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**FRAGILE STATES FACING THE
PROBLEM OF HEALTH AND
DEVELOPMENT.
A FOCUS ON AFRICA.**

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A Federico, alla mia famiglia

Il capitale dei poveri è la salute

Oscar Rodriguez Maradiaga

La salute è il miglior guadagno ...

Siddhārta Gautama Buddha

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INTRODUCTION

This work lays in the middle of a debate as much economic and political as social: the centrality of health in a fragile state's development. Actually, I have decided to begin my thesis analyzing the concept of development through an historical perspective that shows its permanent evolution till reaching its substantial identification with the concept of economic development. Economic development (through economic growth) leads to improved quality of people's lives.

Contextualized in this development debate, health, being a fundamental human right, not only is essential for allowing people to benefit from their "freedoms"¹ but also it is a fundamental prerequisite of each society in order to achieve its own development goals. Hence, health can be assessed both in "social" terms, as "substantive freedom" that improves life and in economic terms as basis for people's economic productivity.

The recognition that health is essential for economic development and for improving human development has led health being at the heart of the Millennium Development Goals (MDG).

However, as argued in Chapter 3, there are countries classified as fragile, experiencing terrible health conditions, that hardly will meet any of health related MDGs by 2015.

In the light of existing definitions of "fragile states", I have tried to give a thorough explanation of state fragility and its effects on development and health.

The most inhibiting factor of development in fragile states are weak state institutions.

Yet, since institutions and political processes normally shape policies, the good or poor quality of these same institutions would in turn affect their societies. Fragile states' institutions are unable to provide norms and rules but also to guarantee not even the core public functions which are expected

¹SEN, A (1999). *Development as freedom*, Oxford, Oxford University Press.

to do; firstly for the security and well being of their citizens, but also for the good functioning of the international system.

States characterized as fragile or conflict-affected usually record far worse population's health indicators than states at similar levels of development. Evidence is increasing on the fact that they have the worst levels of achievement in relation to 2015 health related MDGs.

I decided to focus my study on Africa, in particular on African countries belonging to the Sub-Saharan region because their performances in achieving health-related MDGs prove to be the litmus test for the legitimacy and the consistency of African governments.

Considering the Organisation for Economic Co-operation and Development's list of Fragile States (2012), approximately three quarters of states on the list are affected by an ongoing armed conflict. Africa is one of the most conflict-ridden area in the world; it keeps on witnessing increasing number of conflicts even if less intense than in the past.

Pandemic HIV/AIDS infection along with still too high child and maternal mortality rates have driven African leaders to take cognizance of the fact that MDGs offer the great opportunity to save the lives of million people and to win the challenges of achieving rapid and sustainable socioeconomic development, in order to integrate the continent into the reality of the world economy.

Nevertheless, considering persisting poor health outcomes, it seems that these same African leaders hardly have been able to keep their promises. Starting from empirical data demonstrating the existence of weak links between public spending and good health development results, I have tried to survey in Chapter 5 if it would mean that weak African governments are spending resources on unproductive activities rather than spending them on health services. It has been proved that the leakage of revenues and the consistent public fund readdressing leave governments with less to spend on social sectors, as health and education.

Effectively, corruption and weak governance unravel the reason why resources allocation have not necessarily translated into improved health outcomes.

Yet, resources misallocation does not limit to the highest levels of governments but it creeps also into the same health sector which is assessed one of the most corrupt sectors in Africa.

What distinguishes this form of corruption is its low visibility together with its silence that let it be ubiquitous in Africa health sector but simultaneously not measurable.

Therefore, in addition to existing empirical data, in Chapter 6 I have also reported some true experiences of African victims of corruption in order to give proof of the extent to which “quiet corruption”,² even if not involving big monetary transactions, affects directly larger number of beneficiaries over a long time.

² WORLD BANK (2010), *Silent and lethal. How quiet corruption undermines Africa's development efforts*. Africa Development Indicators. World Bank Publishing, p. 1.

CHAPTER 1: HEALTH IN DEVELOPMENT

“economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace”³

1.1 Introduction

According to the words of the United Nations Secretary General Kofi Annan in 2000, health is the biggest desire of men and women around the world.⁴ The social “daily concern” of diseases and ill health that prevents people from attending school or work and from living adequately joining community activities, has let health being included among human basic rights.

Yet, “the right to the enjoyment of the highest attainable standard of physical and mental health” has its roots in the 1946 Constitution of the World Health Organization (WHO), whose preamble defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.⁵ At that time, the declaration already stressed a living matter, that on discriminations: “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”

Further, it states: “the health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States” and recognizes that “the Governments have a responsibility for the

³WHO, (1978), *Declaration of Alma-Ata, International Conference on Primary Health Care*, Alma-Ata, USSR, 6-12 September 1978.

⁴A Millennium Survey sponsored by Gallup International in 1999 has collected the opinion of 57.000 adults in 60 countries on what matters most for them in live. They have answered that “good health and a happy family life”count more than anything (quoted in ANNAN A. K. (2000), *We the peoples. The role of the United Nations in the 21st century*. New York. United Nations Publishing).

⁵ WHO, (1946), *Constitution of the World Health Organization*. WHO Publishing.

health of their peoples which can be fulfilled only by the provision of adequate health and social measures”.

Article 25 of the 1948 Universal Declaration of Human Rights states that:

*Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.*⁶

Not only it recognizes health as human right but it links to it another fundamental human right as that of security.

The same Universal Declaration of Human Rights focuses special attention on more vulnerable women and children:

*Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.*⁷

Therefore, the right to health cannot be conceived as mere access to health care but it is a broader concept encompassing all other underlying contributors to an healthy life, such as adequate sanitation, health-related education and information, gender equality, safe food and drinking water and healthy working and environmental conditions. It guarantees also the freedoms from non-consensual medical treatment as medical experiments or tortures and punishments.

The right to health inherently contains the right to prevention, treatment and control of diseases as well as the right to access to essential medicines; the right to benefit of equal, quality and adequate basic health services is already embraced by the larger “right to health”.

⁶ UN GENERAL ASSEMBLY, (1948), *Universal Declaration of Human Rights*, art.25.

⁷ *Ibidem*

The International Covenant on Economic, Social and Cultural Rights in 1966 recognized “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”; the singularity of this international document is its equal attention to physical and mental health, usually ignored, and its direct reminder to States to adopt some adequate steps, fundamental for:

- (a) The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child;*
- (b) The improvement of all aspects of environmental and industrial hygiene;*
- (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;*
- (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness;*⁸

in order to reach the full realization of the right to health.

Several other international declarations and conferences have contributed in stressing the central role of health.

Towards the end of 1970s, the concept of health as human right seemed to be firmly confirmed. In order to fulfil the “Health for all by the year 2000” goal, ratified in 1977 during the 30th World Health Assembly, the following year in Alma Ata, it was adopted the Primary Health Care strategy. The Alma Ata Declaration in 1978 considered basic primary health assistance as completing part of the health system of every country; but, above all of the “acceleration of social and economic development”⁹.

About twenty years later, the United Nations Millennium Declaration¹⁰ and the Millennium Development Goals¹¹ reiterated the role of health as beneficiary and

⁸ UN GENERAL ASSEMBLY, (1966), *International Covenant on Economic, Social and Cultural Rights*.

⁹ WHO, (1978), *Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978*.

¹⁰ UN GENERAL ASSEMBLY, (2001), *Road map towards the implementation of the United Nations Millennium Declaration, Resolution A/56/326*.

contributor to development and a key indicator of what the same human development tries to achieve.

1.2 Historical perspective on the concept of development

Over time very few concepts have taken on so different and broad meanings as that of development. Hence, the concept of development, like other fundamental concepts as freedom, democracy or justice, can be better analyzed if properly contextualized. Effectively, there is large agreement on the consideration that “there can be no fixed and final definition of development, only suggestions of what development should imply in particular context”¹².

The concept of development should be generally integrated in a broad societal context and adapted to the very aims of an ever changing society. This explains the substitution of the previous immanent idea of development, as something incorporated into history, by the current conceptualization of it as strictly depending on society actors’ interests.

Hence, the “original” meaning of development might express the qualitative improvement of society.

Therefore, different conceptions of development over time have resembled changing societal purposes.

The end of the World War II got off a new development thinking era marked by the primary need of post-war reconstruction and by the resolute belief in modernization and consequent economic growth.

In the context of the competition of the two superpowers imposing their own economic systems, poverty and lack of development became a security issue. Indeed, fearing that communism would take advantage of European vulnerability after war devastation, the US adjusted some containment measures, such as the Marshall Plan in 1947: a first exemplar contribution to future international development assistance.

¹¹ UN GENERAL ASSEMBLY, (2000), *United Nations Millennium Declaration*, Resolution 55/2.

¹² HETTNE B, (1995), *Development theory and the three worlds: towards an international political economy of development*, Harlow, New York, Longman, p.15 (quoted in KNUTSSON B, (2009), *The intellectual history of development. Towards a widening potential repertoire*. Perspectives N. 13. School of Global Studies. Goteborg, p. 2).

Yet, given the contemporary new attention on the concept of Third World and developing countries, the words of President Truman for the presentation of his “Point four Program” in 1949, contributed even more to the promotion of international development assistance. Stressing the importance of committing to a major development assistance since “their poverty” would hindered world security, Truman underlined the need for industrialized countries to become a model of development to be followed by stagnating countries. “Fourth, we must embark on a bold new program for making the benefits of our scientific advances and industrial progress available for the improvement and growth of underdeveloped areas. ... Their economic life is primitive and stagnant. Their poverty is a handicap and a threat both to them and more prosperous areas”.¹³

Actually, since during the same period began also the second phase of the decolonization, another acceptance of the issue of development disclosed: the concept of backwardness. Accordingly, poor countries should be considered rich countries as a model to follow in order to reach their development level.

Starting from this moment, the concept of development has experienced a substantial identification with the concept of economic growth. According to many scholars, the emergence of development economics in this same period, seems to be due to the same issues of decolonization, modernization and developing countries.

“Basically, all development economists in this period shared two fundamental notions: development equals economic growth and a large injection of investment is crucial in order to achieve it”¹⁴. But the lack of domestic investments of that age could be arranged with more domestic savings and more international development assistance.

Development models established in 1940s and 1950s prevailed in the 1960s together with the problem of backwardness in many developing countries, albeit increasing intervention strategies aiming to promote economic growth as driving force of development.

¹³ TRUMAN S.H, (1949). *Inaugural address*. January 20th, 1949.

¹⁴ KNUTSSON B, (2009), *The intellectual history of development. Towards a widening potential repertoire*. Perspectives N. 13. School of Global Studies. Goteborg, p. 11.

Nevertheless, around 1965 the focus of the debate on development moved from wealth creation to the ability to create it, an ability that strictly depends on a country's population.

Hence, in that period economists considered development, but not actually economic growth, the main problem of developing countries. According to his point of view, development means growth linked to a change; this change should in turn affect not only merely economic but also social and cultural aspects in addition to qualitative rather than quantitative factors. This meant that better nourishment, better education and better health would have improved countries' growth.

In 1970 the United Nations stated that a "second development decade"¹⁵ has begun; during which it became more evident that development should go beyond purely economic conceptualization. The events coming in succession over that period, from *détente* to the breakdown of Bretton Woods system and the progress in communication technology, let the Third World countries responding to the shaping international economy's structure that was disfavouring them. However, even though their demands were ignored by developed countries, contextually poverty and inequality alleviation, creation of employment and basic needs' fulfilment became the aims of the new development strategies promoted by the World Bank and the International Labour Organization.

Meanwhile, many supporters of the dependency theory coming from developing countries, denounced that the main development problem was the exploitation of poor countries by the richest ones. Accordingly, they argued that underdevelopment was not an original condition rather a created status to be found in the colonial penetration and in the international division of labour and resources between centre (developed countries) and periphery (underdeveloped countries).

Actually, also dependentists' contribution played a significant role in letting the development debate more aware of the importance of other factors external to the

¹⁵ UN GENERAL ASSEMBLY, (1970). *International Strategy for the Second United Nations Development Decade*. Resolution 2626 (XXV).

classical development economics, such as environmental or gender and ethnic related problems; those belonging to the so called “another development”.¹⁶

The simultaneous election of Ronald Regan, Margaret Thatcher and Helmut Kohl in West Germany brought with it neoliberalism and monetarism as the key elements of the international economic attitudes during the 1980s.

The succession of events like the dissolution of the bipolar world order, the oil crisis and the international debt crisis, has marked the decline of the primary interest for the social aspects of development, largely sustained in the previous decades. Actually, since the macro-economic stability became of central importance for the economists of that time, the dependency school was substituted by the concept of sustainable development. Therefore, in line with the pillars of neoliberalism, the main development problem became the threat that it could impose on the present and future generations.

Hence, many ideas belonging to the concept of development, centred on human being, already mentioned in Human Right Declaration soon after World War II, were neglected since stabilization and structural adjustment programmes promoted by the World Bank and by the International Monetary Fund gained even more central role.

However, development mainstream of 1980s shared a different aspect of the classical concept of modernization and economic growth; it actually focused on market as the most important agent for development so depriving state of its previous central role.

The criticism against the demands of the World Bank for quick results from developing countries came from several development scholars at the end of the decade. They asserted that this pressure would in the end, just prevent the adoption of a stabilization strategy adequate to the real need of the population. As a matter of fact, during this process of economic liberalization, adjustment and privatization, the concern regarding increasing social inequalities, poverty and other vulnerabilities has been ignored. Social inequality kept on increasing in developed and developing countries as consequence of a long stable economic growth.

¹⁶ UN (1975). *What now : [another development] : the 1975 Dag Hammarskjöld report* prep. On the occasion of the seventh special session of the United Nations General Assembly. Uppsala.

Yet soon, also the neoliberal discourse was abandoned. Accordingly, the state got back its original centrality in providing its society with basic social services and with a functioning institutional framework in order to let market economy working. The 1990s decade marked the beginning of the new “good-governance” era, during which even the concept of development was adapted to the new mainstream. Hence, human development and pro-poor growth contributed to reorient structural adjustment towards a more human and social dimension.

Poverty Reduction Strategies (PRS), fundamental in the debt cancellation initiative (HIPC) for the heavily indebted poor countries, were employed as direct instruments of recipient countries’ governments in order to better satisfy the needs of their own populations.

Yet, while economic globalization accelerated in 1990s, greater disparities disclosed among countries. Indeed, the Human Development Report of 1992¹⁷ recorded that “between 1960 and 1989, the countries with the richest 20% of world population increased their share of global GNP from 70.2% to 82.7%. The countries with the poorest 20% of world population saw their share fall from 2.3% to 1.4%” therefore even more humanitarian interventionism, above all in conflict areas, was stressed.

The so-called “New Wars”, encompassing globalization, identity politics, violation of human rights and organized crime as well, substituted the old security concern due to the communist threat. Development again was linked to security issues strictly dependent on maldevelopment and poverty. These renewed security issues were AIDS/HIV, other communicable diseases, environmental destruction, terrorism and civil war relative to political instability.

¹⁷ UN DEVELOPMENT PROGRAMME (1992). *Human development report 1992*: Oxford University Press, p.34

1.3 “Development as freedom”¹⁸

“It is mainly an attempt to see development as a process of expanding the real freedoms that people enjoy. In this approach, expansion of freedom is viewed as both (1) the *primary end* and (2) the *principal means* of development. They can be called respectively the ‘constitutive role’ and the ‘instrumental role’ of freedom in development. The constitutive role of freedom relates to the importance of substantive freedom in enriching human life. The substantive freedoms include elementary capabilities like being able to avoid such deprivation as starvation, undernourishment, escapable morbidity and premature mortality, as well as the freedoms that are associated with being literate and numerate, enjoying political participation and uncensored speech and so on. In this constitutive perspective, development involves expansion of these and other basic freedoms. Development, in this view, is the process of expanding human freedoms, and the assessment of development has to be informed by this consideration”.¹⁹

These are the famous words written by Amartya Sen that have marked the beginning of a new development era: that of human development which poses individuals at the centre of development.

Accounting for previous conceptualizations on development, it has been generally conceived as improved Gross National Product (GNP) and pro-capita income through industrialization, international trade, Foreign Direct Investment (FDI), technology and more recently, through the strengthening of the so-called human capital. In order to understand the reasons behind the failure of the application of the “economic theory” on development in developing countries, Amartya Sen finds that is “unfreedom” that hinders human achievement.

According to Sen, development must be conceived as “a process of expanding the real freedoms that people enjoy”²⁰. In order to develop and accordingly to live better, it is necessary to remove all the major causes hindering freedom: tyranny, poverty, lacking public services, poor economy. Actually, it’s the same lack of so-

¹⁸ SEN, A (1999), *Development as freedom*, Oxford, Oxford University Press.

¹⁹ *Ivi*, p.36.

²⁰ *Ivi*, p.3

called “substantive freedoms” that entails poverty which in turn prevents people from sufficiently feeding, from receiving adequate health cares, from having access to safe-water.

His capability approach lets freedoms being not merely the primary aims but also the instruments of development, because they are so strictly interrelated that the achievement of a freedom is functional in the achievement of another. Political freedoms, for example, can actually contribute to the achievement of the freedom to be educated. “Political freedom” as democracy and freedom of speech, “economic facilities” as the freedom to conduct business and economic redistribution, “protective security” as social security framework, “transparency guarantees” as public transparency and “social opportunities” as freedoms to benefit of health and education services, are all “instrumental freedoms”.

Therefore, the concept of development as enlargement of human freedoms is more complete than development conceived as economic growth. Income level is not always the right indicator to assess those things considered worthy. In order to measure those necessities that go beyond economic wealth, it is necessary to assess some external variables like the possibility to outlive, enjoying good health within a safe and pacific community. Hence, rather on income, the attention is focalized on human beings and their capacity to be responsible for their own and other people’s wellbeing. From this follows that development and income are not the same thing, however they are often interconnected. The capabilities (freedoms) indirectly influence economic growth if assimilated in the human capital, as well as the social change.²¹ Nevertheless, they can also directly affect development: the capability of being adequately educated entails better abilities in communicating, in reading, in writing, the opportunity to be well considered by other people.

Yet, this conceptualization of development gives a country’s government, but also the entire society, great responsibility in contributing to the enlargement of freedoms. Indeed, individual freedom is fundamental in letting the individual responsible to act in order to improve his wellbeing (and that of other people). Nevertheless, individual freedom is not exempt from personal, social and

²¹ According to Sen (1999), data have demonstrated that the enlargement of education among girls influences fertility and child mortality rates.

environmental influences; just considering that when a child is deprived of his/her freedom to attend school, he/she will be conditioned lifelong since this unfreedom will make him/her less able to exercise his/her responsibilities.

Therefore, considering freedom the fundamental variable, development becomes the process through which the individual can fulfil the status of living that he/she considers appropriate for him/herself, according to his/her personal wellbeing criteria; therefore, a status subjectively estimated and estimable.

1.4 Health in development

Within the same development context as considered by Sen, it must be accepted that improving health of people proves to be a major aim of development.

Amartya Sen,²² by means of the story of a discussion about the ways to earn money between an Indian couple of the eighth century BC, pays attention on the real nature of human condition and the limits imposed by the material world. Indeed, contrary to the reflection of the wife, how far would wealth go to help them to get immortality, Sen states that there is actually a connection between wealth and health, nevertheless it is not so strict as it is depend on circumstances. “The usefulness of wealth lies in the thing that it allows us to do the substantive freedoms it helps to achieve. But this relation is neither exclusive (since there are significant influences on our lives other than wealth) nor uniform (since the impact of wealth on our lives varies with other influences). It is as important to recognize the crucial role of wealth in determining living conditions and the quality of life as it is to understand the qualified and contingent nature of this relationship. An adequate conception of development must go much beyond the accumulation of wealth and the growth of Gross Nation Product and other income-related variables. Without ignoring the importance of economic growth, we must look well beyond it.”²³

²² SEN, A (1999). *Development as freedom*, Oxford, Oxford University Press, Chap.1.

²³ *Ivi*, p.14.

Since among the fundamental freedoms enhancing development there is also the freedom from “avoidable ill-health and from escapable mortality”, the relationship between welfare and good health must be analyzed.

Considering the relationship between a country’s wealth, represented by pro capita national income, and its health, expressed by life-expectancy indicator, it results that as the income increases also life-expectancy increases. Nevertheless, at a certain level of income, the differences on life-expectancy become minimal and the influences of the wealth on health is less strong. This could mean that these improvements in health are no more linked to the living standard of a population, since they could be influenced by other factors such as a country’s welfare, education, good health system, access to safe water; the so-called “instrumental freedoms”.

According to Sen, African Americans’ lower incidence of survival compared to much (economically) poorer Chinese or Indians, shows how life-expectancy could depend on higher income per capita. Nevertheless income, although its positive influence, is not the only contributory factor to better health since other social factors as medical coverage, prevalence of violence, school education and public healthcare contribute to increase life-expectancy.

Yet, the mutual relationship among income and better health entails in turn that better health and survival have great influence on increasing income; healthy people are able to earn income that in turn, can guarantee better nutrition and the possibility to benefit of quality health services in order to enjoy the freedom of a healthier life. Diseases impede well-being and development through a more direct way: avoidable diseases reduce the working age of a person; accordingly, the economic drop due to premature death or chronic disability is high. Disease can have also indirect effects on parents’ investment on the education of their children. Those societies with higher neonatal and infant mortality, usually compensate these frequent losses with higher fertility rates. However, having more children in turn, reduces the economy capacity of parents to properly invest on children’s health and education.

The same Human Development Reports of 1992²⁴ underline the extent to which life-expectancy from 50 to 70 years helps to increase of 1.4 annual percent points the growth rate while a decreased 10 percent in malaria incidence in developing countries entails an annual growth rate increasing of 0.3 percent.²⁵

In virtue of several empirical evidences from different countries recording a substantial improvement of health conditions even without or just poor economic growth levels, as in China and in India, it is necessary to go beyond the mere connection between economic growth and life-expectancy.

