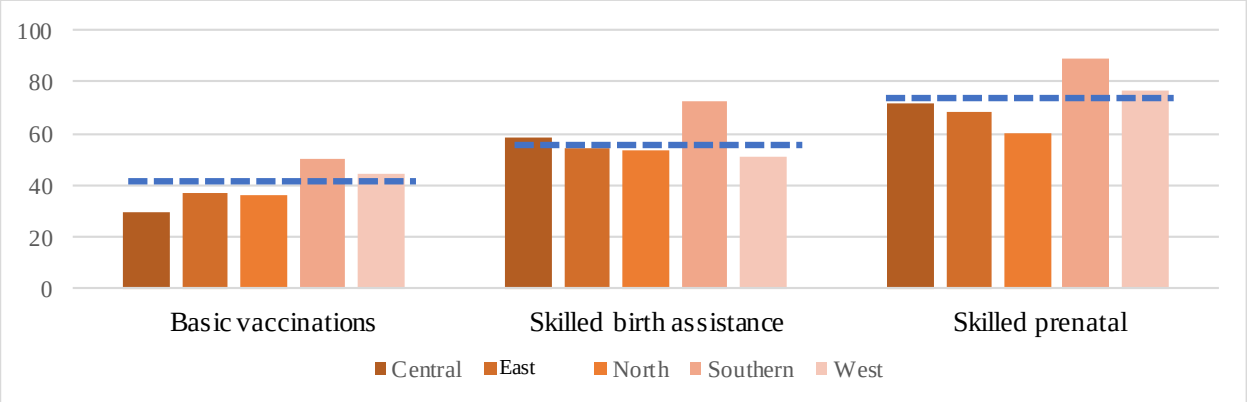
Background note
2021 Africa Business Forum
Investing in women's health

Health outcomes in Africa have improved substantially since the early 2000s. Life expectancy at birth increased from less than 55 to 62.8 years on average during the period 2000–2017. Average maternal mortality ratio decreased from 685 to 439 deaths per 100,000 live births; infant mortality from 50 to 39 deaths per 1,000 live births; and child mortality from 80 to 57 deaths per 1,000 live births in the same period. Despite these encouraging improvements, average figures mask inequalities in access to health care across countries in Africa and accessibility based on gender, location, income, and educational status. Women, rural, less educated, and poorer households exhibit lower values of health outcome indicators than men, urban, more educated, and richer households respectively.[1] For example, in critical health services for women and immunization of children, and birth assistance both limited coverage and inequalities are evident across the sub-regions and inequality of access remains a hindrance towards the achievement of 2030 Agenda and Africa's Agenda 2063.

Figure 1
Basic health-care coverage rates by subregion (in percentages)



Source: ECA calculations based on Demographic Health Surveys (2009–2018) and Multiple Indicator Cluster Surveys (2010–2015).

With regard to access to immunization, a key element of the global response to the coronavirus disease (COVID-19) pandemic, across Africa, household wealth and maternal education are critical factors for children's access to all basic immunizations, while the sex of the household head has less power in determining such access (see figure 2). In Central Africa, household wealth has more weight than other factors in determining the observed imbalance in access to basic immunizations. There is substantial variation within this subregion, with the average contribution of household wealth measuring 73 per cent in Gabon but only 23 per cent

[1] Economic Commission for Africa, "Report on inequalities in accessing health care in Africa", discussion paper, 2019.

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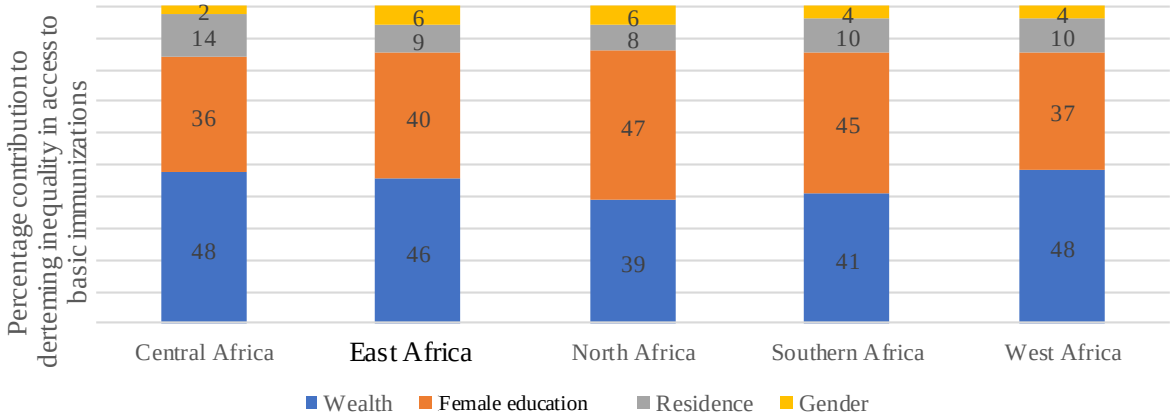
in the Congo. Female education emerges as the predominant factor in Cameroon and Chad, accounting for over 50 per cent of variation in the differentiation index (D-index) [2].

