditionalities are not attached to loans or other financial measures that impair realization of the right to health, and should incorporate

explicit human rights assessments in relation to the right to health in their financial support programmes.

4.2.4.2 International Financial Institutions should explicitly support health financing reform which includes dedicated coverage mechanisms to protect those more vulnerable and disadvantaged whether due to income, gender or other factors, from out-of-pocket spending for health.

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