Sen, as well as other scholars have found a positive correlation between life-expectancy and Gross National Product per capita, but it holds also true that this positive relationship really works through higher (better) expenditure on healthcare and through the eradication of poverty. As a matter of fact, there are some policy factors weakening the connection between economic progress and health improvement. These policy factors are often linked to the way in which income generated by economic growth is actually used; if it is actually addressed to improve public services and to eradicate poverty or if it is used for purposes far from social benefits (like education and health).

In this context, another instrumental freedom of Sen's considerations, plays a fundamental role in the legitimate resources allocation, that is the political freedom of society to be informed and to participate in this checking process.

Within this analysis of health's contribution to development, worth mentioning also the strict relationship among (ill) health and poverty.

Considering again the capability approach of Sen, poverty is defined as "a deprivation of basic capabilities, rather than merely as low income. Deprivation of elementary capabilities can be reflected in premature mortality, significant undernourishment (especially of children), persistent morbidity, widespread illiteracy and other failures."²⁶ The possibility that people has to "satisfy" these elementary capabilities could certainly depend on their initial resources

²⁴ BARRO R.J.(1996). *Health and economic growth*. Washington, DC, World Bank Publishing.

²⁵ GALLUP J.L, SACHS J.D. (2000). *The economic burden of malaria*. CID Working Paper No.52, Centre for International Development Harvard University.

²⁶ SEN, A (1999). *Development as freedom*, Oxford, Oxford University Press, p.21

availability but also on personal abilities to translate these same resources in “functionings”.

Because of its direct and indirect impacts, health is one main determinant of poverty incidence and of its persistency.

Nevertheless, ill health is simultaneously cause and consequence of poverty. It has been estimated that every year about 100 million people become poor because of health-related costs (including out-of-pockets payments).²⁷ Yet, the impossibility to afford these costs, let pre-existing illness even worsen; ill-health in turn, hindering people to work or to study, limits even more productivity.

This recalls the famous concept of “poverty trap” due to the impossibility of countless poor people to collect human capital in order to enlarge their choices and their opportunities of improvement.

²⁷ WORLD HEALTH ORGANIZATION (2010). *Global status report on non-communicable diseases*. WHO Library.

CHAPTER 2: THE CHALLENGES OF THE MILLENNIUM: THE MILLENNIUM DEVELOPMENT GOALS

“The Millennium Development Goals (MDGs) have been the most successful global anti-poverty push in history [...] We are now less than 1,000 days to the 2015 target date for achieving the MDGs [...] one in eight people worldwide remain hungry. Too many women die in childbirth when we have the means to save them. More than 2.5 billion people lack improved sanitation facilities, of which one billion continue to practice open defecation, a major health and environmental hazard. Our resource base is in serious decline, with continuing losses of forests, species and fish stocks, in a world already experiencing the impacts of climate change.”²⁸

2.1 Introduction

The attitude towards development cooperation has gone hand in hand with the evolution of the concept of development. Its origins coincide with the reconstruction plans just after the World War I, but in particular, with the constitution of the League of Nations, whose primary goal was to maintain world peace through an international economic and social cooperation.

Despite the project’s failure due to the urge of the World War II, the League of Nations represented the first step made by Countries to go beyond their egoistic interests of expansion. In 1941 the Atlantic Charter, drafted by U.S. President Roosevelt and British Prime Minister Churchill and stating the rights of the populations to be free from want and from fear, paved the way for the creation of the United Nations Organization (UN) in 1945.

²⁸UN Secretary-General Ban Ki-Moon in United Nations (2013), *The Millennium Development Goals Report*, UN Publishing, p. 8.

The commitment of the United Nations Member States to undertake any individual or collective actions, in collaboration with the UN Organization, in order to promote the international economic and social cooperation is stated in the article 55 of the San Francisco Charter:

With a view to the creation of conditions of stability and well-being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote:

- a) higher standards of living, full employment, and conditions of economic and social progress and development;*
- b) solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; and*
- c) universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.²⁹*

And in the article 56:

All Members pledge themselves to take joint and separate action in co-operation with the Organization for the achievement of the purposes set forth in Article 55.³⁰

Similar dispositions in such a constituent act of an international organization, represented a meaningful deviation from traditional international law that did not envisaged the obligation for a general cooperation.

During the years after World War II, have been established those several organizations and institutions that still today are of relevant contribution for the international cooperation, such as the International Bank for Reconstruction and Development (belonging to the World Bank), aimed at promoting and supporting national development plans; the International Monetary Fund (IMF), which

²⁹ United Nations (1945), *Charter of the United Nations*, San Francisco Conference, art. 55.

³⁰ United Nations (1945), *Charter of the United Nations*, San Francisco Conference, art. 56.

fosters the global monetary cooperation and finances the national debt of south and developing countries; and the Organization for Economic Cooperation and Development (OECD) supporting policies for the economic and social wellbeing at global level.

As the fifties and the sixties were devoted to the post war reconstruction and to the economic growth, the same goal of the contemporary commitment for development focused on income growth through the promotion of industrialization, which became a key factor for countries' progress and modernization. Moreover, during this same period became widespread the consideration that massive (technological and financial) resources transfer from economic developed countries to developing countries would be the only solution to increase their Gross Domestic Product (GDP) pro capita in order to make up for their development delay and to make them independent from external support.

Unfortunately, these first cooperation attempts proved to be unsatisfactory; meanwhile social and economic disparity as well as poverty, increased.

Therefore, the World Bank together with the United Nations undertook a new paradigm of cooperation, according to which the international support had to be translated into effective actions from which developing countries could directly benefit. Vaccinations, safe-water access, schools, hospitals and other rural infrastructures' construction were the initiatives undertaken.

This was the new approach of the so-called "basic human needs" that aimed to poverty reduction and to the improvement of living-conditions in developing countries. During the same period, several non governmental organizations made the scene in order to directly organize and finance specific (development) projects, such as the constructions of public infrastructures.

Yet, later these too specific projects funding were substituted by the financing of consistent programs, for example for applying economic reforms in developing countries. But also these programs of structural adjustments proved to be useless.

Actually, these same failures have led in the nineties the international community to rethink about the centrality of poverty reduction within the debate on development cooperation. Hence, poverty eradication together with the establishment of a new relationship between development and ecological and

social sustainability became the central aims of the renewed development cooperation community-driven approach, in a context of careful assessment of institutions and governance's quality.

As even more attention is given to the human being, nowadays the international cooperation considers development even more "human" and a goal to be achieved through the economic growth (as means). Therefore, the current paradigm of Human Development bases on:

- equality and equity;
- intra/inter generational approach;
- productivity of human factor;
- empowerment.

Even if this commitment has contributed to improve the living conditions of million of people, still persist huge disparities between developed and developing countries suffering for widespread rooted poverty. The larger concept of poverty encompasses not only the "economic" poverty, but also lack of nutrition, of health, of education and impossibility of social participation. In developing countries, one in three children is prevented from completing primary education, one in ten children dies before reaching his/her fifth birthday, nine in ten persons HIV/AIDS affected live in these countries.

All these facts have fuelled the international (states, NGOs, institutions) commitment in adopting a common development cooperation policy that is mostly characterized by Official Development Assistance (ODA). (See Box 2.1)

About donors' motivations to address their conspicuous support to developing countries, it has been discussed for a long time. It could be a sort of moral duty for donor countries to help developing ones or according to the economists, money invested in developing countries would have better output than the same amount spent in economically more developed countries. Consequently, through a sort of global interdependence, progress in poorer countries would increase the global demand translating into benefits also for donor countries.

Box 2.1 Official Development Assistance

Flows of official financing administered with the promotion of the economic development and welfare of developing countries as the main objective, and which are concessional in character with a grant element of at least 25 percent (using a fixed 10 percent rate of discount). By convention, ODA flows comprise contributions of donor government agencies, at all levels, to developing countries (“bilateral ODA”) and to multilateral institutions. ODA receipts comprise disbursements by bilateral donors and multilateral institutions.

— OECD, *Glossary of Statistical Terms*

2.2 The new challenges of the Millennium

The long debate on development and development cooperation discussed within the community of donor countries together with developing countries, in 2000 has led to the adoption of the Declaration of the Millennium.

The Declaration, ratified by the 189 member states of the United Nation General Assembly, represents a cornerstone for the creation of a development agenda based on the values of “freedom”, “equality”, “solidarity”, “tolerance”, “respect for nature” and “shared responsibility” which function as inspiration for the global political commitment.³¹

In order to translate these shared values into action, the Declaration gathers in every sections several objectives calling for the contribution of developed and developing countries on “development and poverty eradication”, “protecting our common environment”, “human rights, democracy and good governance”, “protecting the vulnerable”, “meeting the special needs of Africa”, “strengthening the United Nations” in addition to the “peace strengthening, global security and disarmament” objectives.

Hence, the disposition 5 states that:

We believe that the central challenge we face today is to ensure that globalization becomes a positive force for all the world’s people. For while globalization offers great opportunities, at present its benefits are very

³¹ UN General Assembly, (2000), *United Nations Millennium Declaration*, Resolution 55/2.

*unevenly shared, while its costs are unevenly distributed. We recognize that developing countries and countries with economies in transition face special difficulties in responding to this central challenge. Thus, only through broad and sustained efforts to create a shared future, based upon our common humanity in all its diversity, can globalization be made fully inclusive and equitable. These efforts must include policies and measures, at the global level, which correspond to the needs of developing countries and economies in transition and are formulated and implemented with their effective participation.*³²

One year later (2001), the most important exponents of the United Nations, together with the World Bank, the International Monetary Fund and the OECD signed the commitment for the achievement of the specific objectives known as Millennium Development Goals. During the fifty-sixth session of the General Assembly, the Secretary General presented a new document “*A road map toward the implementation of the Millennium Declaration*” which proposed the fragmentation of Sections III (“Development and poverty eradication”) and IV (“Protecting our common environment”) of the previous Declaration in eight Goals, eighteen targets and forty-eight indicators. (See Appendix 1)

Time-bounds targets (the majority have 2015 as deadline) function as useful means to keep a continuous and more regular system of recording and follow-up, even if some targets prove to be easier to be monitored than others. The 1990 has been selected as baseline year for the monitoring process which covers the entire decade during which all the conferences and the attempts to reach this project have taken place.

The attainment of MDGs requires a constant collaboration and a global interdependence among all private and public, governmental and non-governmental participants. The sharing of international experiences and information helps the international community to adopt better and more country-driven strategies of intervention.

The goals must be considered as a whole since they, together with targets, are interrelated. They have been conceived in order to establish a partnership among

³² *Ivi*, point 5.

developed and developing countries “to create an environment – at the national and global levels alike – which is conducive to development and the elimination of poverty”.³³

Hence, from Goal 1 (eradicate extreme poverty and hunger) to Goal 7 (ensure environmental sustainability) the commitment should be kept mostly by developing countries in order to improve those policies that should be crucial for their development. Goal 8 (develop a global partnership for development) instead, encompasses commitments mainly from developed countries to support the efforts of developing countries through a rearrangement of ODA distribution. It also encourages the collaboration for a more open trade and financial system.

Donors countries and developing ones have to face principally five challenges in order to obtain some good results in the MDGs achievement:

1. Finanziare lo sviluppo: uno dei problemi presenti nell'ambito della cooperazione internazionale e soprattutto nei riguardi delle ONG, è assicurare le risorse finanziarie sufficienti per raggiungere gli obiettivi; diverse sono state le idee nel modo in cui erogare finanziamenti ai progetti nei PVS. Un supporto economico da parte della comunità internazionale è indispensabile perché si possa intervenire rapidamente. Risulta, inoltre, fondamentale che i fondi finanziari raccolti siano utilizzati nel modo giusto, ovvero per migliorare le condizioni sanitarie e igieniche, le condizioni di salute e l'accesso e la qualità dell'istruzione nei paesi destinatari.

2. Migliorare l'efficacia degli aiuti: il modo migliore è ordinare gli interventi in base alle priorità identificate del paese beneficiario e migliorare il coordinamento con gli altri donatori operanti nel posto. I paesi beneficiari devono collaborare identificando chiaramente quali sono le priorità che gli aiuti sono chiamati a finanziare, migliorando la gestione e la trasparenza dei conti pubblici e permettendo in questo modo il monitoraggio dell'impiego delle risorse. La relazione che si instaura tra paese beneficiario e paese donatore deve basarsi su una reciproca fiducia, trasparenza e reciproca responsabilità in modo da permettere di raggiungere un interesse ed obiettivo comune.

3. Aumentare la coerenza delle politiche: la realizzazione degli MDG richiede politiche e condizioni coerenti e favorevoli all'obiettivo dello sviluppo, da parte dei PVS e dei paesi industrializzati, affinché gli interventi funzionino nel miglior modo possibile. Assicurare una coerenza

³³ UN General Assembly, (2001). *Road map towards the implementation of the United Nations Millennium Declaration*, Resolution A/56/326, p. 55.

significa anche ricostruire interessi, a volte diversi, che caratterizzano le diverse aree dell'azione di governo. Bisogna anche dire che la coerenza si misura anche rispetto alle modalità e volontà di collaborazione e coordinamento tra i donatori.

4. Ridurre la vulnerabilità dei PVS: in particolare ai disastri naturali, allo scoppio di conflitti, alle crisi economiche nei confronti soprattutto dei gruppi più vulnerabili della popolazione. I PVS sono caratterizzati da istituzioni deboli, da una struttura produttiva scarsa, da un'inadeguata capacità di prevenzione, di mitigazione delle conseguenze e di reazione; perciò il sollevarsi di uno dei fattori come quelli appena descritti, può causare disastri a livello economico, sociale e politico. La comunità internazionale gioca un ruolo importante nel diminuire la vulnerabilità: attraverso aiuti che contribuiscono alla prevenzione dei disastri con sistemi di monitoraggio e con la condivisione di informazioni e di allarme; finanziando fondi per rispondere alle situazioni di emergenza e per supportare la ricostruzione. Anche i paesi vulnerabili non devono essere considerati esenti nel fare questo, soprattutto essi devono essere considerati responsabili nell'adozione di politiche che minimizzino le conseguenze dei disastri, per esempio nella pianificazione urbana e nella libertà di informazioni. Anche la tutela dei diritti umani, programmi per la partecipazione delle donne e dei bambini, politiche di pacificazione sociale, promozione del rispetto della legge, creazione di programmi di sviluppo economici e sociali ed una promozione ad un accesso più equo alle risorse sono considerati fonte di riduzione della vulnerabilità di questi paesi.

5. Sensibilizzare l'opinione pubblica: si afferma che un'opinione pubblica più consapevole rispetto ai problemi che caratterizzano il mondo dei PVS, potrebbe garantire un'attenzione maggiore da parte dei governi ai problemi dello sviluppo e offrirebbe anche più sostegno alle agenzie che si occupano di cooperazione. Ciò si potrebbe conseguire per esempio attraverso l'aumento di fondi destinati all'educazione pubblica su temi di solidarietà e di sviluppo, così come cercare di inserire all'interno delle scuole un insegnamento sull'educazione allo sviluppo. La scuola dovrebbe quindi offrire ai ragazzi la possibilità di conoscere e sviluppare dibattiti e confronti su questi temi, in modo da creare anche una propria posizione a riguardo. Bisognerebbe dedicare inoltre più attenzione al rispetto, alla valorizzazione delle differenze, alla difesa dei diritti umani, all'analisi dell'interdipendenza globale e al rispetto dell'ambiente³⁴.

³⁴ BONAGLIA F, DE LUCA V. (2006). *La cooperazione internazionale allo sviluppo*, Bologna, Il Mulino, p.128-129.

The global commitment on development has been refreshed and implemented in several occasions during the time frame soon after the Millennium Declaration till today. In 2002 the Johannesburg Declaration has treated the matter of sustainable development; in 2005 and in 2008 international community leaders have met respectively in Paris and in Accra in order to sign the Paris Declaration to increase, harmonise and align aid effectiveness and its delivery.

The countries and the institutions involved have committed again to improve their collaboration in the achievement of development.

2.3 Country heterogeneity in MDGs performances

MDGs' performances deeply vary within regions and countries. Considering for example poverty rates in Sub-Saharan Africa, Bourguignon³⁵ reports that countries with same growth rates (annual 2.5 percent rate) as Ghana and Uganda, have experienced respectively an annual decrease of 4.6 percent and an annual increase of 3.8 percent of poverty rate between 1999-2006. Consequently, in those countries experiencing poverty decline, mortality rate has followed, reducing till an annual 2 percent, on the contrary it has increased more than 1 percent annually in those countries with worse performing poverty reduction.

Unfortunately, it is still hard to find the factors that differentiate so widely MDGs performances among countries. Moreover, it seems due not to a single reason, but to a complex combination of countries' features and their initial conditions, along with geographic and institutional features. This is the reason why every MDG is considered a goal independent from another; therefore their assessment must be separate. The multidimensionality of development remains valid, even if it is trapped in the contexts' net.

³⁵ BOURGUIGNON F. et Al. (2008). *Millennium Development Goals at Midpoint: where do we stand and where do we need to go?* European Report on Development, November 2008.

2.3.1 MDG 1: Eradicate extreme poverty and hunger

The MDG target has been met but according to MDG Report 2013, 1.2 billion people still face extreme poverty.

Data reveal that the target has been already reached five years aheads the 2015 deadline since the 47 percent of people living on less than US\$ 1.25 has become 22 percent in 2010. The proportion is still widespread in Sub-Saharan Africa which all in all has recorded a good progress.

Poverty is also fuelled by the actual (in 2012) slowing of the economic growth: it has hindered even more employment capacity of several developing countries.

“According to the International Labour Organization (ILO), unemployment has increased by 28 million since 2007, and an estimated 39 million people have dropped out of the labour market”³⁶; in addition, it must be considered that employment ratio (in 2012) still suffers for the gender gap, with a 24.8 percent points difference between men and women, especially in Northern Africa and Southern and Eastern Asia.

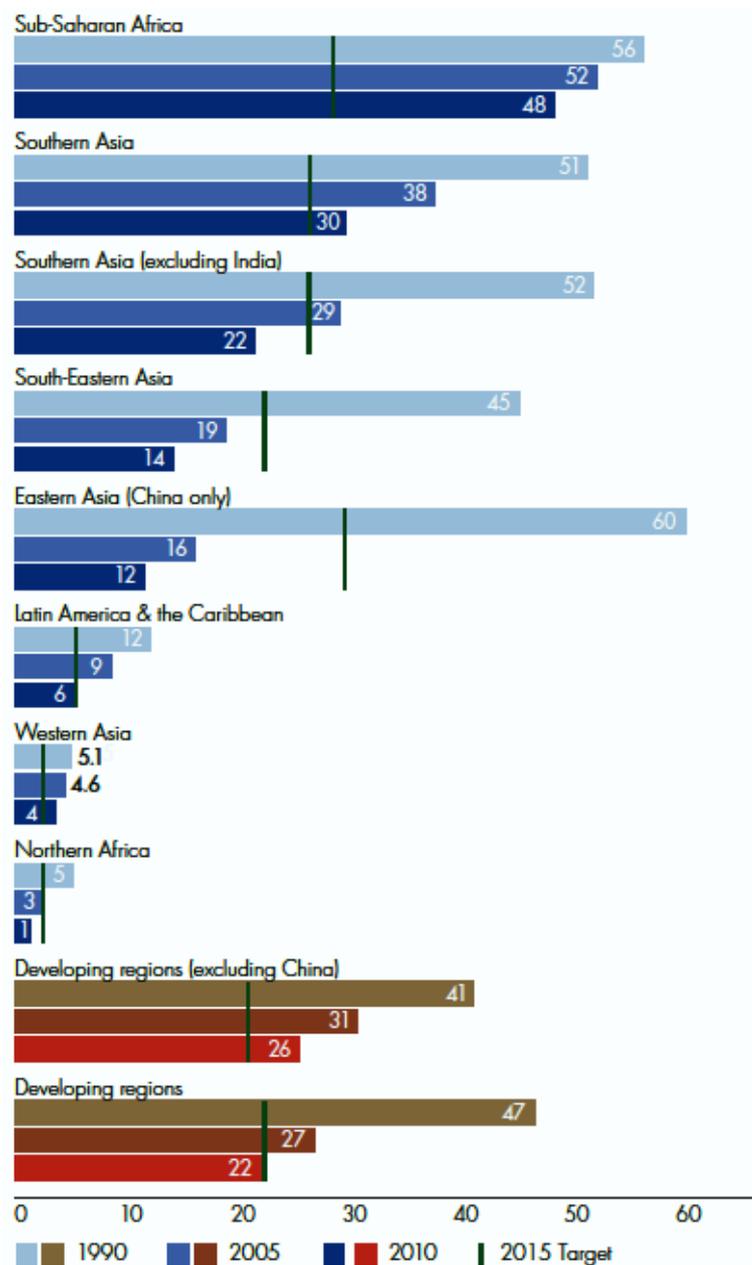
Strictly related to widespread poverty, are about 852 million chronically undernourished people (one in eight worldwide) in developing countries, despite their decreasing from 23.2 percent in 1990 to 14.9 percent in 2010-2012.

“Globally, an estimated 101 million children under age five were underweight in 2011. This represents 16 per cent of all children under five that year, or one in six. The number of underweight children in 2011 fell by 36 per cent from an estimated 159 million children in 1990. Still, this rate of progress is insufficient to meet the MDG target of halving the proportion of people who suffer from hunger by 2015”³⁷.

³⁶ UN (2013), *The Millennium Development Goals Report*, UN Publishing, p. 8.

³⁷ *Ivi*, p.11

Fig. 2.1 Proportion of people living on less than \$1.25 a day, 1990, 2005 and 2010 (Percentage)



Source: UN, MDG Report (2013)

Yet, since poverty is a key factor of hunger and inadequate access to food, it in turn indirectly affects labour productivity and the ability to generate income. This is the so-called poverty trap, which forces people to live (and survive) in poverty.