In East Africa, household wealth still counts for more than other factors but the gap between it and the second most influential factor, namely mother's education, is much narrower than in Central Africa. The average contribution of household wealth to inequality in access to basic immunizations reaches 83 per cent in South Sudan, followed by 63 per cent in Ethiopia and 53 per cent in the Democratic Republic of the Congo and Madagascar. What emerges clearly from this is that there is significant gender and income inequality in access and that investing in women's education and health has positive spillovers in terms of the accessibility of immunization and medicines.

Figure 2
Shapley decomposition [3] of access to basic immunizations at the regional level (in percentages)



Source: ECA calculations based on latest Demographic Health Surveys and Multiple Indicator Cluster Surveys (2010–2018) in Africa.

The affordability of health services remains a critical aspect of universal health coverage. Total spending on health care in Africa remained within a narrow band of between 5 and 6 per cent of gross domestic product (GDP) over the period 2000–2015 on average, although, in per capita terms, it almost doubled from $150 to $292, in constant purchasing power parity (PPP) dollars, with wide variation across countries. On average, health care in Africa is predominantly financed through out-of-pocket expenses (36 per cent), causing low-income households to decline into poverty when faced with extraordinary health costs. National health systems in most countries struggle with insufficient and inequitably distributed resources and the poorest countries and vulnerable populations bear a disproportionately high share of the burden of disease and injury.[4] Overall, there is an estimated health financing gap

[2] The D-index compares average coverage rate of access to a public service based on a nationally representative sample in a country to the coverage rates of various circumstance groups in the same sample. The D-index is therefore a measure of how dissimilar access rates are in each circumstance group relative to the national sample and ranges between 0 to 1 (or 0 per cent to 100 per cent). In the event of perfect equality the D-index equals 0, while in the event of perfect inequality it is equal to 1.
[3] Shapley decomposition enables the resolution of this problem and estimates the marginal or average contribution of each circumstance group to the observed inequality. The estimated Shapley contributions indicate in percentage terms the contribution of each of the four circumstance groups to observed inequality and meet the criterion of adding up to 100 per cent.
[4] Economic Commission for Africa, *Healthcare and Economic Growth in Africa* (Addis Ababa, 2019).

of $66 billion per annum for the continent, based on the threshold of 5 per cent of GDP for government expenditure. At the macro level, the large bill ensuing from pharmaceutical imports in Africa, constituting over 97 per cent of the continent's pharmaceutical market worth about $14.5 billion, less than 2 per cent of which is manufactured in Africa, renders affordability a serious concern.

These development deficits and delays in Sustainable Development Goal trajectories have been exposed during the current COVID pandemic. Men and women experience the negative effects of health and economic crises unevenly because they typically have different roles in the labour market and in their homes. In previous recessions, men have tended to suffer greater job losses than women, while women have borne the brunt of increased austerity and cutbacks in public services as a result of their role in unpaid (care) work. Early predictions about the COVID-19 crisis have indicated, however, that women will be disproportionately affected in both the workplace and the home.[5] This is because women predominate in many of the so-called "non-essential" retail and service occupations that have been severely affected by the crisis and that cannot be performed remotely, such as those in the personal care, restaurant, hospitality and domestic work sectors.[6] Furthermore, people's ability to undertake paid work or work the same hours as before will be influenced by what is happening in the home. The unprecedented closure of schools and childcare facilities and the scaling back of many non-COVID-19 health-care services resulted in a dramatic increase in care work within households. Given entrenched social norms about who should be responsible for care, it has been predicted that women would bear much of this additional burden.[7]