2.3.2 MDG 2: Achieve universal primary education

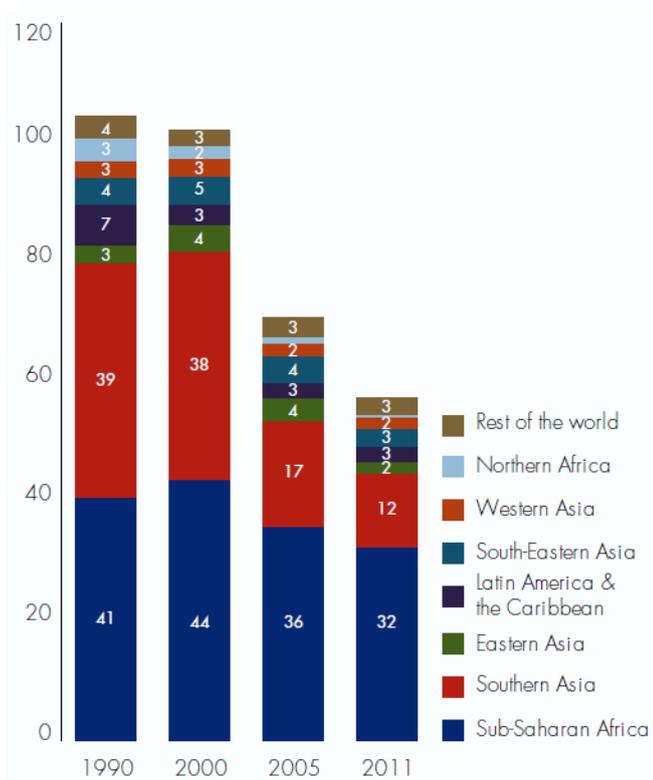
At a general level, developing countries have increased their net enrolment rate from 83 percent in 2000 to 90 percent in 2011. However, recent data show that this achievement has slowed. From 2008 to 2011 the number of children not attending school is decreased by only 3 million; this means that this Goal will be hardly met. Sub-Saharan Africa has the greatest number of children out-of-school (Fig.2.2); contrary to Southern Asia, that has made good progresses: the number of children going to school has increased from 78 percent in 2000 to 93 in 2011. Poverty functions as key factor of the slow progress in achieving MDG 4; according to MDGs Report 2013, children living in poorest countries are three time as likely to be out of school in comparison of children of richest countries. Yet, urban-rural gap as well as gender gap within the same country proves to be a deterrent for progress in guaranteeing children and girls wider access to school. Rural children out-of-school are nearly twice as likely to be out of school as urban children. In 63 countries girls don't have access to school more often than boys, but if they have the opportunity to start school, they usually complete the last grade of primary school, except in Eastern and Western Asia. Yet, at the global level, the majority of children attending school, do not complete even the first grade of primary school often because of poor health and nutrition or the potential risks along the way to reach school.

2.3.3 MDG 3: Promote gender equality and empower women

Developing countries have recorded good results in improving gender parity index (GPI)³⁸ which is (0.97) close to the accepted measure for parity of 1.03; but disparities among men and women still persist not only at all levels of education but also at employment levels.

³⁸ "GPI is defined as girls' school enrolment ratio in relation to boys' enrolment ratio" in United Nations (2013), *The Millennium Development Goals Report*, UN Publishing, p. 18.

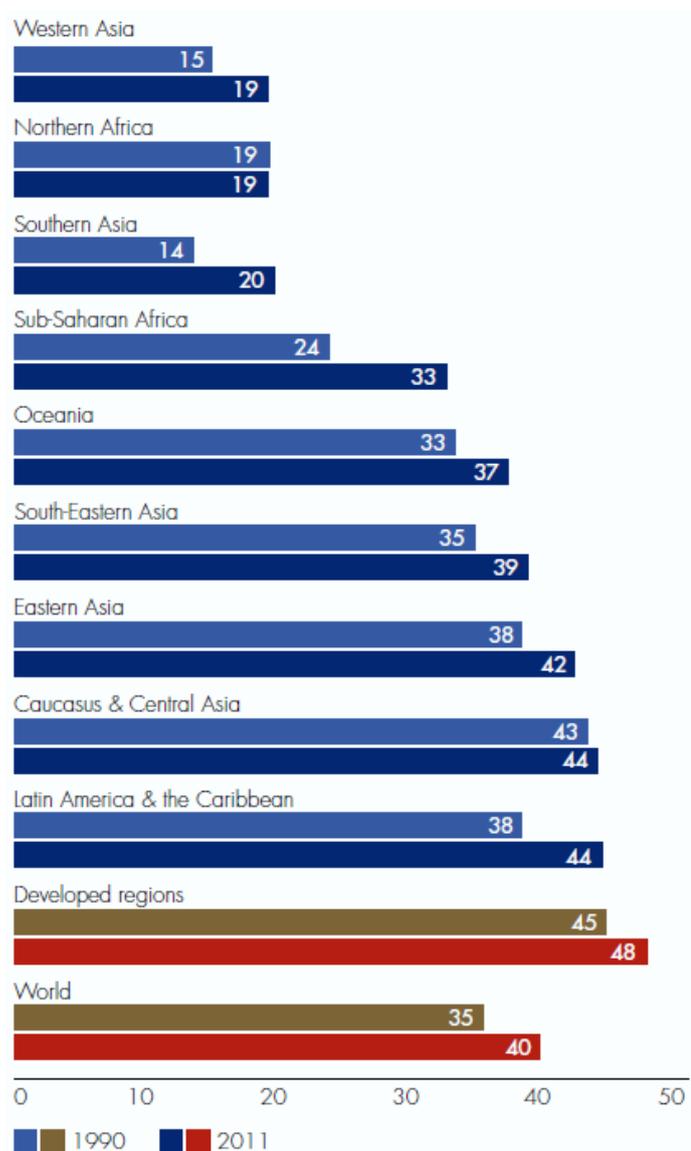
Fig. 2.2 Number of out-of-school children of primary school age, 1990, 2000, 2005 and 2011 (Millions)



Source: UN, MDG Report (2013)

Actually, an improvement in women’s access to paid employment has been registered: in 2011, in every 100 wage-earning jobs in non-agricultural sector, 40 were held by women, comparing to the 35 in 1990. But great disparities are recorded among regions: Eastern Asia, the Caucasus and Central Asia, and Latin America and the Caribbean have nearly reached women/men parity in holding wage-earning jobs, they differ from Western Asia, Northern Africa and Southern Asia where only less than 20 per cent of women have this opportunity. It maybe due to the “risk” of major autonomy, self-reliance in their personal development, and decision-making power that benefiting from more regular income would entail.

Fig. 2.3 Employees in non-agricultural wage employment who are women, 1990 and 2011 (Percentage)



Source: UN, MDG Report (2013)

2012 registered an important increase in the global number of women members of parliament, nevertheless Haiti, Micronesia, Nauru, Palau, Qatar and Vanuatu were the only countries that in that same year did not have any woman in their parliamentary chambers.

2.3.4 MDG 7: Ensure environmental sustainability

Ensuring environment sustainability is crucial for reaching all other goals: preserving environment indirectly contributes to poverty reduction. The rural poor, suffer more than other for the loss of forests since they provide them with food, wood fuel, medicines, both to consume and to sell. Hence, increasing deforestation is hampering progress in developing countries: the largest actions of deforestation occur in South America and Africa, where respectively 3.6 million hectares and 3.4 million hectares per year have been deforested between 2005 and 2010, despite forest laws and international policies.

As shown in Fig. 2.4, developing countries surpass developed countries in CO₂ emissions with an increase of 7 percent between 2009 and 2010; on the contrary, developed regions emissions have declined by 7 percent in 2000 and by 1 per cent in 2010.

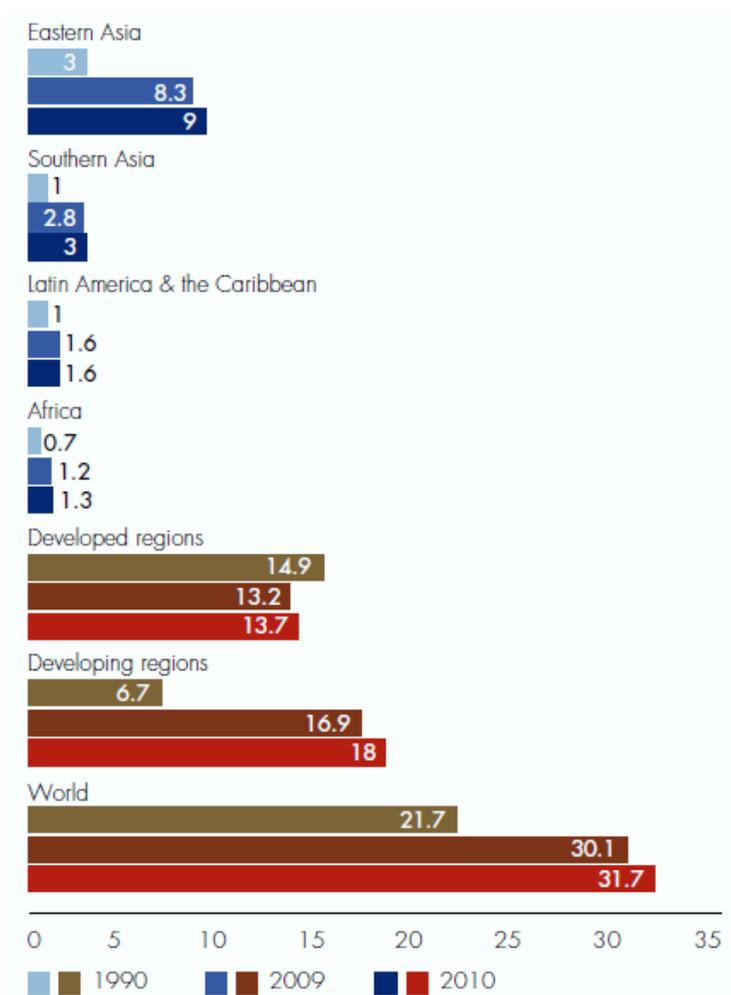
MDG 7 targets also towards reducing the proportion of people without sustainable access to safe drinking water. Nevertheless, 768 millions people in 2011 still employ water coming from unimproved sources, 83 percent of them live in rural areas.

More than 180 million people still rely on rivers, streams, ponds or lakes to meet their daily drinking water needs.

Significant progresses have been reached by Eastern Asia in increasing access to sanitation facilities (latrine, flush toilet): in twenty-one years (1990-2011) 626 million people have gained access. Unfortunately, not all countries can benefit of the same progresses; Sub-Saharan Africa, along with Oceania actually still lag behind.

According to MDG Report 2013, from 1990 to 2011 more than 240.000 people per day have gained access to improved sanitation conditions.

Fig. 2.4 Emissions of carbon dioxide (CO₂), 1990, 2009 and 2010* (Billions of metric tons)



Source: UN, MDG Report (2013)

Nevertheless, this MDG target would be reached only if 660.000 people per day between 2001 and 2015 will benefit of better sanitation facilities.

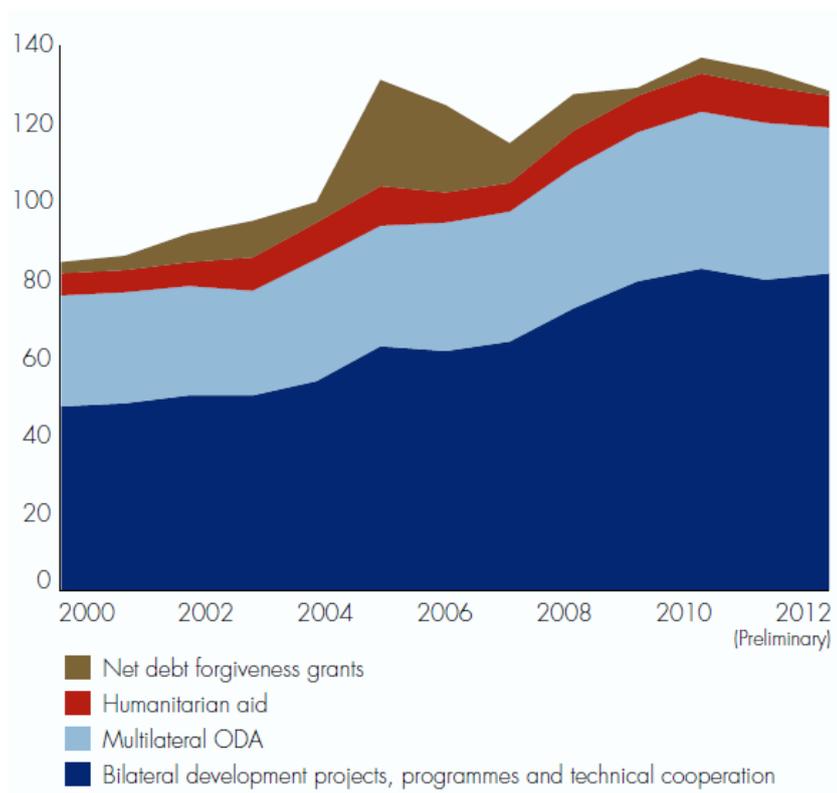
2.3.5 MDG 8: Develop a global partnership for development

Recently, ODA has felt the after effects of the global financial crisis. Therefore in 2012 it dropped of 4 percent from 2011, which was in turn already 2 percent below the 2010 level.³⁹ ODA from largest donors such as USA, Germany,

³⁹ United Nations (2013). *The Millennium Development Goals Report*, UN Publishing, p.52.

United Kingdom and France is mostly addressed to solve gender issues and women empowerment.

Fig. 2.5 Official development assistance (ODA) from OECD-DAC countries, 2000-2012 (Constant 2011 US\$ billions)



Source: UN, MDG Report (2013)

Curiously, according to United Nation’s 2013 Report on MDGs, the decline in bilateral ODA has been mostly recorded in least developed countries. Actually, in 2012, it fell by 13 percent, corresponding to US\$ 26 billion. Recently, it has been proved that aid has been addressed toward middle-income countries rather than less developed countries and Africa.

Among its targets, MDG 8 urges for a cooperation with private sector in order to make available the benefits of new technologies, especially information and communications. Hence, according to United Nations’ estimations, by end of 2013, 2.7 billion people (39 percent of world’s population) at the global level, should have had access to internet facility. However, also for this target, huge

gaps do exist among regions: in developed countries 77 percent population is online, compared to the only 31 percent of developing countries; among them Sub-Saharan Africa is the region that less benefits from this commodity. Inequality do exist also among internet users: at global level, men benefit of internet more often than women; but, the gender gap is even more evident in developing regions where 16 percent of fewer women than men are using internet.

2.4 Progress towards health MDGs

International community's concern for global health is reflected directly or indirectly in nearly half of the Millennium Development Goals.

Actually, health is represented in three of the eight MDGs but its contribution is also instrumental for the achievement of all the others.

According to Dodd and Cassels (2006), MDG have helped to crystallize the challenges in health improvement; this would mean that through the selection of these international Goals, the bottlenecks to global development have become evident. The authors have effectively recognized five main challenges:

- “strengthen health system”: without efficient health systems, countries will not succeed in starting diseases or prevention programs;
- health must be “prioritized within overall development and economic policies”: to survey beyond the mere health system in order to address the factors of ill-health (lower education, poverty, gender gap and unhealthy behaviours);
- “to develop health strategies that respond to the diverse and evolving needs of countries”: “designing cost-effective strategies to address those diseases and conditions that account for the greatest share of the burden of disease, now and in the future”;
- “to mobilize more resources for health in poor countries”: donor country should increase their support, limiting its volatility;

- “to improve the quality of health data in order to measure each country’s progress towards the MDG”.⁴⁰

Despite the acknowledgment of previous challenges, overall data on health are not encouraging; the WHO states that if trends recorded during 1990s continue, the majority of developing countries will not meet any health MDG.

Poorest regions prove to be not on track for meeting the child mortality target; unfortunately it must be said the same for maternal mortality. This rate decreases in countries having already experienced, lower levels of mortality, while it increases or stagnates in those regions with high maternal mortality.

Coverage-related data are more positive: Asiatic regions for example, have significantly increased their incidence of skilled medical assistance during delivery, as well as their use of insecticide-treated bednets and TB treatments. However, child health coverage interventions are not following the same good trend, but its median coverage rate still remains between 20 and 25 percent.

2.4.1 MDG 4: Reduce child mortality

Figure 2.6 shows the enormous worldwide progresses in reducing mortality for children under-five: from 87 deaths per 1,000 live births in 1990 to 51 in 2011.

But more commitment is needed to reach the 2015 target of reducing of two-thirds child mortality, since in 2011 6.9 million children (19.000 a day) died for preventable diseases.

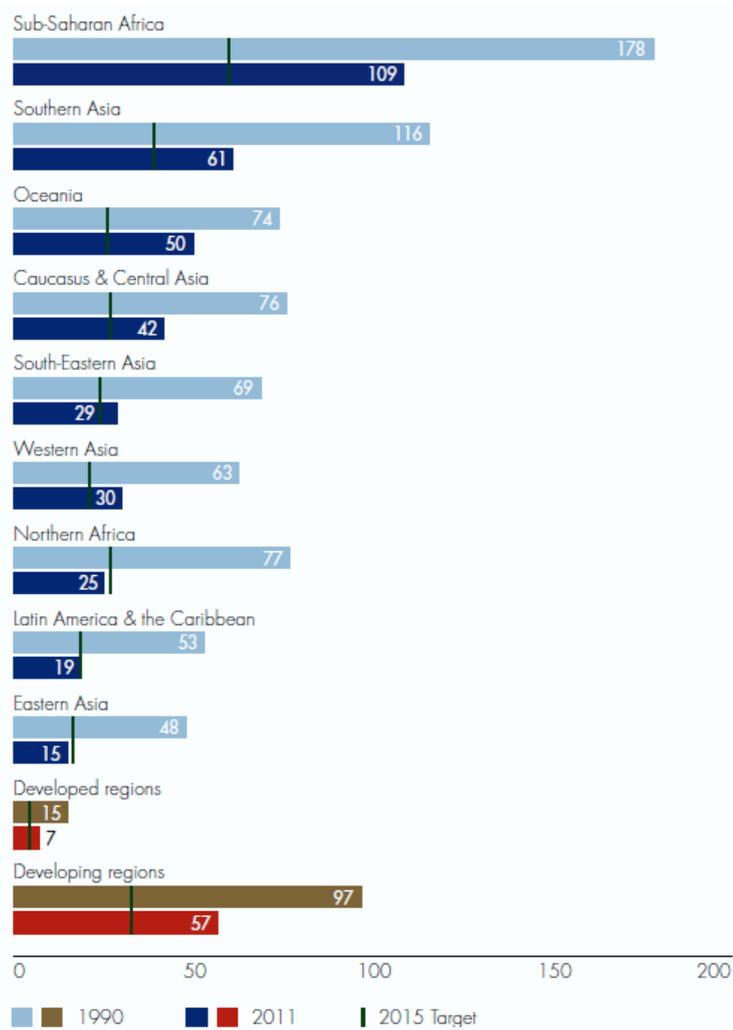
Eastern Asia and Northern Africa have made more improvements in this Goal, actually having already reached it; on the contrary, all other regions of the world, from Caribbean, to Western and South-Eastern Asia have reduce the under-five mortality rate but are still far from attaining the 2015 target.

This still too high mortality rate depends also on the high incidence of deaths at birth or in the few days and months soon after birth. According to MDG Report 2013, the number of neonatal deaths among under-five mortality trend has grown

⁴⁰ DODD R, CASSELS A. (2006). *Health, development and the Millennium Development Goals*, Annals of tropical Medicine, Vol. 100 (5-6), pp.379-387.

from 36 percent in 1990 to 43 percent in 2011. In Latin America, in the Caribbean as well as in Southern Asia, they accounted for more than half of under-five deaths.

Fig. 2.6 Under-five mortality rate, 1990 and 2011 (Deaths per 1,000 live births)



Source: UN, MDG Report (2013)

More attention must be spent on surveying the main factors of child deaths; besides diseases such as pneumonia, diarrhoea, malaria and undernutrition, those that can be prevented through simple and cost-effective interventions, the same rural and urban gap, poverty, mother denied basic education and violence or conflicts are considered all drivers of high rate of child mortality.

Measles belongs to the group of causes of under-five mortality: “an estimated 10.7 million deaths were averted from 2000 to 2011 due to immunizations against

measles. In 2011, the disease killed 158,000 people, mostly children under five, far less than the estimated 548,000 measles deaths in 2000. Still, these deaths were preventable.”⁴¹

Unfortunately, in remiss countries as Southern Asia and Sub-Saharan Africa, where the routine immunization systems are weak and disease controls are often delayed, the epidemic of measles still kills million of vulnerable children.

2.4.2 MDG 5: Improve maternal health

This Goal proves to be the most hard to be achieved since the rate of maternal mortality is still too high because of lack of access “to emergency obstetric care, assistance from skilled health personnel at delivery and the provision of antiretroviral therapy to all pregnant women who need it”.⁴²

Despite that, all regions have made progresses, with highest reduction in Eastern Asia, Northern African and Southern Asia.

Among the several factors behind high maternal mortality rates, WHO recognizes the fundamental importance of skilled attendant during delivery in order to reduce maternal mortality or disability. Data reveal that in developing countries the incidence of mothers delivering with skilled personnel has increased of 11 percent from 1990 to 2011; nevertheless in 2011, still 46 million of women have delivered alone or without adequate care. This is recorded mostly in rural areas where in 2011, 53 percent of women received skilled attendance at the delivery, in comparison to the 84 percent of women living in urban areas; in Sub-Saharan Africa and in Southern Asia gaps are still more evident.

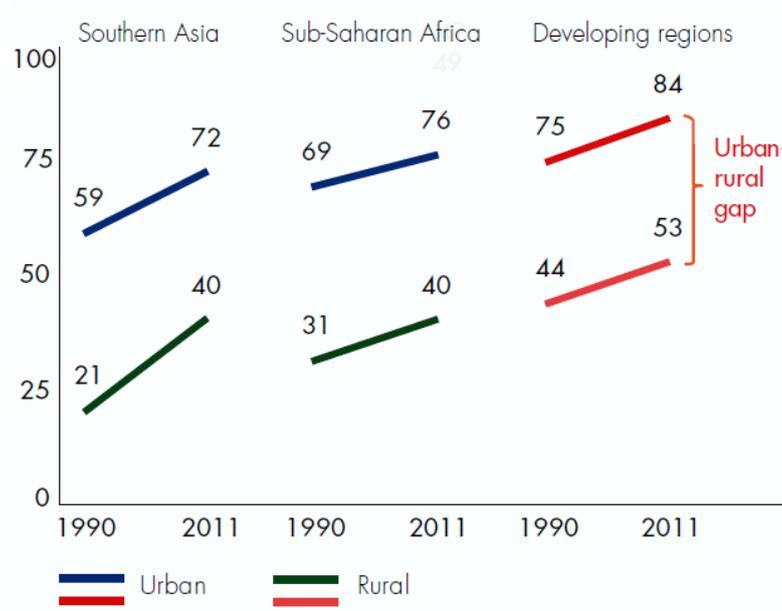
Globally, the recommendation by WHO of a minimum of four antenatal care visits in order to safeguard mothers and children’s lives, has been largely followed. Northern Africa and South-Eastern Asia are doing better than Southern Asia and Sub-Saharan Africa, they are still far from reaching this target; considering that in 2011 only 36 percent and 49 percent of pregnant women

⁴¹ UN (2013). *The Millennium Development Goals Report*, UN Publishing, p.27.

⁴² *Ivi*, p.29

respectively, received at least four antenatal care visits during their latest pregnancy.

Fig. 2.7 Proportion of deliveries attended by skilled health personnel, urban and rural areas, 1990 and 2011 (Percentage).

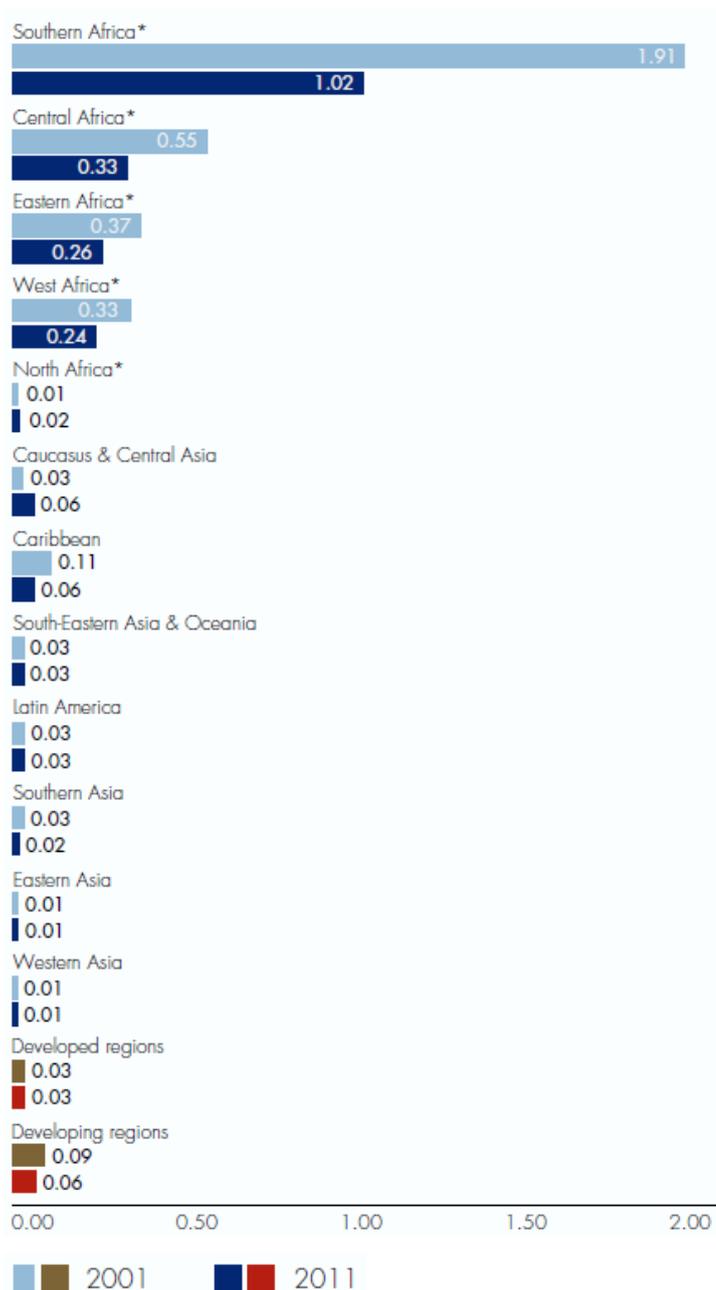


Source: UN, MDG Report (2013)

2.4.3 MDG 6: Combat HIV/AIDS, malaria and other diseases

Worldwide HIV new infectious' rate keeps on decreasing, dropping of 21 percent between 2001 and 2011. However, it is curious the extent to which HIV incidence has increased besides Sub-Saharan Africa, in other “new” regions like Caucasus and Central Asia, where in 2011 there were 27.000 newly infected. The majority of these 27.000 newly infected are women because of their vulnerability and their lack of access to prevention information and services. Yet, thanks to large antiretroviral therapy programs, significant progresses have been reached since 2005, the year during which AIDS infectious caused the highest number of deaths. It has been recorded a decline of 25 percent since 2005. Data from 2011 reveal that about 1.7 million people died from AIDS. With nearly 1 in every 20 adults dying for AIDS, Sub-Saharan remains the worst country in reaching MDG 6.

Fig. 2.8 HIV incidence rate (Estimated number of new HIV infections per year per 100 people aged 15-49), 2001 and 2011



Source: UN, MDG Report (2013)

Improvement in the use of insecticide-treated mosquito net and indoor residual spraying have helped to reduce mortality rates by more than 25 percent from malaria between 2000 and 2010 worldwide. Data have demonstrated that 50 of 99 countries in 2011 were already on track in meeting the 2015 target of reducing

their malaria incidence rates by 75 percent, nevertheless in rural areas it remains one of the main causes of under-five mortality.⁴³

⁴³ All given information about the current trends in achieving MDGs are available from UN (2013), *The Millennium Development Goals Report*, UN Publishing.

CHAPTER 3: WHY DO FRAGILE STATES MATTER?

“One sixth of the world’s population lives in Fragile States, which are also home to one of every three people surviving on less than a dollar a day. Of all the children in the world who die before reaching their fifth birthday, half were born in these countries. Of all the women who die in childbirth, one in three dies in these countries. While other developing countries are making progress towards achieving the Millennium Development Goals these fragile nations, ranging from Haiti to Nepal, from Burundi to Uzbekistan, are falling behind.”⁴⁴

“Poverty rates are 20 per cent higher in countries affected by repeated cycles of violence of the last three decades. People living in countries currently affected by violence are twice likely to be undernourished and 50 per cent more likely to be impoverished. Their children are three times as likely to be out of school.”⁴⁵

3.1 Introduction

The end of the Cold War, bringing with it a long series of civil conflicts and the resulting fragility circumstances, gave birth to a new central concern for the international community. The facts of 9/11 and more recent events, came in succession from the 2008 food, fuel, and financial crisis to the current Arab Spring, have sharpened even more the debate on the nature and implications of fragility.

According to the Organisation for Economic Co-operation and Development-OECD (Box 3.1), fragile states’ governments cannot, or even will not deliver fundamental functions to their people. Lacking the will and/or the ability to

⁴⁴ OECD (2010). *Concepts and Dilemmas of State Building in Fragile Situations: From Fragility to Resilience*. OECD/DAC Discussion paper, Paris: OECD Publishing (quoted in UNITED NATIONS ECONOMIC COMMISSION FOR AFRICA, Sub-Regional Office for West Africa-ECA/SRO-WA, (2012), *Fragile States and development in West Africa*, ECA/SRO-WA Publishing, p.29).

⁴⁵ WDR (2011). *World Development Report 2011. Conflict, security, and development*. Washington: WDR Publishing.

govern (weak governance) they are unable to assure basic services, to protect and to support poor and more vulnerable groups.

Fragile states matter because, with their combined population of 871 million people, they house 14% of the world's population but within them they also account for nearly 30 % of those living on less than US\$ 1 a day.⁴⁶ Actually, they represent a significant challenge to poverty eradication and MDGs achievement.

The list of fragile states usually adopted is the OECD's list (Fig.3.1) which identifies fragile states according to their results on the harmonised Country Policy and Institutional Assessment (CPIA) index.⁴⁷

“A fragile state is defined as having a harmonised CPIA rating of 3.2 or lower, or the presence of a UN and/or regional peace-keeping or peace-building mission during the past three years. While the CPIA index is not intended to measure fragility as such, it provides a useful proxy indicator for fragility, and a way of charting progress”.⁴⁸

The OECD list comes up with 47 fragile states, a large number of which are located in Sub-Saharan Africa. (Fig. 3.1)

The 47 states currently defined as ‘fragile’ are significantly worse off than non fragile states in terms of key health and social determinants of health indicators.

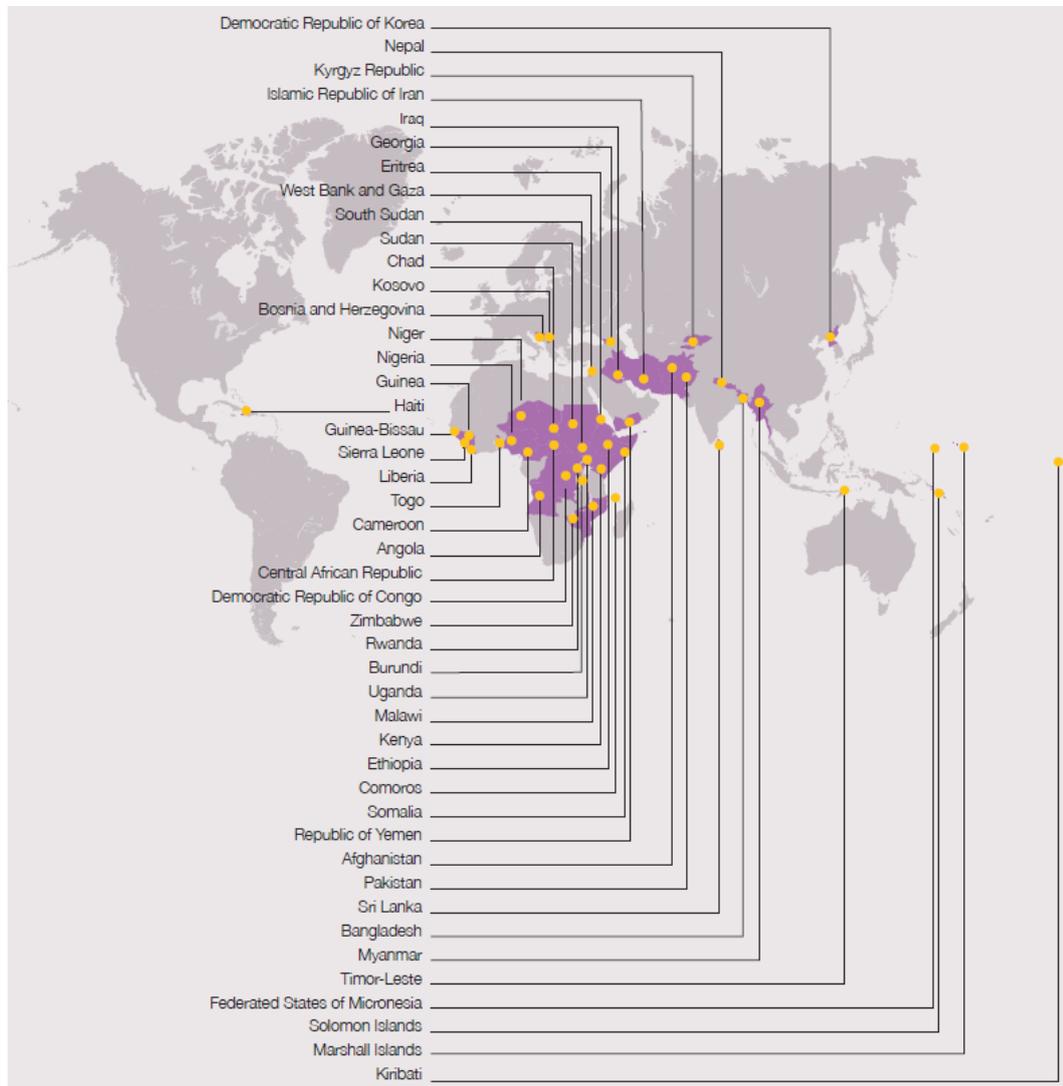
⁴⁶ BRANCHFLOWER A et al. (2004). *How important are difficult environments to achieving the MDGs*. PRDE Working Paper 2, Department For International Development-DFID (quoted in VALLINGS C, MORENO-TORRES M. (2005), *Drivers of Fragility: What makes states fragile?* Poverty Reduction in Difficult environments (PRDE) Working Paper No. 7, PRDE Publishing, p.5).

⁴⁷ “The Country Policy and Institutional Assessment (CPIA) is a diagnostic tool initially created by the World Bank and then adapted by other multilateral development banks, including AfDB. It measures the extent to which a country's policy and institutional framework supports sustainable growth and poverty reduction, and consequently how effectively the country is using its development resources. The CPIA consists of 16 criteria grouped into four equally weighted clusters: Economic Management, Structural Policies, Policies for Social Inclusion and Equity, and Public Sector Management and Institutions. For each of these 16 criteria, countries are rated on a scale of 1 (low) to 6 (high). The scores depend on the absolute level of performance in a given year, rather than on changes in performance compared to the previous year. Ratings are given on the basis of actual policies and demonstrated performance, rather than on promises or intentions”.

AFRICAN DEVELOPMENT BANK GROUP. AfDB (2012). *Development Effectiveness Review 2012. Fragile States and Conflicted Affected Countries*. Tunisia, AfDB Publishing, p.13.

⁴⁸ *Ibidem*

Fig.3.1 The 47 Fragile States



Source: OECD (2012)

3.2 The central driver of fragility: weak political institutions

Although no clear common opinion exists on the definition of fragility, there is general agreement on considering “state-fragility a multi-faceted concept”⁴⁹ which resumes the imbalance between state functions and ability to

⁴⁹ MENACOL, A. R. (2010). *State-building for Peace – A New paradigm for international engagement in post-conflict fragile states*, RSCAS 2010/24, EUI Working papers (quoted in UNITED NATIONS ECONOMIC COMMISSION FOR AFRICA, Sub-Regional Office for West Africa-ECA/SRO-WA, (2012), *Fragile States and development in West Africa*, ECA/SRO-WA Publishing, p.15).

deliver on the one hand, and societal expectations on the other⁵⁰. It is an essentially dynamic process but with not always evident signs.

Box 3.1 The OECD definition of fragility

“A fragile region or state has weak capacity to carry out basic governance functions, and lacks the ability to develop mutually constructive relations with society. Fragile states are also more vulnerable to internal or external shocks such as economic crises or natural disasters. More resilient states exhibit the capacity and legitimacy of governing a population and its territory. They can manage and adapt to changing social needs and expectations, shifts in elite and other political agreements, and growing institutional complexity. Fragility and resilience should be seen as shifting points along a spectrum .(OECD 2012a)¹

Each fragile situation is unique since its vulnerabilities are different from another fragility circumstance, but researchers have generally identified a set of common issues, specifically effectiveness, authority and legitimacy, being at the core of the diverse definitions and manifestations of fragility.

According to Samy and Carment⁵¹, “authority measures the extent to which a state possesses the ability to enact binding legislation over its population, to exercise coercive force over its sovereign territory, to provide core public goods, and to provide a stable and secure environment communities. Legitimacy describes the extent to which a particular government commands public loyalty to the governing regime and generates domestic support for its legislation and policy. Capacity refers to the potential for a state to mobilize and employ resources toward productive ends”⁵².

⁵⁰ *Ibidem*

⁵¹ SAMY Y, CARMENT D (2011). *The Millennium Development Goals and Fragile States: focusing on what really matters*. Fletcher Forum of World Affairs, Vol. 35, Issue 1, p.95.

⁵² *Ibidem*

Drivers of fragility are hard to recognized as they seem to be simultaneously features, causes and consequences of it. Even more, they can be both self and mutually reinforcing.

The central driver of fragility is weak state institutions.

In fragile states political institutions are unable to perform not even minimal functions which are expected to be done firstly for the security and well being of their citizens, but also for the good functioning of the international system.

Yet, according to Vallings and Moreno Torres⁵³, more than the nature of regime or government, what really influences political stability is the consistency of institutions. Consistency is the way of acting that societies in general, expect to be adopted by their state institutions in order to maintain the authority of the rule of law. It has been demonstrated that states with partial democratic institutions have always shown high risk of state failure and consequently of fragility (see Fig. 3.2). As further proof of this fact there is the current socio-political situation of Sub-Saharan Africa.

Usually in a democratic country, state institutions are those appointed to transmit the rule of law, the only legal way in which individual, collective and political activity should be arranged. “Where such institutions are governed openly and transparently they reinforce each other, providing the constraints on an executive, the so-called ‘checks and balances’, necessary for stability”.⁵⁴

On the contrary, as shown in Table 3.1, in countries where institutions always change or go through a transitional phase, as for autocracies and for partial democracies, the institutional system is even more weakened and individual parts of it become victims of the force of powerful groups.

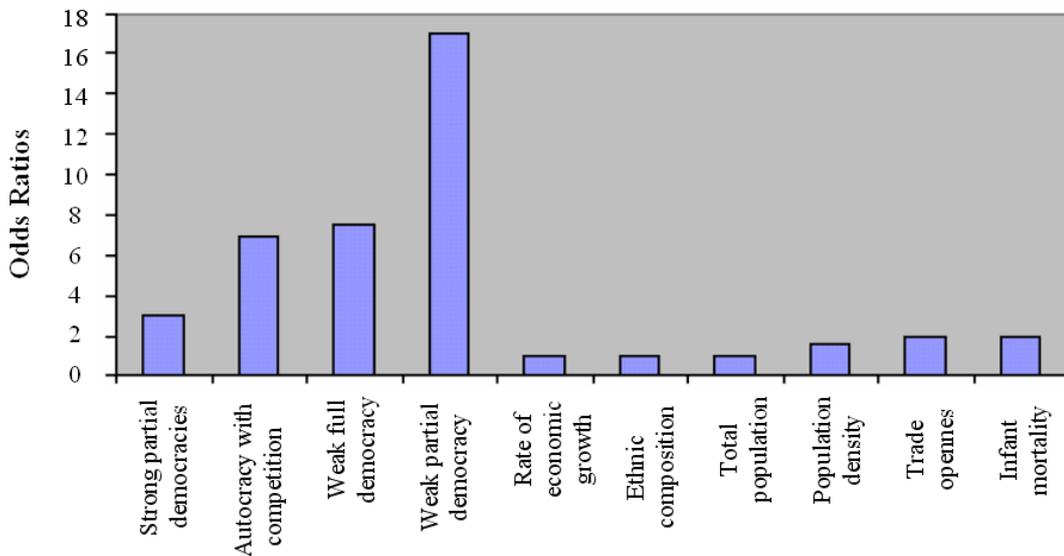
This represents the specific situation that let unsatisfied population finding alternative means of support through illegal or informal activities regardless of state institutions.

But, institutions could show their inconsistency even in inadequate resources or services allocation.

⁵³ VALLINGS C, MORENO-TORRES M. (2005), *Drivers of Fragility: What makes states fragile? Poverty Reduction in Difficult environments* (PRDE) Working Paper No. 7, PRDE Publishing.

⁵⁴ *Ivi*, p.8

Fig. 3.2 Relative importance of political institutions in state failure (All countries)



Source: Goldstone (2004)

The incompetence to deliver resources even in instances where resources are plenty, brakes institutions' capacity to meet the expectations of society; leading again to a state of fragility. Since the sudden changes of society's expectations could easily become the opposite of state institutions' ability to satisfy them, instability worsens even more. Therefore, it is necessary that state remains in permanent contact with its population, giving it the chance to joint national affairs. As a matter of fact, participation together with selection and control, represent the three main elements that let the balance of state institutions functioning. Participation indicates the level of involvement of public society to the political processes; it is greater in countries headed by relatively sound political groups. On the contrary, persisting institutionalized limits restrict it. By selection it is meant whatever method of electing and replacing leaders of government; from the most democratic to the most closed process (the royal succession). Finally, the limit imposed on the executive's power, which is the responsible, is expressed by the concept of control. Therefore, if the political system is not well-balanced, and one of these three elements results more influential than the others, the state will show signs of fragility.⁵⁵

⁵⁵ Ivi, p.9

Table 3.1 Political regimes typology

OPEN AND COMPETITIVE SELECTION OF POLITICAL LEADERS	
<i>Strong full democracies</i> (India, Costa Rica, Botswana)	<ul style="list-style-type: none"> • Highly institutionalised and cooperative political participation • Executive is formally controlled by other government institutions
<i>Weak full democracies</i> (Mexico, Romania, Philippines)	<ul style="list-style-type: none"> • Either an unconstrained executive power • Or a restricted or factionalised participation
<i>Weak partial democracies</i> (Indonesia, Cote d'Ivoire)	<ul style="list-style-type: none"> • Neither control on the executive power • Nor cooperative/institutional participation
LIMITATIONS ON ACCESS OR COMPETITION IN THE SELECTION OF LEADERS	
<i>Strong partial democracies</i> (Russia, Turkey)	<ul style="list-style-type: none"> • Either a degree of control over the executive • Or a highly institutionalised and cooperative participation
RESTRICTIONS ON ACCESS OR COMPETITION IN SELECTION OF LEADERS	
<i>Autocracies</i> (Burma, North Korea)	<ul style="list-style-type: none"> • Executive is selected through succession, designation, self-selection or a mix • Authority is not subordinate or constrained • Political participation is highly restricted
<i>Autocracies with some competition</i> (Egypt, Morocco, Pakistan)	<ul style="list-style-type: none"> • Limited space for political competition, although with little real power
<i>According to research based on the Polity IV dataset, political types in shade have a higher risk of political instability</i>	

Source: Vallings C, Moreno-Torres M. (2005)

What seems to balance this system and help guarantee state's stability is the united contribution of control and participation.