While the COVID pandemic has exposed vulnerabilities, in particular in terms of gender inequality, it has presented a number of opportunities for building back better through the leveraging of the African Continental Free Trade Area (AfCFTA) and smart social investments in uplifting the most vulnerable. The benefit of focusing on gender in building back better from the pandemic is also borne out by economic estimates of the effects of shifting from merely residual fiscal outlays on gender to smart investments in this area. For example, the costs of high levels of adolescent childbearing range from 1 to 30 per cent of annual GDP across African and other low and middle-income countries, measured as the forgone income of young mothers over the course of their lives. The lack of education and economic opportunities that results in the diminished participation of women in the labour force is estimated to cost Africa $60 billion in economic losses every year. On the other hand, Africa could gain $500 billion per year through multisectoral investments in adolescents and young people, in particular girls, by capitalizing on demographic windows of opportunity.[8]

The socioeconomic gains of gender-focused investments are complementary to the strengthened affordability and accessibility of health care across the continent as a result of leveraging the benefits of AfCFTA. AfCFTA is the world's largest free trade area since the creation of the World Trade Organization. When fully rolled out, AfCFTA will consolidate the currently fragmented markets of Africa into a single market of more than 1.3 billion people

[5] Titan Alon and others, "The impact of COVID-19 on gender equality", Working Paper 26947 (Cambridge, MA: National Bureau of Economic Research, 2020).
[6] Alison Andrew and others, "How are mothers and fathers balancing work and family under lockdown?" IFS Briefing note BN290 (London: Institute for Fiscal Studies, 2020).
[7] See footnote 5 above; and Sarah Cattan and others, "Trying times: how might the lockdown change time use in families?" IFS Briefing note BN284 (London: Institute for Fiscal Studies, 2020).
[8] African Development Bank, *African Economic Outlook 2020: Developing Africa's Workforce for the Future* (Abidjan, Côte d'Ivoire, 2020).

(projected to rise to 1.7 billion by 2030) and GDP of over $3.4 trillion. At the regional level, AfCFTA offers enormous economic opportunities for subregional economies. For example, as one of the most dynamic subregional economies, the East African Community, with a combined GDP of $880 billion and a population of 420 million, has the potential to generate gains of between $737 million and $1.1 billion and to create 2 million new jobs.[9]

The potential of AfCFTA in the health sector was recognized when ECA, in collaboration with the African Union Commission, the African Union Development Agency, the World Health Organization, the Joint United Nations Programme on HIV/AIDS, the Intergovernmental Authority on Development and Seychelles, representing the continent's small island States, commissioned a pharmaceutical project piloted in 10 African countries, namely, the Comoros, Djibouti, Eritrea, Madagascar, Mauritius, Rwanda, Seychelles and the Sudan, anchored by Ethiopia and Kenya. The pilot project follows a three-pronged approach: assessing the feasibility of a pooled procurement process; capacitating local production, while ensuring quality products; and engaging the private sector across the entire pharmaceutical value chain to play its important role in shaping health outcomes in the continent. Furthermore, the project focuses on maternal, neonatal and child health to highlight the effectiveness of pooled procurement, local production and quality standards in efforts to attain the Sustainable Development Goals and the Agenda 2063 goals of increasing the availability of essential medicines for mothers and children; and increasing the number of women whose reproductive health needs have been met, leading to an increase in the number of women in the productive and economically viable workforce.

The findings from the feasibility study and situational analysis of the 10 pilot countries are significant and confirm that AfCFTA represents a continentally anchored investment blueprint of scale for the socioeconomic transformation of African States, including the improved health of women and children and productivity gains. For example, from a total procurement budget of $1.3 billion in the 10 countries, cost savings of 43 per cent can be realized through pooled procurement. In Ethiopia and Kenya, as key pharmaceutical producers in East Africa, locally produced products are procured at rates which are some 4–5 times cheaper and sold at retail prices which are 5–10 times lower than those of imported products – thus becoming more affordable. As a result, Governments gain fiscal space through cost savings and consumers improved affordability of medicines. The efficiency gains through improved access and availability will improve the health status of women and children by an estimated 5–15 per cent with substantial productivity gains.[10]

The centralized pooled procurement of the pharmaceutical initiative, anchored in AfCFTA, which is recommended for all ten pilot countries, was based on the market readiness assessment score[11] across all parameters. The model was found to be beneficial for all participating countries with smaller countries likely to gain slightly more than larger countries,

[9] Economic Commission for Africa, *Creating a Unified Regional Market: Towards the Implementation of the African Free Trade Area in East Africa* (Addis Ababa, 2020).