As described in Table 3.1, in a full democracy power is controlled and equally distributed among legislative, executive and judicial institutions. When this equally distributed collaboration misses and there is no limit or constraints to a potential abuse of power, the entire political system becomes unstable and the immediate result for the state is fragility. The importance of participation is not limited to the sole election event but goes further to the participation of society in political processes. Substantial proportions of population are discriminated and excluded from electoral process and wider political representation, most often in countries with two large and equal groups. This means that institutions have been too weak and unable to manage tensions between groups. One more time the weakness of institutions leads to fragility.

3.3 Other causes of fragility

Fragility is the result of the interconnection of several internal and external causes.

Economic factors as poverty, low incomes or economic decline are logically important in fragility issues since bad economic performances mismatching with societal expectations, could worsen the popularity of governments.

Societal dissatisfaction leads to civil unrest, violence and potential armed conflict which could be contained and even avoided if corrective and outstanding security measures would be quickly taken.

Among other structural factors, access to natural resources (water, minerals, oil, forestry) or lack of natural resources wealth as well, can perpetrate fragility.

A. Economic factors:

Economic growth is a necessary condition for poverty reduction. Economic growth in turn, cannot happen without strong institutions. This explains why countries that have experienced institutional changes suffer for economic decline while others with the same income situation but permanent institutions, have grown economically. Fragile states with weak institutions are doomed to suffer for chronic lack of investments not only in human development but also in state infrastructures.

Fragility, driving economic uncertainty, functions as deterrent for investment.

Indeed, the volume and composition of foreign capital flows to these countries is significantly different from patterns observed in developing countries. Fragility has negative effect on the number of foreign direct investment (FDI) projects and on their value. They could increase the productive capacity of these fragile states and generate employment. Through the improvement of managerial and technological proficiency, local firms' productivity and competitiveness would be enhanced and at the end this could provide access to international markets.⁵⁶

⁵⁶ MIGA WIP REPORT (2010), *Investment and Political Risk in Conflict-Affected and Fragile Economies*. In AAVV, *World investment and political risk*. Washington. WDR Publishing. Chapter 2.

Foreign assistance and official development assistance (ODA) also constitute significant sources of external financing for fragile states. According to Samy and Carment⁵⁷, during 1990 to 2008 period, US\$ 470 billion in official development assistance (ODA) was allocated to fragile states but in most years, per capita growth rates were lower than in the low-income and lower middle-income countries (Fig. 3.3). Being aid highly concentrated in these countries, it tends also to be “volatile”. In many cases, aid to fragile states has been higher than the capacity of the country to absorb it, mining the possibility of returns to investments.

Low levels of GDP per capita in fragile states are associated with state incapacity. If a state is not able to impose revenues on its population in order to ensure public services to it, it will be weakened. If it cannot neither improve those infrastructures needed to promote economic growth, it will leave its institutions weak. If a state cannot take care of its population, the same population will exploit alternative ways to survive bypassing the institutions. This will strengthen one more time the vicious cycle of state institutions fragility.

B. Natural resources:

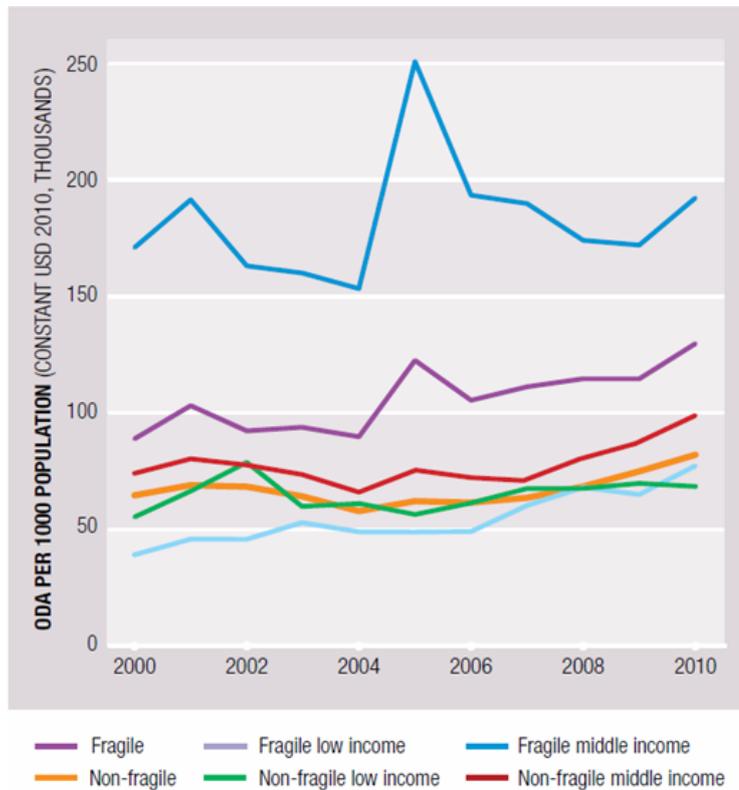
Studies have demonstrated that a country with natural resources has three time the possibility to be instable compared with another country without natural resources.⁵⁸

In this specific case, instability can derive from two circumstances: access to resources and distributions of the benefits coming from the exploitation of them. Mostly, conflicts begin since competing groups argue in order to have a corner on the natural resources supply.

⁵⁷ SAMY Y, CARMENT D (2011). *The Millennium Development Goals and Fragile States: focusing on what really matters*. Fletcher Forum of World Affairs, Vol. 35, Issue 1.

⁵⁸ ACBF (AFRICAN CAPACITY BUILDING FOUNDATION) (2011). *Africa capacity indicators: capacity development for Fragile States, South Africa*, ACBF Publishing (quoted in UN ECONOMIC COMMISSION FOR AFRICA, Sub-Regional Office for West Africa-ECA/SRO-WA, (2012), *Fragile States and development in West Africa*, ECA/SRO-WA Publishing).

Fig. 3.3 Per capita ODA to fragile states is higher than to non-fragile states (2000-2010)



Source: OECD (2012)

Those who can have access to it, more often members of an incumbent regime, gain a great “opportunity” to control the distribution as they please. In addition, leaders of countries rich of natural resources may be reluctant to invest in the institutions to mediate violence, since the same institutions could challenge their regime and reduce their share of the benefits.

Africa represents the most blatant example of conflicts’ escalation due to unequal access to natural resources. Just mentioning conflicts occurred or even still taking place in Angola, Sudan, Sierra Leone and the most known in the Democratic Republic of Congo that took place during the civil war of the 1990s till the current rebel taxation of artisanal mining of coltan, tin and gold deposits in the eastern part of the country.

Kofi Annan⁵⁹ in 1998 has accused African politics and its “winner-takes-all” political attitude as the major cause of fragility.

C. Violent conflicts:

Violent conflicts can be simultaneously a cause, a symptom or a consequence of fragile situations. It’s in itself a self-reinforcing process that contributes to instability.

Among the 47 states defined as fragile, there is a sub-group of 23 countries considered to be “conflict-affected” because they are affected by an ongoing conflict or they are post-conflict states.

According to the MIGA WIP Report⁶⁰, in all cases, conflict is inversely correlated with per capita incomes, so low-income and fragile states countries are more at risk of violence. Yet, the World Bank states that poverty affects 54 percent of people living in fragile states compared to 22 percent in low-income countries as a whole.

Just doubling per capita income, the risk of civil war roughly halves. But in a country emerging from a conflict, the restoring challenge is hard and not always definitive; there is approximately a 30 percent risk of return to conflict within five years. As a matter of fact, conflict of the twenty-first century are not one-off events but are ongoing and repeated. “ 90 percent of the last decade’s civil wars exploded in countries that had already suffered for civil conflict in the last 30 years”.⁶¹

Where armed violence reaches epidemic levels, it upsets livelihoods, carries cycles of poverty, and undermines local confidence in state institutions. Loss of confidence can let in turn households and communities moving to neighbouring countries or to developing countries which hosting millions of refugees, add strain to their local and national capacities, often for a protracted period of time.

⁵⁹ ANNAN A. K. (2000), *We the peoples. The role of the United Nations in the 21st century*. New York. United Nations Publishing, p.31.

⁶⁰ MIGA WIP REPORT (2010), *Investment and Political Risk in Conflict-Affected and Fragile Economies*. In AAVV, *World investment and political risk*. Washington. WDR Publishing. Chapter 2.

⁶¹ WDR (2011). *World Development Report 2011. Conflict, security, and development*. Washington: WDR Publishing, p.2.

Table 3.2 Countries often relapse into conflict

Decade	Onsets in countries with no previous conflict (%)	Onsets in countries with a previous conflict (%)	Number of onsets
1960s	57	43	35
1970s	43	57	44
1980s	38	62	39
1990s	33	67	81
2000s	10	90	39

Source: WDR (2011)

The main explanation to this, seems to be, here again, the weakness of state's institutions. Being placed under extreme stress during the conflict, they are unable to satisfy population's expectations.

Even when a sort of reform tentatively shapes, it could also fail because of the so called "premature load bearing" of institutions: the institutions are overloaded by too many demands, requests and expectations in a too short period. The failure of the state to deliver the expected services causes a further loss of confidence and doubts about the legitimacy of the state, so exacerbating even more instability. The state may react to this dissatisfaction in repressive way starting again the vicious cycle of repeated violence.

3.4 Development impacts of fragility

Despite discordances among the unlimited definitions of fragility; there is general consensus in considering state of fragility as a continuum and the surrounding definitions as descriptions of different levels of it. Fragility, being deep-rooted or just transitory, brings with it arduous challenges concerning the socio-developmental dimension, as well.

The Organization for Economic Co-operation and Development states that "one sixth of the world's population lives in fragile States, which are also home to one out of every three people surviving on less than a dollar a day. Of all the children in the world who die before reaching their fifth birthday, half were born in these

countries. Of all the women who die in childbirth, one in three dies in these countries. While other developing countries are making progress towards achieving the Millennium Development Goals these fragile nations, ranging from Haiti to Nepal, from Burundi to Uzbekistan, are falling behind”.⁶²

The lack of state-capacity to support socio-economic progress in these fragile states is preventing the achievement of most of the global targets. From a policy perspective, it is nonsense claiming that the international community is globally reaching the MDGs when these countries are often excluded from the analysis and left behind.

As a matter of fact, the OECD again observes that “fragile states are the furthest away from achievement of MDGs and account for 75% of the MDG deficit worldwide”.⁶³

The World Development Report (2011)⁶⁴ makes similar observations and states that no low-income fragile or conflict-affected country has yet achieved a single MDG.

Thus, fragile states represent an important threat to the overall MDG campaign: among all developing nations, failed and fragile states account for 28 to 35 percent of the absolute poor⁶⁵. In particular, poverty reduction in regions affected by civil war or major violence is on average nearly a percentage point slower per year than in regions not facing violence. But analyzing the situation after a few years of violence, the gap could seem starker: the countries that have experienced violence during the 1980s lagged in poverty reduction by “just” 8 percentage points. While countries facing civil war during the 1980s and 1990s lagged by 16 percentage points.

⁶² OECD (2010), *Concepts and Dilemmas of State Building in Fragile Situations: From Fragility to Resilience*. OECD/DAC Discussion paper, Paris: OECD Publishing (quoted in UNITED NATIONS ECONOMIC COMMISSION FOR AFRICA, Sub-Regional Office for West Africa-ECA/SRO-WA, (2012), *Fragile States and development in West Africa*, ECA/SRO-WA Publishing, p.29).

⁶³ Ivi, p. 30

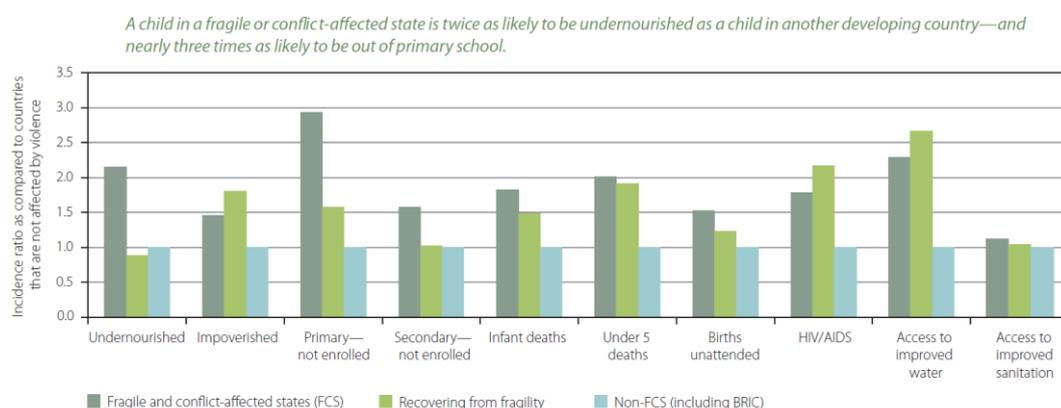
⁶⁴ WDR (2011). *World Development Report 2011. Conflict, security, and development*. Washington: WDR Publishing.

⁶⁵ SAMY Y, CARMENT D (2011). *The Millennium Development Goals and Fragile States: focusing on what really matters*. Fletcher Forum of World Affairs, Vol. 35, Issue 1.

On average, a country suffering for major violence during the entire period (1981-2005) had a poverty rate of about 21 percentage points higher than a country that saw no violence.⁶⁶

In fragile states live: “32 to 46 percent of children that do not receive a primary education”⁶⁷ often because war destroys infrastructures, such as schools and hospitals, and displaces teachers, as well. (Fig. 3.4 describes in detail violence constraints to MDGs).

Fig. 3.4 Violence is the main constraint to meeting the MDGs



Sources: World Bank 2010; WDR team calculations based on Gates and others 2010.

Note: Figure 3.4 shows the incidence of each of the ills associated with unmet MDGs for fragile, conflict-affected, and recovering countries in relation to the incidence for all other developing countries. The ratio is weighted by the affected population, so each bar can be read as the odds-ratio of a person being affected relative to a person in a non-fragile or conflict-affected state: for example, children of primary school age are three times as likely to be out of school in fragile and conflict-affected states as those in other developing countries.

Source: WDR (2011)

⁶⁶ WDR (2011). *World Development Report 2011. Conflict, security, and development*. Washington: WDR Publishing, p.60.

⁶⁷ SAMY Y, CARMENT D (2011). *The Millennium Development Goals and Fragile States: focusing on what really matters*. Fletcher Forum of World Affairs, Vol. 35, Issue 1, p.93.

3.5 Health in Fragile States

State instability and violence are fundamental drivers of health inequity in fragile states. States characterized as fragile or conflict-affected tend to have far worse population's health indicators than states at comparable levels of development. Evidence is increasing on the fact that they have the worst levels of achievement in relation to 2015 health related MDGs. (See Table 3.3)

Vulnerable groups, including women, children, refugees and the elderly, in such states are generally more affected: “41 to 51 percent of children die before their fifth birthday; 33 to 44 percent of maternal deaths; 34 to 44 percent of those living with HIV/AIDS; and 27 to 35 percent of those lacking safe drinking water”.⁶⁸

Poor outcomes in health indicators are the product of inadequate governance and service development, disruptions of health and determinants of health like clean water and sanitation, destruction of infrastructures.

Considering the impact of violent conflict on health, the Special Report⁶⁹ has recorded that “in most conflicts the greatest impacts on civilian morbidity and mortality are indirect, and nonviolent deaths far outnumber violent ones. A study reviewing World Health survey data estimated that 378,000 nonviolent war-related deaths occurred annually from 1985 to 1994 (a range of 156,000 to 614,000). In Darfur, 87 percent of excess civilian deaths between 2003 and 2008 were non-violent.”

These “non-violent-deaths” could be the result of an increasing rate of infectious diseases secondary to the decline of preventive measures like vaccinations and access to clean water and shortages of medication and supplies for treatment, all likely derived from the sole destruction of infrastructures, as well.

Since violence is also highly gendered in its perpetration and victimization, the results in gender indicators concerning the exposure to situations which have an impact on health, help also understand who has access to health-care services, and how such services are planned and provided. Differential exposure to sexual

⁶⁸ BRANCHFLOWER A et al. (2004). *How important are difficult environments to achieving the MDGs*. PRDE Working Paper 2, Department For International Development-DFID (quoted in SAMY Y, CARMENT D (2011). *The Millennium Development Goals and Fragile States: focusing on what really matters*. Fletcher Forum of World Affairs, Vol. 35, Issue 1, p.93).

⁶⁹ HAAR R. J, RUBESTEIN L. S. (2012), *Special Report. Health in Postconflict and Fragile States*. UNITED STATES INSTITUTE OF PEACE (USIP), Washington, USIP Publishing, p.3.

violence can lead to higher rates of sexually transmitted infections like HIV/AIDS. As a matter of fact, “HIV infection rate in adolescent girls post-conflict has been reported to be up to four times that of adolescent boys”.⁷⁰

Yet, what seems to be the blatant proof of the instability of government more than the impact of conflict violence is the under-five mortality indicator. It has been demonstrated that in “sub-Saharan Africa more than 60 percent of under-five deaths occur in areas of chronically unstable governance, and of these almost two-thirds are preventable”.⁷¹

Studies have demonstrated that “improved health services can increase trust in government and thus modestly contribute to reinforcement of the authority and legitimacy of the state through developing human capital, providing quality health services, promoting citizen oversight of health programs, generating fiscal reform, and creating monitoring mechanisms”.⁷²

Health services are a necessary but quibbling feature of a government; if government is not able to provide other basic services such as education, transportation, water and justice, it may not be ever considered so reliable to ensure improvements in health system.

Table 3.3 Health-related MDG Status: Fragile States & Other Developing Countries

	Fragile States	Other Developing Countries
MDG 4: Child mortality rate, per 1000	138	56
MDG 5: Maternal mortality rate, per 100,000	734	270
MDG 6: % of people living with HIV/AIDS	2%	0.5%
MDG 6: Malaria death rate per 100,000	90	7

Source: *Health Unlimited - Delivering Health Service in Fragile State sand Difficult Environments(2007)*

⁷⁰ RANSON K , POLETTI T , BORNEMISZA O, SONDORP E. (2007). *Promoting health equity in conflict-affected fragile states*. Prepared for the Health Systems Knowledge Network of the World Health Organisation’s Commission on Social Determinants of Health, Health Systems Knowledge Network Publishing, p.VII.

⁷¹ HAAR R. J, RUBESTEIN L. S. (2012). *Special Report. Health in Postconflict and Fragile States*. UNITED STATES INSTITUTE OF PEACE (USIP), Washington, USIP Publishing, p.3.

⁷² *Ivi, p.5.*

CHAPTER 4: “STATE AND POWER IN AFRICA”⁷³

“Africa...is the only continent not on track to meet any of the goals of the Millennium Declaration by 2015.”⁷⁴

“in Africa...the world is furthest behind in progress to fulfill (the MDGs)...Africa is well behind target on reaching all the goals..”⁷⁵

“Sub-Saharan Africa, most dramatically, has been in a downward spiral of AIDS, resurgent malaria, falling food output per person, deteriorating shelter conditions, and environmental degradation, so that most countries in the region are on trajectory to miss most or all of the Goals...The region is off-track to meet every MDG”.⁷⁶

4.1 Introduction

Africa is falling behind the rest of the world for what concerns economic welfare. Even though world poverty is successfully decreasing, thanks to the exponential economic growth recorded by India and China, Africa contributes barely to this decline.

As a matter of fact, despite the real steady progress the continent as a whole is making in reaching just few Millennium Development Goals, still today many African nations are completely off track.

State fragility remains the major constraint on Africa’s development. Conflicts and poverty are intertwined in very complex ways making Africa the most-conflict ridden continent in the world with conflicts, even if less intense,

⁷³ HERBST J.I. (2000). *State and power in Africa: comparative lessons in authority and control*. Princeton University Press, p. 280.

⁷⁴ UN, (2005). *Resolution adopted by the General Assembly 60/1*. World Summit Outcome, 24 October 2005. UN Publishing, p. 19.

⁷⁵ COMMISSION FOR AFRICA (2005). *Our common interest: Report of the commission for Africa*, London, Commission for Africa, Publishing (quoted in EASTERLY W (2007). *How the Millennium Development Goals are unfair to Africa*, Global Economy and Development, Working Paper 14, November 2007, Brookings Global Economy and Development Publishing, pg.2).

⁷⁶ UN Millennium Project (2005). *Investing in Development: a practical plan to achieve the Millennium Development Goals*, (Main Report), New York, UN Publishing, p.2.

increasing every year. Conflicts, spilling out their national borders, become regional phenomena from which individual states cannot escape.

Fragility, food security and natural resources management so closely interlinked, often could represent key drivers and simultaneously consequences of a conflict. Just noting that Africa, relying more than other low-income countries on food imports; is hence more vulnerable to price shocks.

African performances in achieving the MDGs function as litmus test for the legitimacy and the consistency of African governments.

Fig. 4.1 Fragile States and conflict- affected countries in Africa



Note: According to OECD Fragile States List 2012, African Fragile States are: Angola, Burundi, Cameroon, Central African Republic, Chad, Comoros, Democratic Republic of Congo, Ethiopia, Guinea, Guinea-Bissau, Kenya, Liberia, Niger, Nigeria, Rwanda, Sierra Leone, Somalia, Sudan, Togo, Uganda, Zimbabwe.

Source: rearranged from OECD (2012)

4.2 Pattern of conflict in Africa

Considering the OECD's list of Fragile States, around three quarters on the list are affected by an on-going armed conflict.

Africa is one of the most conflict-ridden area in the world; it keeps on witnessing increasing number of conflicts even if less intense than in the past.

The notion of conflict systems in Africa is characterized by the fact that what might at first appears as individualised conflict, in fact is part of wider pattern of conflict regionally. Specifically there are two complexes in Africa: one goes from Nigeria across Chad and Sudan to the Horn of Africa and the other afflicting the Great Lakes region, passing through the Democratic Republic of Congo, Uganda and the Central African Republic.

As the Arab Spring with its revolutions and civil conflict in the relative stable and prosperous North Africa has demonstrated; development could function as conflict-driver if it does not assure economic opportunity to the majority of the population. Climate change and competition for resources as water and land, trigger violence elsewhere, as happened in DRC, Sierra Leone, Angola, and Sudan.

Yet conflicts, inequitable distribution of resources and all other factors associated with fragility are in themselves linked to weak state institutions as a driving force and function as a proof that African political institutions are not strong enough to manage effectively the natural conflicts that occur in society.

4.3 “State and Power in Africa”⁷⁷

Among several studies of comparative economic development, trying to find an answer to the vexata quaestio of what could explain state-fragility; the most convincing theory found is that “it is institutions - the way societies are

⁷⁷ HERBST J.I. (2000). *State and power in Africa: comparative lessons in authority and control*. Princeton University Press, pp. 280.

organized- that are the fundamental cause of countries' development or underdevelopment"⁷⁸.

The close interconnection between institutions/state's failure and negative development results, is well-rendered in Africa.

In Africa, institutions and their inability to make their statehood functioning are the central driver of fragility.

A state is supposed to guarantee specific public-goods to the entire society; it should provide law and order, defense and infrastructures. But, the great majority of African states is able to assure just very few of these basic functions. Specifically in Sub-Saharan region, state institutions are less developed than almost anywhere else.

Political instability has been prevalent in the decades during which the region reached its independence from the colonial rule; but today this state of uncertainty still persists. National governments can control only tenuously people, organizations and activities within their jurisdiction. The ethnic lines dividing populations, most often have been the triggering cause of the constant threat of political disorder or in other several cases have lead to real civil wars. Consequently, some governments have periodically stopped to exercise control over important areas of the territory and the population supposed to be under their jurisdiction. This was what happened in Angola, Chad, Ethiopia, Sudan, Nigeria and Uganda that temporarily ceased to be "states" since their central governments have been defeated in the struggle against the rival political organizations.

It could be useful, as suggested by Jackson and Rosberg⁷⁹, trying to understand the feasible causes of African failure, enquiring into the weakness and vulnerability of the great majority of African states, through the analysis of the empirical and juridical components of statehood.

Just only using the famous definition of statehood given by Max Weber⁸⁰, it becomes clear that several Africa's governments would not qualify as states since

⁷⁸ ROBINSON, J.A. (2002). *States and Power in Africa by Jeffrey I.Herbst: a Review Essay*. Journal of Economic Literature, Vol. XL, pp. 510-519, p.510.

⁷⁹ JACKSON R.H, ROSBERG C.G. (1982). *Why Africa's weak states persist: the empirical and the juridical in statehood*, World Politic, Volume 35, Issue 1, pp. 1-24.

⁸⁰ "... a corporate group that has compulsory jurisdiction, exercise continuous organization, and claims a monopoly of force over a territory and its population, including 'all action taking place in the area of its jurisdiction' ". WEBER M, (1964). *The theory of social and economic organization*, Talcott Parsons, New

they are unable to impose their monopoly of force within their territorial jurisdiction. Conversely, in Africa more often groups or organizations rivals to the national governments have been able to exercise their control over territories and populations for long periods – as for the cases of Biafra in Nigeria and Katanga in Congo. Furthermore, the governmental institutions of many African countries are often unable to control effectively all the fundamental public activities within their jurisdiction. Or they are so precarious that laws and regulations cannot be enforced with confidence and are not always hold .

There is a better definition of statehood sharing some features with Max Weber's description but that gives them a different emphasis. This is written by Ian Brownlie, a British legal scholar, who describes “a State as a legal person, recognized by international law, with the following attributes: (a) a defined territory, (b) a permanent population, (c) an effective government, and (d) independence, or the right to enter into relations with other states”.⁸¹

These two definitions could act as useful starting points for analyzing the empirical and juridical statehood in contemporary Africa.

In order to understand what Brownlie wants to intend with “ permanent population” it could be useful to exploit a socio-political explanation according to which societies are culturally homogenous or fragmented, grounded on common norms and values or not. But, according to this description, it is easy to notice that very few African countries share this characteristic. Yet, the populations of several African countries are often internally divided because of religion, language, race or region of residence, as for the case of Sudan. This situation of ethnic incomprehension causes political tensions and conflicts that lead to political instability and affect the capacity of government to control the territory under its jurisdiction.

In Africa, the politicization of ethnic conflicts has often lead to serious civil conflicts: “Sudan (1956-1972); Rwanda (1959-1964); Zaire (1960-1965; 1977-1978); Ethiopia (1962-1982); Zanzibar (1964); Burundi (1966-1972); Chad

York, Free press (quoted in JACKSON R.H, ROSBERG C.G. (1982), *Why Africa's weak states persist: the empirical and the juridical in statehood*, World Politic, Volume 35, Issue 1, p.2).

⁸¹ BROWNLIE I. (1979), *Principles of Public International Law*, 3d edition, Oxford: Clarendon Press, pp. 73-76 (quoted in JACKSON R.H, ROSBERG C.G. (1982), *Why Africa's weak states persist: the empirical and the juridical in statehood*, World Politic, Volume 35, Issue 1, p.3).

(1966-1982); Uganda (1966; 1978-1982); Nigeria (1967- 1970); and Angola (1975-1982)”.⁸²

African politics is still characterized by the aversion of most African governments to competitive party system. They have a general propensity instead for political monopoly, rejecting federalism and political liberties.

But, always considering the definition of statehood given by Brownlie, what seems to better describe precarious African situation is the feature of “effective government”. Through it, Brownlie means “centralized administrative and legislative organs”. It recalls a somewhat Eurocentric attitude of intending the role of government: not only administering but also legislating. In Africa, governments do not necessarily govern through legislation since “personal” leader often adopt an arbitrary and autocratic way of governing, through the use of commands, edicts, or decrees. Therefore for the specific case of Africa, it seems more useful applying another definition to explain what Brownlie means with “effective government”; that is “to exercise control – as the ability to pronounce, implement and enforce commands, laws and policies and regulations - over a state’s territory and the people residing in it”.⁸³

The ability of African governments to exercise control relies firstly on the political authority which in this region, tends to be personal rather than institutional. As a matter of fact, governmental institutions in Africa are dominated by rulers with very strong personalities, both civilian or military. They “are autocrats and it is as autocrats, and not as preludes to liberalism (or, for that matter, to totalitarianism), that they, and the governments they dominate, must be judged and understood.”⁸⁴

It is worthy saying that in those regions where African governments have been able to exercise a “significant” control, always personal rulers have taken firm command. Just taking as examples autocratic regimes as those in Ivory Coast, in Malawi, in Gabon, in Cameroon; or oligarchic regimes such as Senegal, Sudan or

⁸² JACKSON R.H, ROSBERG C.G. (1982). *Why Africa’s weak states persist: the empirical and the juridical in statehood*, World Politic, Volume 35, Issue 1, p.5.

⁸³ BROWNLIE I. (1979), *Principles of Public International Law*, 3d edition, Oxford: Clarendon Press, pp. 73-76 (quoted in JACKSON R.H, ROSBERG C.G. (1982), *Why Africa’s weak states persist: the empirical and the juridical in statehood*, World Politic, Volume 35, Issue 1, p.6).

⁸⁴ JACKSON R.H, ROSBERG C.G. (1982), *Why Africa’s weak states persist: the empirical and the juridical in statehood*, World Politic, Volume 35, Issue 1, p.7).

the most known, in Kenya; or ideological regimes as those established in Tanzania, or Guinea.

However in some other African countries, the strong omnipresence of these leaders has led to an excessive arbitrary and abusive personal rule, as for the case of Uganda under Idi Amin.

The alienation of important elites from the government, particularly military one, represents another evidence of the institutional weakness in African states. It had been estimated that between 1958 and the summer of 1981 more than 41 coups has taken place in 22 African countries; soldiers in Africa have often become government officials or in the best (or worst) cases rulers of their countries.

The incapacity to govern of some African countries can be assessed through their apparatus of power, as well. In general in proportion to the vastness of territories and the numerous populations, the apparatus of power it can be considered "underdeveloped" because of the lack of financial, materiel and personnel resources and the deployment of these.

Undoubtedly the most significant feature that characterizes both civilian and military African administrations is the "questionable reliability of staffs"; yet, many African governments must be work among corruption and disorder as reported in 1977 by Julius Nyerere about socialist progress in Tanzania. "He noted that ministries were overspending in disregard of severe budgetary restraints; the Rural Development Bank was issuing loans that were not being repaid; state enterprises were operating far below capacity-sometimes at less than 50 percent; "management" was preoccupied with privilege and displayed little enterprise; and "workers" were slack, incompetent, and undisciplined".⁸⁵

A third feature that affects governmental negligence is represented by the economic circumstances worsened by the limited presence of skilled work force and by the ever-increasing birthrates. Depending heavily on food and on primary necessity goods' imports, African countries are always at the mercy of the uncontrollability of prices' fluctuations; in particular, countries without oilfields have suffered severe balance-of-payments problems because of unexpected price

⁸⁵ NYERERE (1977). *The Arusha Declaration Ten Years After*, Dar es Salaam: Government Printer, in chap. 3: *Our Mistakes and Failures*, pp. 27-48 (quoted in JACKSON R.H, ROSBERG C.G. (1982). *Why Africa's weak states persist: the empirical and the juridical in statehood*, World Politic, Volume 35, Issue 1, p.9).

increases of oil imports. Therefore, as long as agricultural sector and associated industries will not be enforced, African countries will be doomed to lie in this “grim reality” of uncertainty and stagnant growth where most of the times, the economy is exploited to support and enrich just the political class.

Unfortunately, what remains the main obstacle for the advance of African continent is the reticence to admit that underdevelopment is not a problem deriving from economy or society, but spreading from government.

4.4 Development in Africa

According to the African Development Bank Group ⁸⁶ it seems that a moderate group of African fragile states has lately recorded, even though just perceptible, a little improvement of the standard governance indicators. In effect, the Mo Ibrahim Index ⁸⁷ demonstrates that Africa’s fragile states have improved their capacity to endorse human development and to “create sustainable economic opportunity”. ⁸⁸

Yet even though, unreliable weak governmental institutions lacking of legitimacy represent the main brake to the human development. Moreover, the continuing fear of conflicts threatens to reverse the just perceptible development gains in many parts of the African continent.

African leaders recognize that MDGs offer a great opportunity to win the challenges of achieving rapid and sustainable socioeconomic development, in order to integrate the continent into the reality of the world economy. It has been evidenced by the decision of the top echelon of African leadership of undertaking some important development initiatives such as the establishment of the African

⁸⁶AFRICAN DEVELOPMENT BANK GROUP. AfDB (2012).*Development Effectiveness Review 2012. Fragile States and Conflicted Affected Countries*. Tunisia, AfDB Publishing.

⁸⁷ “The Mo Ibrahim Index of African Governance (IIAG) monitors governance standards across all the countries of Africa. Funded and led by the Mo Ibrahim Foundation, it is designed as a tool for civil society in African countries to hold their governments to account. The index assesses national governments against four categories and 57 criteria, representing the core obligations of any government to its citizens: i) Safety and Rule of Law; ii) Participation and Human Rights; iii) Sustainable Economic Opportunity; and iv) Human Development” quoted in AFRICAN DEVELOPMENT BANK GROUP. AfDB (2012).*Development Effectiveness Review 2012. Fragile States and Conflicted Affected Countries*. Tunisia, AfDB Publishing, pg.5.

⁸⁸AFRICAN DEVELOPMENT BANK GROUP. AfDB (2012).*Development Effectiveness Review 2012. Fragile States and Conflicted Affected Countries*. Tunisia, AfDB Publishing, pg.5.

Union and the adoption of the New Partnership for Africa's Development (NEPAD) which is essential to support Africa's efforts towards achieving the MDGs.

Due to its "distinctive" problems of extreme poverty and spreading HIV/AIDS, Africa relies upon direct support from UN Member States as well, in order to address the challenges of poverty eradication and to achieve faster and better results in the fight against HIV/AIDS.

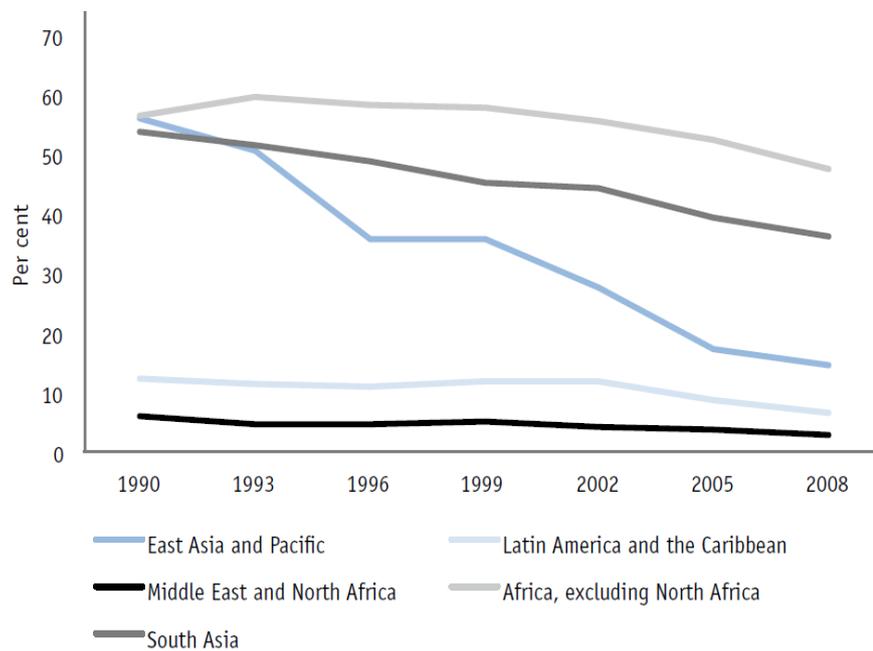
Even if the joint action of the entire international community and Africa's own development plans could raise hopes of achieving the MDGs on the continent by 2015, studies have revealed that "like the other regions, Africa also experienced a decline in the poverty rate as well as the absolute number of poor people. However, its rate of decline in poverty is too slow to achieve the target by 2015. For instance, the proportion of people living on less than \$ 1.25 a day in Africa (excluding North Africa) decreased marginally from 56.5 per cent in 1990 to 52.3 per cent in 2005 and further to 47.5 per cent in 2008. Only East Asia and the Pacific, and the Middle East and North Africa have reached the target".⁸⁹ (See Fig. 4.2).

Not only for the MDG 1 (Eradicate extreme poverty and hunger), but also for the rest of MDGs, institutional constraints represent the main obstacle that prevent the achievement of the goals in Africa, most especially sub-Saharan Africa. This is the reason why it is argued that Africa is presently off track and very slow in its implementation of the MDGs (See Table 4.1).

⁸⁹ UNDP (2012). *Assessing progress in Africa toward the Millennium Development Goals, Emerging perspectives from Africa on the post-2012 development agenda, MDG Report 2012*, New York, UNDP Publishing, p.2.

Fig.4.2 Proportion of population living below \$1.25 a day , 1990

2008



Source: Compiled from World Bank, <http://data.worldbank.org/indicator/SI.POV.DDAY?page=4>, updated February 2012.

Source: UNPD MDG Report 2012

So far in the long way for achieving the MDGs in Africa, there are significant advances together with important set-backs which often reflect differences in initial conditions.

Lingering on health-related MDGs in the next chapter, the actual developmental African situation on just five of the seven Goals is described below.

4.4.1 MDG-1: Eradicate extreme poverty and hunger

The first MDG, calling for reducing the proportion of people living on less than \$1 per day in 1990 to half by 2015 and for reducing by half the proportion of people suffering from hunger, is not an end in itself. It's above all a means to quicken achievement of the rest of the MDGs. "Progress on this indicator has positive knock-on effects that create a virtuous circle between Goal 1 and other

MDGs⁹⁰, as a matter of fact increased purchasing power facilitates access to school and to health services.

Table 4.1 Africa’s MDG’s performance at a glance, 2012

Goals and Targets (from the Millennium Declaration)	Status	Remarks
Goal 1: Eradicate extreme poverty and hunger	Off track	<ul style="list-style-type: none"> • \$1.25-a-day poverty in Africa (excluding North Africa) declined from 56.5% to 47.5% during 1990–2008
Goal 2: Achieve universal primary education	On track: net enrolment	<ul style="list-style-type: none"> • Average enrolment exceeds 80% • Issues of quality remain • Most countries are not expected to meet the completion target
Goal 3: Promote gender equality and empower women	On track	<ul style="list-style-type: none"> • Good progress at primary level but weak parity at secondary and tertiary levels of education • High representation in parliament
Goal 4: Reduce child mortality	Off track	<ul style="list-style-type: none"> • Declining, but slowly
Goal 5: Improve maternal health	Off track	<ul style="list-style-type: none"> • Declining, but slowly
Goal 6: Combat HIV/AIDS, malaria and other diseases	Off track	<ul style="list-style-type: none"> • HIV/AIDS on the decline, especially in Southern Africa, due to behavioural change and access to antiretroviral therapy
Goal 7: Ensure environmental sustainability	On track: improved water supply	<ul style="list-style-type: none"> • Few countries have reforestation plans • Emissions minimal for most countries with little increase • Most countries reduced consumption of ozone-depleting substances by more than 50%

Source: UNPD MDG Report 2012

According to the World Bank, Africa (excluding North Africa) made the least progress in reducing poverty. It is about 41 per cent off the 2015 target, versus 25 per cent in South Asia and 6.1 per cent in Latin America, taking an annual average, poverty declined by only 0.5 per cent from 1990 to 2008. What seems to explain the regional disparities in the results gained in this indicator, is the difference in economic growth elasticity of poverty. In Africa it is less than other regions, being in some areas (Eastern and Southern Africa) less than a half that of Latin America and the Caribbean. “The low growth elasticity of poverty marks a

⁹⁰ *Ivi, p.1*

weak connection between growing sectors of the economy and the sectors where the poor work, as well as spatial disparities between areas with strong growth and areas where the poor live”.⁹¹ Lacking adequate access to modern physical and social infrastructures, large rural population cannot contribute to economic growth and to the consequent reduction of poverty and inequality.

“In contrast with the past trend where the number of people in extreme poverty (below \$1.25 a day) has increased considerably in Africa (excluding North Africa) from 289 million (1990) to 394 million (2005), the trend was reversed by 2008”.⁹² Significant decrease (about 9.0 million) in the number of people living below the threshold has been registered. However lately, about 3.2 million people live below the \$2.00-a-day poverty line, there is more vulnerability between the \$1.25 and \$2.00-a-day lines. “This new poverty dimension hits some of the middle class that plays a critical role in Africa’s growth process, and confirms the finding from AfDB (2011) that, although Africa’s middle class has grown over the past 30 years, some segments remain vulnerable”.⁹³

Poverty in Africa pervades rural areas. The “rural” way of living and thinking stays behind the precarious conditions of infrastructures and the limited access to good standards of education. More often, access to education is forbidden to women since in countries like Egypt, Morocco, Cameroon, Kenya, Cape Verde, South Africa, Guinea and Madagascar it is still dominant the “feminized” nature of poverty. Women often are forced to work home so they are prevented from getting money, while on the chance they could have a job, albeit mostly in poor conditions, they are underpaid.

Malnutrition and undernourishment are closely linked to income poverty. Few African countries have made progress in reducing the proportion of underweight children, but not enough to achieve certainly the target by 2015. “Central, East, Southern and West Africa improved slightly from 27 percent to 22 per cent between 1990 and 2009”⁹⁴.

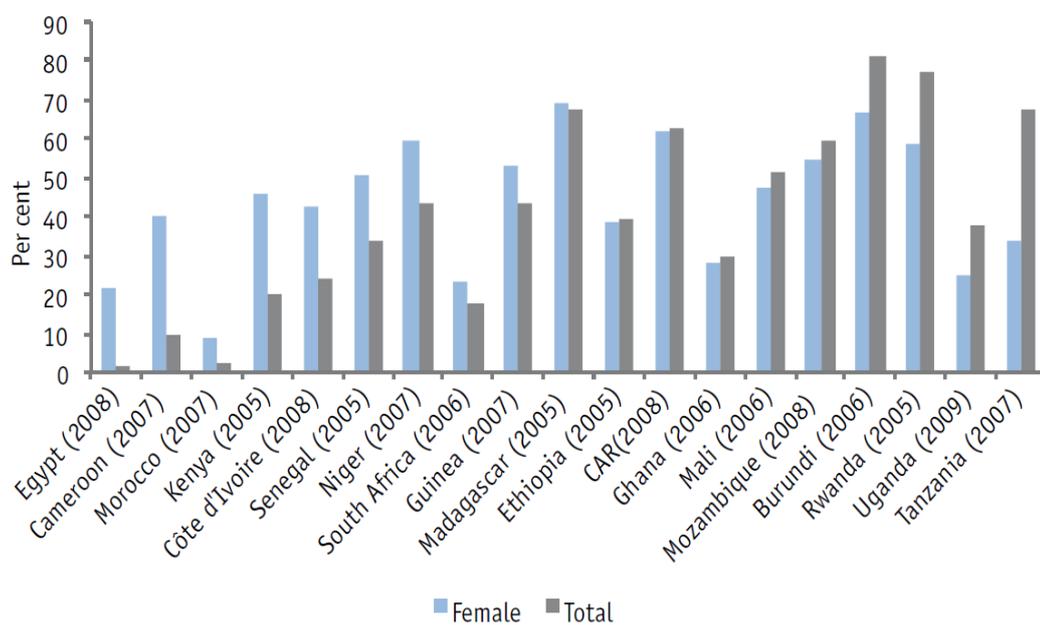
⁹¹ *Ivi*, p.12

⁹² *Ivi*, p.2

⁹³ *Ibidem*

⁹⁴ *Ivi*, p.20

Fig. 4.3 Poverty is higher among women in many countries



Source: UNPD MDG Report 2012

Malnutrition of children affects other MDGs as it could be an “underlying cause of more than a third of under-five deaths and more than 20 per cent of maternal death”.⁹⁵

“Adequate nutrition is central to achieving many MDG targets. Well-nourished children have strong immune systems and are less likely to die prematurely from communicable diseases. Infants who are undernourished in the first 1,000 days of life can suffer irreparable damage to their physical and mental development, handicapping them for life. Malnutrition affects children’s cognitive learning and educational performance and status in life. On reaching adulthood, they are likely to give birth to another generation of low-birth-weight babies. Malnourished mothers are at greater risk than healthy mothers of dying during childbirth and of giving birth to underweight, stunted and wasted children with less chance of surviving infancy than well-nourished infants.”⁹⁶

⁹⁵ UNICEF (2011b). *Levels and Trends in Child Mortality: Report 2011*. New York: UNICEF (quoted in UNDP (2012), *Assessing progress in Africa toward the Millennium Development Goals, Emerging perspectives from Africa on the post-2012 development agenda, MDG Report 2012*, New York, UNDP Publishing, p.22).