[10] Economic Commission for Africa, "Assessing the situational analysis and feasibility of the AfCFTA – anchored pharmaceutical pilot project in 10 select countries in Africa and focused on reproductive, maternal and child health products (RMNCH)", discussion paper, 2019.

[11] The following market readiness assessment score indicators are used in the feasibility study and situational analysis report: population size; health burden profile; percentage of pharmaceuticals imported; health financing; supply pool size; procurement profile; logistics and distribution profile; human resources; governance profile; medicine regulatory capacity; data and information technology.

but with an overall positive effect of 7 per cent in terms of availability, access and affordability.[12]

A complementary initiative, the Africa Medical Supplies Platform (AMSP), was launched in June 2020 by Cyril Ramaphosa, President of South Africa, in his capacity as current Chair of the African Union. The platform is a collaborative project of the African Union, the Africa Centres for Disease Control and Prevention, ECA, the African Export-Import Bank (Afreximbank), under the leadership of African Union Special Envoy, Strive Masiyiwa. The AMSP portal – which is an offshoot of the AfCFTA pharmaceutical initiative – is a digital consolidated online marketplace that facilitates the provision of COVID-19-related medical products by addressing supply chain issues such as shortages, delays in distributing supplies, accessibility and affordability. According to preliminary estimates, COVID-19-related pharmaceutical products purchased through the platform cost 30–50 per cent less than on the international market, resulting in substantial economic gains.

Key findings from the AfCFTA-anchored pharmaceutical initiative indicates improvements ranging from 21 to 76 percentage points in the accessibility of family planning products in the 10 pilot countries, which demonstrates a demand gap by women and concurrently presents a business opportunity for the private sector – for both local and regional suppliers – stemming from the aggregation of African countries into a single market by AfCFTA. For example, oxytocin (as the first line medicine on call for controlling post-partum haemorrhage in maternal health) is largely an imported pharmaceutical product, imported by both public and private bodies with uncoordinated quality control and supply chain management. Strategic public-private partnerships both in the local production of maternal and child essential medicines and in ensuring a harmonized regulatory quality standard are a vital component of investments in women's health achieved by leveraging the benefits of AfCFTA. Despite the potential benefits of public-private partnerships, private sector involvement and contributions to financing in Africa have not been optimized. Challenges in enhancing the role of the private sector include the lack of effective dialogue among stakeholders; weak regulatory systems and policies specifically related to health financing schemes and strategies; and a poor environment in terms of ease of doing business.

The key importance of the AfCFTA pharmaceutical initiative, consisting in its ability to enlist the private sector in playing a critical role in addressing market distortions in the health sector, was convincingly demonstrated by the findings of the feasibility and pooled procurement reports. Lessons learned from the 10-country study include the need to engage the private sector in forming partnerships with African governments to improve health outcomes and the importance of scaling up the initiative to other subregions across the continent. In response, the African Business Coalition for Health has started discussions with ECA and partners to roll out the initiative in West Africa, working along with the Private Sector Health Alliance of Nigeria in selected countries to sustain the project.

In conclusion, it is clear that investing in women's health has positive socioeconomic repercussions: results of the AfCFTA-anchored pharmaceutical initiative pilot project have demonstrated its significant positive effects on the availability, accessibility and affordability and efficacy of maternal and child pharmaceuticals and, in purely economic terms, on health investments, job creation, cost savings and productivity gains. Some obstacles still remain to the readiness of markets to take full advantage of AfCFTA, including the lack of harmonized

[12] The feasibility study and situational analysis report is being adopted by all the 10 participating countries.

quality standards and institutions. Recognizing this challenge, at its thirty-second ordinary session in February 2019, the Assembly of Heads of State and Government of the African Union adopted decision Assembly/AU/Dec.735(XXXII), by which it reaffirmed decision EX.CL/1141(XXXIV) of the Executive Council to establish the African Medicines Agency, placing emphasis on investment in regulatory capacity strengthening. The African Medicines Agency is a specialized agency of the African Union, entrusted with the regulation of medical products in order to improve access to quality, safe and efficacious medical products on the continent. This will result in improved trading in health-care products and improved women's health and will stimulate local production and facilitate coordinated national and regional regulatory schemes.