4.4.2 MDG-2: Achieve universal primary education

The Millennium Development Declaration set the still difficult deadline of 2015 for all children both boys and girls to complete a full course of primary schooling.

Education gives great contribution to human development and the progress gained on this indicator can again have positive “knock-on effect” on others MDGs. Primary education for girls and boys could be a preventive solution against HIV/AIDS. Higher levels of education especially granted for women, provide them with better employments and wages and more important, grow their knowledge for improving maternal and children health, immunization rates and good family nutrition.

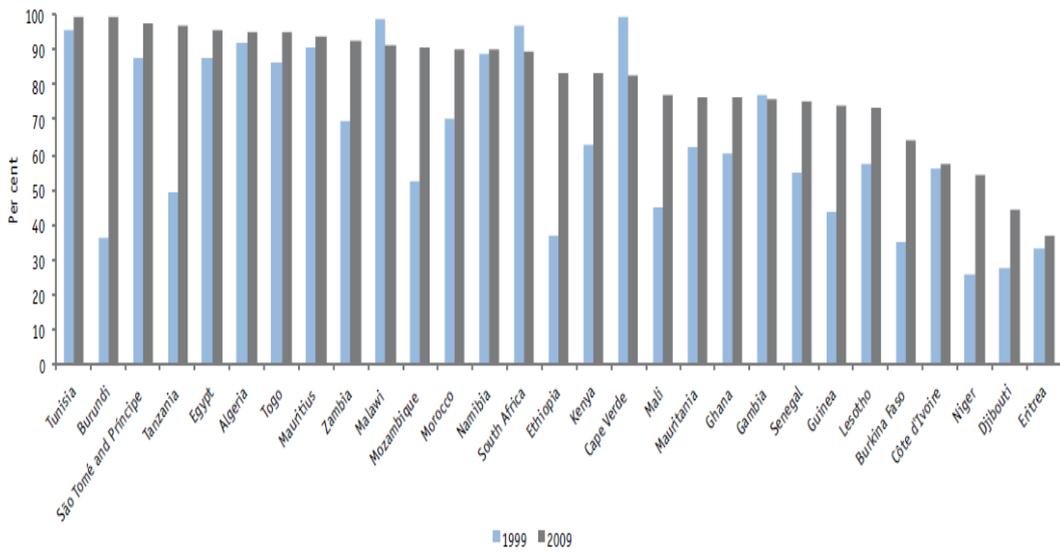
Africa’s progress at least on this indicator is gaining momentum: “Of the 35 African countries with data for 2009, 17 had net enrolment ratios above 90 per cent. Algeria, Burundi, Egypt, São Tomé and Príncipe, Tanzania, Togo and Tunisia have already reached or exceeded the minimum target to achieve 95 percent net enrolment by 2015. Ten countries have made considerable strides to improve their net enrolment ratios by more than 20 percentage points between 1999 and 2009 (table 2.1). It is heartening that some of the fragile states, such as Burundi, and non-resource rich countries, including Madagascar, Rwanda, São Tomé and Príncipe, and Tanzania have achieved or are nearing the goal of universal primary education. Seven countries registered increases in primary school enrolment ratios of 10–20 percentage points. However, countries such as Djibouti and Eritrea still have very low net enrolment (Figure 4.4).”⁹⁷

In order to reach these good results, African countries have apply their own, but similar, ways of encouraging primary education; among all the introduction of free compulsory education has been the major driver.

⁹⁶ VICTORIA C.G. et al. (2008). *Maternal and Child Undernutrition: Consequences for Adult Health and Human Capital*. The Lancet, Vol. 371, No. 9609, pp. 340–57 (quoted in UNDP (2012), *Assessing progress in Africa toward the Millennium Development Goals, Emerging perspectives from Africa on the post-2012 development agenda, MDG Report 2012*, New York, UNDP Publishing, p.23).

⁹⁷ UNDP (2012), *Assessing progress in Africa toward the Millennium Development Goals, Emerging perspectives from Africa on the post-2012 development agenda, MDG Report 2012*, New York, UNDP Publishing, p.26.

Fig. 4.4 Net enrolment in primary education, 1999 and 2009



Source: UNPD MDG Report 2012

Some example could let better understand, countries such as Namibia have introduced compulsory education in their constitution, Mauritius has decided to impose penalties on parents who do not send their children to school, Seychelles has eliminated any educational discriminations and Tanzania increasing its budgetary allocations, has gained progress on primary school-enrolments. Yet, a few countries like Cape Verde, Malawi, South Africa and Gambia suffering for lacking of qualified teachers or adequate educational management and infrastructures have recorded notable reversals in net enrolment in primary education.

Conversely, completion rates in primary school are by far discouraging. Due to individual factors that directly affect pupils, or household situation together with school factors such as school location or teacher absenteeism “only six countries recorded primary completion rates of 90 per cent and above in 2009. From 1999 to 2009, seven countries recorded huge gains of more than 30 percentage points. Apart from Madagascar, Tanzania and São Tomé and Príncipe, they started from a very low primary completion rate (of below 30 per cent)... Another seven countries (Burkina Faso, Chad, Côte d’Ivoire, Djibouti, Eritrea, Equatorial Guinea and Niger) can be classified as seriously off track because their completion rates

in 2009 were below 50 per cent and on current trends their rates may not even exceed that by 2015.”⁹⁸

4.4.3 MDG-3: Promote gender equality and empower women

Promoting gender equality and empowering women is what the MDG 3 commits. Surveys conducted on the consequences resulted from the societies’ decision of not investing in gender equality and female empowerment, demonstrate that “over 2005–2015, wide gender gaps in education at primary and secondary levels were estimated to reduce economic growth by 0.4 percentage points annually, increase birth rates by about one child per woman, increase child deaths by 32 per year (per 1,000 live births) and raise by 2.5 percentage points the prevalence of underweight children”⁹⁹.

The third Goal also calls for eliminating the enrolment gap between boys and girls in primary and secondary education. In Africa the progress situation is rather mottled nevertheless there are some countries that are close to achieving this goal. According to UNESCO (2012) of 49 countries in Africa having data, 31 countries have a gender parity index in primary school enrolment of less than 1.0 (that is, girls’ enrolment is less than boys’), 16 countries have an index of 1.0 (boys’ enrolment is equal to girls’), and in two countries girls’ enrolment is higher than boys’ (Table 4.2).¹⁰⁰

Together with the progresses reached for the first target, there are also great advances on the proportion of seats held by women in national parliament. Probably due to the adoption of legal frameworks guaranteeing a minimum number of women representatives in parliament, “seven countries have reached the target of 30 per cent women in the national parliament – Rwanda, South Africa, Mozambique, Angola, Tanzania, Burundi and Uganda.

⁹⁸ Ivi, p.28.

⁹⁹ ABU-GHAIDA D, KLASSEN S. (2004). *The Costs of Missing the Millennium Development Goal on Gender Equity*. World Development, Vol. 32, No. 7, pp. 1075–1107 (quoted in UNDP (2012), *Assessing progress in Africa toward the Millennium Development Goals, Emerging perspectives from Africa on the post-2012 development agenda, MDG Report 2012*, New York, UNDP Publishing, p.37).

¹⁰⁰ UNESCO (2012). *World Atlas of Gender Equality in Education*. Paris, UNESCO Publishing (quoted in UNDP (2012), *Assessing progress in Africa toward the Millennium Development Goals, Emerging perspectives from Africa on the post-2012 development agenda, MDG Report 2012*, New York, UNDP Publishing, p.38).

Table 4.2 Changes in primary completion rate, 1999-2009

Gains of 20 percentage points or more		Gains of 1–20 percentage points		Declines	
Tanzania	45.1	Burkina Faso	19.8	Equatorial Guinea	-5.2
Madagascar	44.0	Ghana	16.2	Malawi	-8.0
Mozambique	42.6	Senegal	14.3	Namibia	-8.4
São Tomé and Príncipe	36.8	Eritrea	13.5	Mauritius	-10.5
Ethiopia	34.5	Chad	13.4		
Guinea	32.7	Djibouti	10.9		
Burundi	30.2	South Africa	8.2		
Morocco	26.6	Lesotho	7.5		
DRC	25.0	Egypt	6.6		
Cameroon	24.8	Togo	6.5		
Zambia	23.1	Algeria	5.9		
Niger	21.5	Côte d'Ivoire	5.2		
Sudan	21.4	Gambia	2.7		
		Tunisia	0.5		

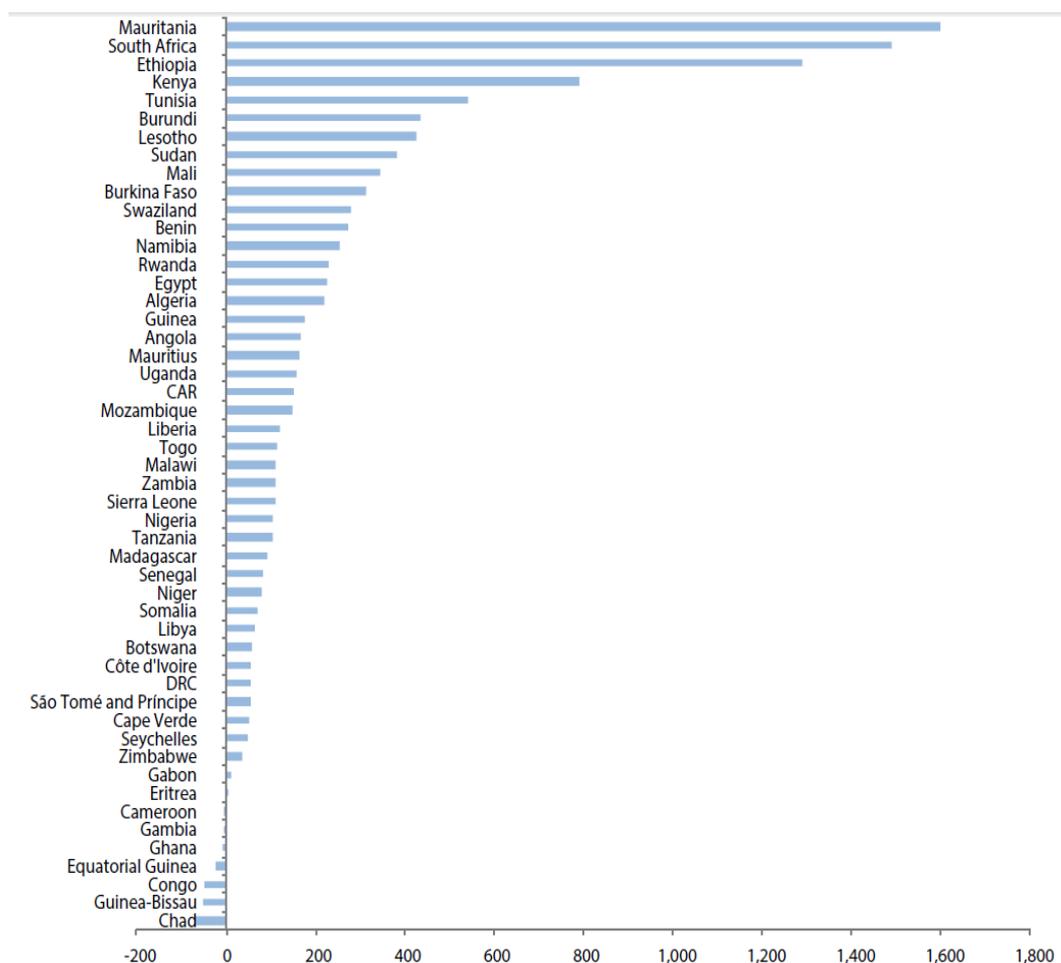
Source: UNPD MDG Report 2012

Three countries are very close to reaching the target: Ethiopia, Tunisia and Sudan. Countries with the fastest growth after 1990 (at over 500 per cent) include Morocco, Mauritania, South Africa, Ethiopia, Kenya and Tunisia. Forty-four countries had made progress by 2011. Yet 15 countries still have fewer than 10 per cent of women in the national legislature. Countries that regressed are Niger, Chad, Guinea Bissau, Congo, Equatorial Guinea, Ghana, Cameroon and Comoros”.¹⁰¹ (Figure 4.5)

On the contrary, despite good results in gender equality and woman’s empowerment, Africa remains off-track in meeting gender parity in secondary and tertiary levels. Likely, this could depend on girls’ high drop-out rates in secondary education.

¹⁰¹ UNDP (2012). *Assessing progress in Africa toward the Millennium Development Goals, Emerging perspectives from Africa on the post-2012 development agenda, MDG Report 2012*, New York, UNDP Publishing, p.51).

Fig. 4.5 Changes in proportion of seats held by women in national parliament



Source: UNPD MDG Report 2012

Many factors seem account for it: from cultural and family constraints, to lack of good school management unable to develop girl-responsive secondary schools that provide a right representation of female teachers in order to be taken as role models for girls. Right female representation in school could also promote gender-sensitive sanitation facilities in most schools. But, even worst, their (of girls) vulnerability to violence, in and out of educational settings, can be a major constraint to the achievement of this target.

4.4.4 MDG-7: *Ensure environment sustainability*

One more time, lack of coordination among authorities coupled with incompetent governmental staff in regards of environmental issues and shortage of financial resources, are the brakes that hold Africa back from achieving the seventh MDG. It would ensure environmental sustainability. Weak forestry institutions, and regulatory frameworks leave the forest areas being over-exploited for satisfying basic human needs.¹⁰²

Usually this Goal is tied up (only) with the good results achieved at the global level, in the commitment to enlarge the access to safe drinking water and basic sanitation by 2015. Actually, “this MDG target has globally been met well in advance of the MDG 2015 deadline. Over 2 billion people (89 per cent versus the 88 per cent target) gained access to an improved drinking water source during 1990–2010, such as piped supplies and protected wells (WHO/UNICEF, 2012)”.¹⁰³

But this could not be applied to the specific case of Africa: “the relevant proportion has indeed increased over the period, from 56 per cent to 66 per cent, but the rate of progress is still too slow to hit the continent-wide 78 per cent target by 2015”.¹⁰⁴

However, there are other curious signs of reversals that testify for a decreasing access to safe water rate in urban areas (from 86 per cent to 85 per cent), partially due to exponential urbanization and growth of slums. (See Figures 4.6)

A clear contrast between urban and rural realities is also recorded for the rate regarding the population access to sanitation facility that in 2010, registered “54 per cent and only 31 per cent, respectively”.¹⁰⁵ But lately, because of rapid urbanization, urban areas have decreased their access rate to sanitation facility.

¹⁰² “In 1990, Africa (excluding North Africa) had 31.2 per cent of land area covered by forest; by 2010, this had shrunk to 28.1 per cent” quoted in UNDP (2012). *Assessing progress in Africa toward the Millennium Development Goals, Emerging perspectives from Africa on the post-2012 development agenda, MDG Report 2012*, New York, UNDP Publishing, p.93).

¹⁰³ *Ivi*, p.101.

¹⁰⁴ *Ibidem*.

¹⁰⁵ UNDP (2012). *Assessing progress in Africa toward the Millennium Development Goals, Emerging perspectives from Africa on the post-2012 development agenda, MDG Report 2012*, New York, UNDP Publishing, p.107).

With just 5 percentage point more than in 2010, it is very likely that not even this target will be reached in Africa, where high costs of infrastructures and low returns to private investment in this sector, still represent the main constraints to an effective progress.

4.4.5 MDG-8: Develop a global partnership for development

Achieving the MDGs will require greater international cooperation and assistance by the industrial countries. Promises made by donors countries to increase development financing towards the continent often have been not kept. Nevertheless, the international community has met again to find new solutions in order to avoid to go back on their promises to accelerate progress towards MDGs. On September 2010 during the Summit on Accelerating Progress towards the MDGs some donors have decided to increase the official development assistance (ODA) committing to the target of 0.7 per cent of gross national income (GNI)¹⁰⁶. Some others have will commit 0.15-0.20 per cent of GNI to least developed countries.¹⁰⁷

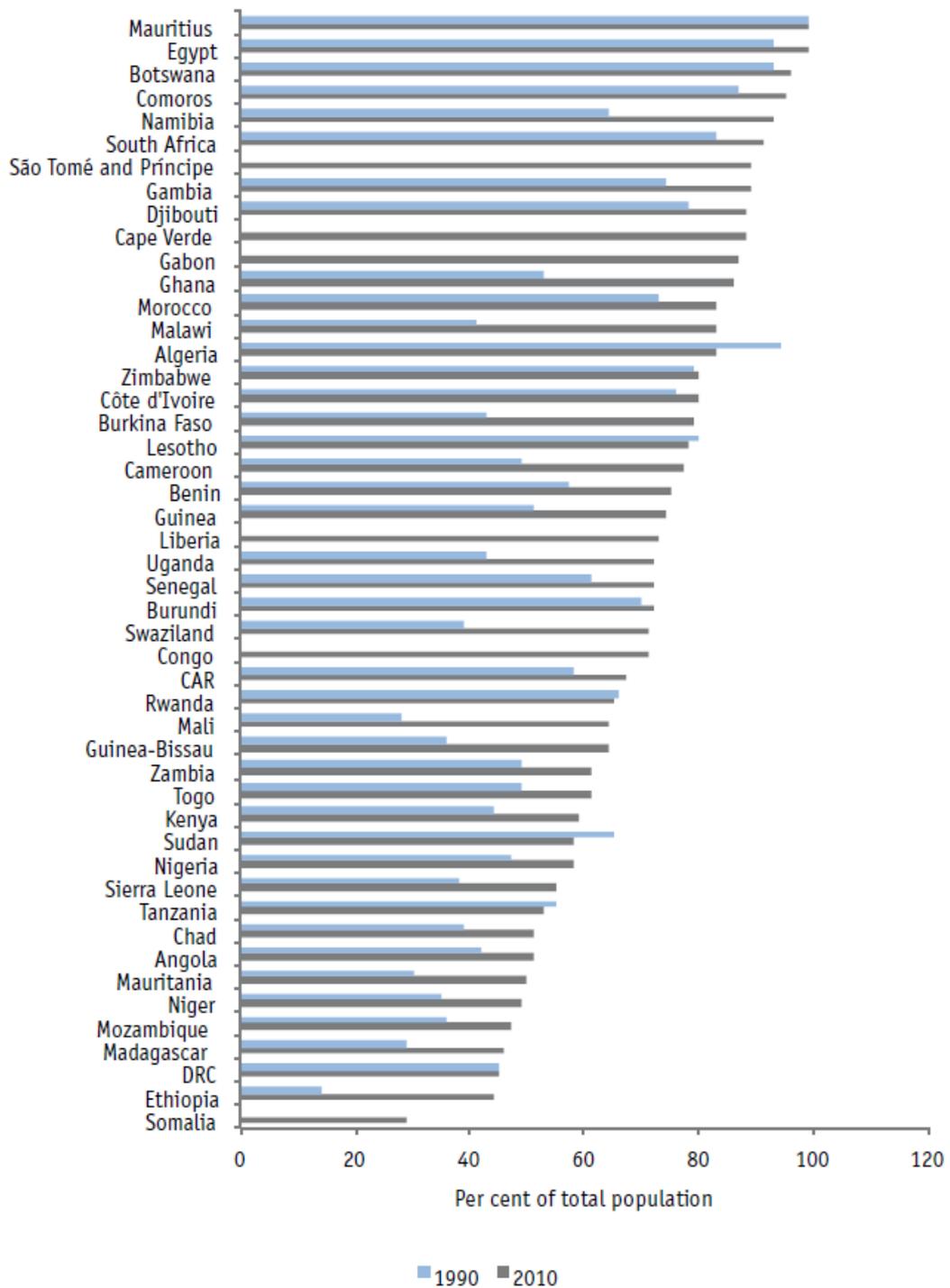
However, the recipients countries have decided to reduce their dependence on aid over time, reaffirming national policies and expanding domestic capital markets. But, because of the 2008– 2009 global economic and financial crisis, international environment has become critical, especially for fragile and low-income states as Africa, that face serious resource constraints and enormous challenges in meeting the MDGs.

Recent studies show that achieving the MDGs would require doubling present ODA flows (MDG 2010 Report). “Debt relief under the HIPC Initiative would also need to be enlarged and sustained. And the industrialized countries would need to reduce the agricultural subsidies and remove the remaining protectionist trade barriers that still discourage exports, particularly from the less developed countries (e.g. Africa).

¹⁰⁶ Belgium, Finland, Germany, Liechtenstein, Monaco and the United Kingdom. The Republic of Korea and Romania also pledged to increase their ODA as a share of GNI to 0.25 per cent and 0.17 per cent by 2015, respectively. Denmark, Luxembourg, Norway and Sweden pledged to maintain their levels of over 0.7 per cent.

¹⁰⁷ Australia.

Fig. 4.6 Changes in access to an improved water sources, urban and rural, 1990-2010



Source: UNPD MDG Report 2012

Table 4.3 DAC member's net ODA, 2010

	2010		2009		% change
	ODA	ODA/GNI	ODA	ODA/GNI	2009 to 2010
Country	\$ million	%	\$ million	%	in real terms ^a
Australia	3,826	0.32	2,762	0.29	11.4
Austria	1,208	0.32	1,142	0.30	9.6
Belgium	3,004	0.64	2,610	0.55	19.3
Canada	5,202	0.34	4,000	0.30	14.3
Denmark	2,871	0.91	2,810	0.88	4.5
Finland	1,333	0.55	1,290	0.54	6.7
France	12,915	0.50	12,602	0.47	7.3
Germany	12,985	0.39	12,079	0.35	12.1
Greece	508	0.17	607	0.19	-14.9
Ireland	895	0.52	1,006	0.54	-4.9
Italy	2,996	0.15	3,297	0.16	-5.1
Japan	11,054	0.20	9,457	0.18	11.9
Korea, Rep.	1,174	0.12	816	0.10	26.4
Luxembourg	403	1.05	415	1.04	0.5
Netherlands	6,357	0.81	6,426	0.82	2.4
New Zealand	342	0.26	309	0.28	-6.8
Norway	4,580	1.10	4,081	1.06	3.7
Portugal	649	0.29	513	0.23	31.6
Spain	5,949	0.43	6,584	0.46	-5.3
Sweden	4,533	0.97	4,548	1.12	-7.0
Switzerland	2,300	0.40	2,310	0.45	-4.3
United Kingdom	13,053	0.57	11,283	0.51	13.3
United States	30,353	0.21	28,831	0.21	4.2
Total DAC	128,492	0.32	119,778	0.31	6.3

Source: UNPD MDG Report 2012

Even if tariffs and quotas are greatly reduced, many developing countries will still face difficulties realizing the benefits. Global Poverty Report (2002) suggests that if trade protection were reduced by half, developing countries would gain about \$200 billion by 2015. But only \$2.4 billion of this would go to Sub-Saharan Africa. To make trade an effective source of growth, developing countries need to

increase the efficiency of their trading sectors. Developed countries can help by providing “aid for trade” and sharing knowledge needed to establish competitive export industries.”¹⁰⁸

These important initiatives taken by the international community are fundamental for supporting the MDGs in Africa, but the greatest commitment should be made by the same African countries. They should find alternative sourcing of financing and mobilize domestic resources. Additionally, “African countries also need to enhance their bargaining power with all development partners to ensure that these partnerships are mutually beneficial”.¹⁰⁹

4.5 Stalling demographic transition

Unfortunately, it is conceivable that Africa’s social and economic development will also suffer the effects due to its slow pace of fertility transition. Actually, this distinctively unexpected slow fertility decline, since the early 2000s in sub-Saharan Africa may have severe implications for future demographic evolution, as imperceptible decreases in fertility rate would have large repercussions on bulk and age structure of future African population.

United Nations’ hypothesis¹¹⁰ estimates to nearly 9.6 billion the world population in 2050 however, the main growth will take place in developing countries “with more than half in Africa”¹¹¹.

According to scholars who have observed demographic transition for the first time for Northern and Western Europe during the interwar years in 19th and 20th century, all countries are expected to undergo a demographic process moving from high mortality and fertility rates to lower mortality and fertility trends.

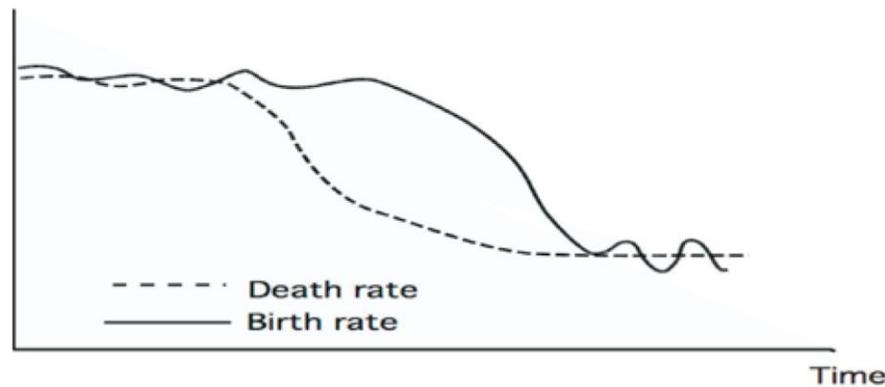
¹⁰⁸ ALEYOMI M. B (2013), *Africa and the Millennium Development Goals: constraints and possibilities*. International Journal of Politics and Good Governance. Volume 4, No. 4.1.

¹⁰⁹ UNDP (2012), *Assessing progress in Africa toward the Millennium Development Goals, Emerging perspectives from Africa on the post-2012 development agenda, MDG Report 2012*, New York, UNDP Publishing, p.123.

¹¹⁰ UN DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS, June 13th 2013, available from: <http://www.un.org/en/development/desa/news/population/un-report-world-population-projected-to-reach-9-6-billion-by-2050.html>

¹¹¹ *Ibidem*

Fig. 4.7 The demographic transition



Source: Bo Malberg (2008)

Since the 1960s the majority of developing countries have started their demographic transition towards a considerably rapid decrease in fertility rate; according to UN estimates, by 2000 some of these countries had reached a total fertility rate (TFR) of 2.1 children per woman¹¹² and even more fertility drops will be expected in the future.

Also Sub-Saharan Africa undertook this process even if lacking data impede an exact estimation of the beginning of mortality rates' decline. Yet, United Nations consider that mortality rate began to lower in conjunction with the widespread use of DDT spraying after 1945; actually, since the early 1950s, with a death rate of 27 per thousand, Sub-Saharan Africa undertook the mortality decline phase of the demographic transition. However, birth rate of 49 per thousand made the natural population growth rather high (2.2 percent) till reaching its maximum of 3.0 percent per year in 1980-85. Southern Africa, though housing "just" 10 percent of African population, has largely contributed in decreasing infant mortality since 1950 when its Infant Mortality Ratio (IMR) was below 100 deaths per thousand births compared to the IMR close to 200 of other African regions. Its more developed economy along with better public health measures, as the anti-malaria

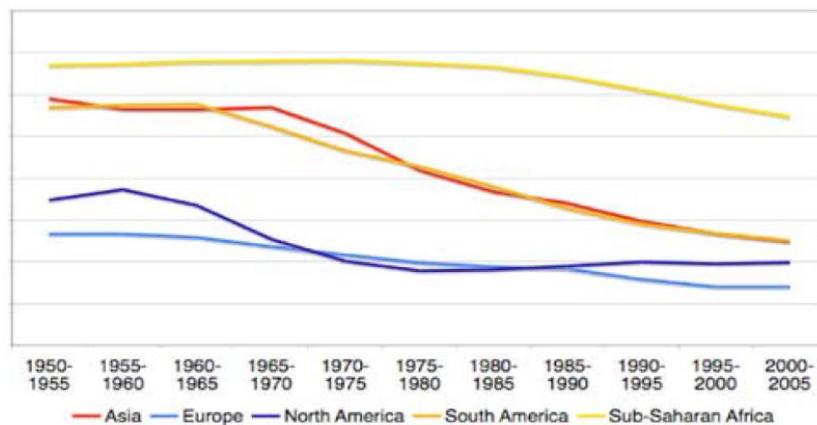
¹¹² UNDP (2012), *Assessing progress in Africa toward the Millennium Development Goals, Emerging perspectives from Africa on the post-2012 development agenda, MDG Report 2012*, New York, UNDP Publishing.

campaign, probably due to a large presence of white population, proved to be fundamental in this “progress”.¹¹³

African fertility phase of the demographic transition started around 1980 when fertility began to fall from an averaged seventh children per women to the current trend of 5.1. From these data, it can be discerned that Sub-Saharan Africa has so far experience any significant decline in its fertility rates.

According to Bo Malmberg, Figure 4.5 shows that current fertility rates of the sub continent are those recorded by Asia and South America towards the end of 1970s.

Fig. 4.8 Total fertility rate by world regions 1950-2005



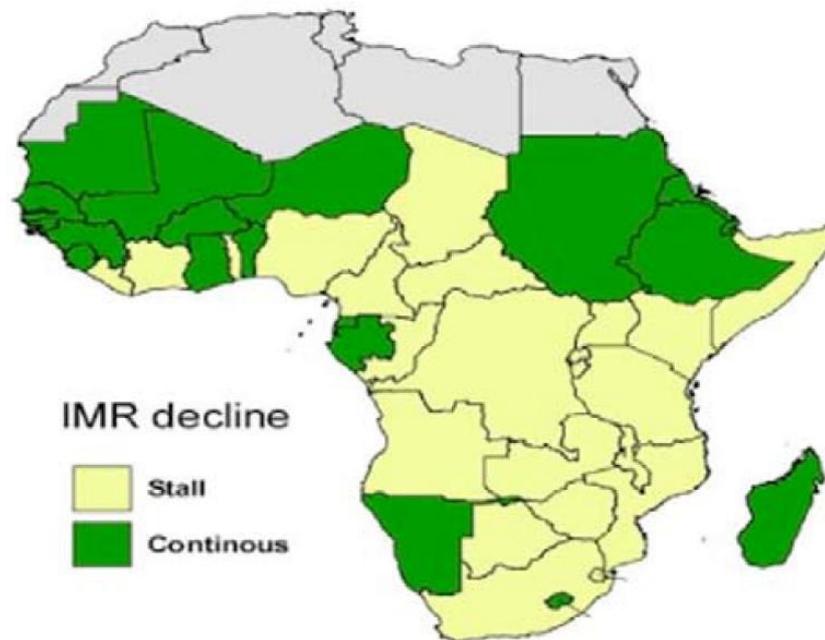
Source: Bo Malberg (2008)

4.5.1 Infant mortality

Infant mortality rate is the most widely used indicator of the general health condition of a country. In Africa this indicator has recorded different averages among countries: it has been rather continuous in some countries while in the rest, it remains above 100 per thousand births, as shown in Fig. 4.9.

¹¹³ “In fact, it has been suggested that apartheid was first conceived as a policy aimed at protecting the white population from malaria infection.”. MALBERG BO, (2008). *Demography and the development potential of Sub-Saharan Africa*, Current Africa Issues No 38, Uppsala, Nordiska Afrikainstitutet Publishing, p.8.

Fig. 4.9 Infant mortality incidence in Africa



Source: Bo Malberg (2008)

The African stall in this indicator during the last two decades of the 20th century could be due to political-economic causes which have in turn affected health improvement.

4.5.2 Life expectancy

Life expectancy indicator is instrumental in measuring death risks over the entire lifespan. African life expectancy trend increased until late 1980s, but after the widespread of HIV epidemic in 1990s declined again.¹¹⁴ Southern, Eastern and Central Africa, have paid the worst consequences of this epidemic with a decreasing in their life expectancy of respectively 10-22 and 4-8 years.

¹¹⁴United Nations. Population Division (2006). *World Population Prospects : The 2004 Revision*. New York: United Nations.

4.5.3 (*Stalling*) fertility rate

Recent surveys have recorded a less rapid decline in fertility rate compared to the earlier hypothesis. Moreover, in some countries this low decrease in fertility has become even a stall. Hence, since the early 2000s countries' evidence of fertility stall or even reversals of fertility decline have been collected and analyzed in several African countries; among the others, Kenya and Ghana were the first to experience a stall in fertility decline.

Actually, most African countries are still recording relatively higher fertility rates; yet, total fertility rate varies not only among countries but also within the same country because of the socioeconomic variation among rural and urban regions.

Scholars have tried to find a correlation between high fertility rates in Africa and its inherited socio-cultural attitudes which make population resistant to external influences. Applying this consideration on the specific issue of fertility rate, this would mean that high fertility trends in Africa are legacies of reluctant population to succumb to external changes.

In addition to the "legacy-hypothesis", many other cultural factors prove to be pivotal in precluding fertility decline. The traditional religious belief system, for example, imposes lineage continuation. In order to face high infant mortality's concern that threatens generations' succession, African cultural heritage exalts fertility; as a matter of fact, large families are socially well-considered in Africa.

Early marriages, polygamy and rapid remarriage of widows are all practices enlarging even more the possibility to breed.¹¹⁵

African countries where TFR is stalling are those with an average rate of 5.6 children per women compared to the 4.9 of countries "in transition"; because of their forced prohibition of reproduction's control, only 11 percent of women use modern contraceptive compared to 28 percent in transition countries.

Policy makers considered that the solution to high population growth due to high fertility rates could be the promotion of better education to potential users of family planning; however, family/partner opposition is not the only reason behind

¹¹⁵ CALDWELL J, CALDWELL P. (1987). *The cultural context of high fertility in sub-Saharan Africa*. Population and Development Review, Vol.13, No 3, Population Council Publishing (quoted in EKANE D, Fertility trends in sub-Saharan Africa. Stockholm University).

the high percentage of women not using family planning. Women avoid any form of contraception as they think that they cannot get pregnant no more or that they could have side effects or they simply lack physical and financial access to buy it.

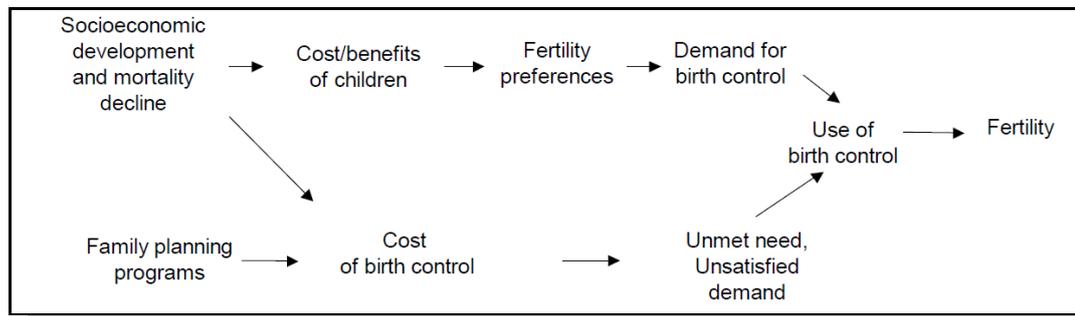
According to the most employed method of defining a fertility stall, Sub-Saharan Africa is classified to be in a stall since its annual pace of fertility (TFR) has failed to decrease between the two most recent Demographics and Health Surveys (DHS).

Socio-economic development is usually considered a factor of slow fertility decline in Africa: declining GDP per capita during 1990s together with lowering of life-expectancy due to AIDS spreading, have contributed to the current stalling fertility in several African countries.

As a matter of fact, scholars have demonstrated that fertility decline accelerates when socio-economic conditions improve, contextually to the increase of the demand for smaller families and the moving away from the socio-cultural values against contraceptive use. According to Bongaarts: “Socioeconomic development is considered the main cause of a decline over time in the benefits of children and a rise in their costs. These changes in the cost/benefit ratio lead parents to want fewer children, and mortality decline raises child survival so that families need fewer births to achieve the desired number of surviving children. These trends in turn raise the demand for birth control (i.e., contraception and induced abortion), and, to the extent this demand is satisfied, lower fertility results. Family planning programs facilitate this transition by reducing the cost of birth control (broadly defined to include social costs), thus raising the level of implementation of the demand for contraception and reducing the unmet need for contraception. Higher levels of socioeconomic development also reduce the cost of birth control”.¹¹⁶

¹¹⁶BONGAARTS J, (2005), *The Causes of Stalling Fertility Transitions*, Policy Research Division Working Papers 204, New York, Population Council Org. Publishing, p.3.

Fig 4.10 Analytic framework for the determinants of fertility



Source: Bongaarts (2005)

4.5.4 Population growth

The combination of high fertility rates and decreasing mortality rate seems to be the key determinant of rapid population growth in Sub-Saharan Africa. According to Bo Malberg, African population in the last 50 years has undergone a population growth resembling that of Europe between 1750 and 1950; actually, Africa, like Europe has quadrupled its population from 180 million to 769 million in just fifty years.¹¹⁷

In particular, the slow pace of fertility decline entails heavy effects on size and age structure of coming African populations. Growing population in turn, would affect economic and social development, threatening natural resources allocation and consequently food security.

Considering that age indicator of a country population is instrumental for development policy making, very young population of African continent means larger proportion of young in working-age, more workforce and even increasing proportion of population in school age. Nevertheless, in addition to the others, current consequences of it are political instability due to high levels of unemployment.

¹¹⁷ MALBERG BO. (2008). *Demography and the development potential of Sub-Saharan Africa*, Current Africa Issues No 38, Uppsala, Nordiska Afrika Institutet Publishing.

Therefore, an uncoordinated demographic transition leaving Africa the epicentre of the “demographic arc of instability”¹¹⁸, leads to a plethora of failed opportunities for improving a country’s economic and human development.

¹¹⁸ CINCOTTA, R (2010), *The Future of Sub-Saharan Africa’s Tentative Fertility Decline*, New Security Beat.

CHAPTER 5: AFRICAN CORRUPTION: A DEVELOPMENT ISSUE

“ in 2008 a woman in Africa died as a result of pregnancy or childbirth every 2,5 minutes-24 an hour, 576 a day and 210.223 a year. ”¹¹⁹

“Corruption in Africa: A crime against development”¹²⁰

5.1 Introduction

Immediately after the independence, countries in Sub-Saharan Africa rapidly broaden access to health services to wider segments of their populations, therefore an effective improvement in health indicators was actually recorded.

Major communicable diseases were monitored through public health programs, several attempts to strengthen health systems were made and there was a general inclination among actors and institutions to allocate a proportionate amount of resources in order to improve the health status of the population.

Nevertheless, these gains have now been reversed. Sub-Saharan Africa population still faces a stagnating health scenario; housing 12 percent of world's population, this region accounts for 22 percent of the total global disease burden in addition to the more 68 percent of other people living with HIV/AIDS.¹²¹ Twenty-four African countries still count above 100 under-five children's deaths per 1.000 live births (in 2010) while maternal health still remains a grave concern for most of the

¹¹⁹UNDP (2012). *Assessing progress in Africa toward the Millennium Development Goals, Emerging perspectives from Africa on the post-2012 development agenda, MDG Report 2012*, New York, UNDP Publishing, p.65.

¹²⁰FURPHY C. 16 November 2010. *Corruption in Africa: A crime against development*, on-line article published in Consultancy Africa Intelligence website.

¹²¹USAID (2008). *Health financing in Africa today: challenges and opportunities*. USAID Publishing, p.VIII.

continent, given that in 2008 maternal mortality ratio averaged about 590 deaths per 100.000 live births.¹²²

With only (underpaid) 2 percent of the global health workforce¹²³ and only 1 percent of the world's health expenditures¹²⁴, Sub-Saharan African countries are ill-equipped to properly face their health problems.

The actual health status experienced by this region reflects a more general critical reality in health financing due to governments' inadequate capacity to address health challenges in their countries.

Indeed, even despite substantial support coming external resources in Africa large gaps remain between actually available and needed resources for health improvement.

As a matter of fact, government accountability and pertaining effectiveness are even more recognized as key determinants in achieving health-related MDGs.

Empirical evidence of the link between governance and health outcomes has shown the importance of transparent and accountable health governance in order to increase immunization rates and lower under-five mortality rates, as measured by the World Bank's Country Policy and Institutional Assessment (CPIA) score.

Hence, corruption in its wider definition of capture of public resources and decision-making, affects public spending decisions. The leakage of revenues and the consistent public fund readdressing leave governments with less to spend on social sectors, as health and education.

African governments consider more appropriate to allocate significant amounts of money in defence (improvement) or new infrastructures building than ensuring quality health services.

¹²² UNDP (2012). *Assessing progress in Africa toward the Millennium Development Goals, Emerging perspectives from Africa on the post-2012 development agenda, MDG Report 2012*, New York, UNDP Publishing, p.56; 65.

¹²³ "The lowest quintile for doctors is made up of 37 countries of which 28 are low-income countries of sub-Saharan Africa. For nurses and midwives, the situation is slightly better with 22 sub-Saharan African countries among the lowest 37 in the world" in AFRICA WORKING GROUP, (2006). *The Health Workforce in Africa. Challenges and Prospects*, Africa Working Group of the Joint Learning Initiative Publishing, p.8.

¹²⁴ GOTTRET P, SCHIEBER G, (2006). *Health Financing Revisited: A Practitioner's Guide*. Washington, DC. World Bank Publishing, p. 3

5.2 Health outcomes in Sub-Saharan Africa

Stagnating health situation in Africa is probably the main challenge for the economic development of the entire continent and for the achievement of MDGs. The period following the colonial era brought with it a renewed welfare in Africa that translated also into an improvement of health indicators. Then, it was Alma Ata declaration in 1978¹²⁵ that tried to raise hopes for poorer populations, calling for an international action to improve primary health care. Nevertheless, the commitment was not so deeply felt in Africa whose life expectancy is estimated to have barely increased in most of the region from 1970 till now. In 1970 life expectancy at birth was 45 years. This rose to 49.2 years in the late 1980s but it stopped to just 51 years during the 1990s and early 2000s. Overall, in 2009 life expectancy for people born in the African Region would be higher, if it were not for estimated six years of life lost due to the sole impact of HIV/AIDS. (See Fig. 5.1)

Africa hardly will reach any of the three health-related MDGs; it has made some progresses but they are not yet enough to accelerate African development.

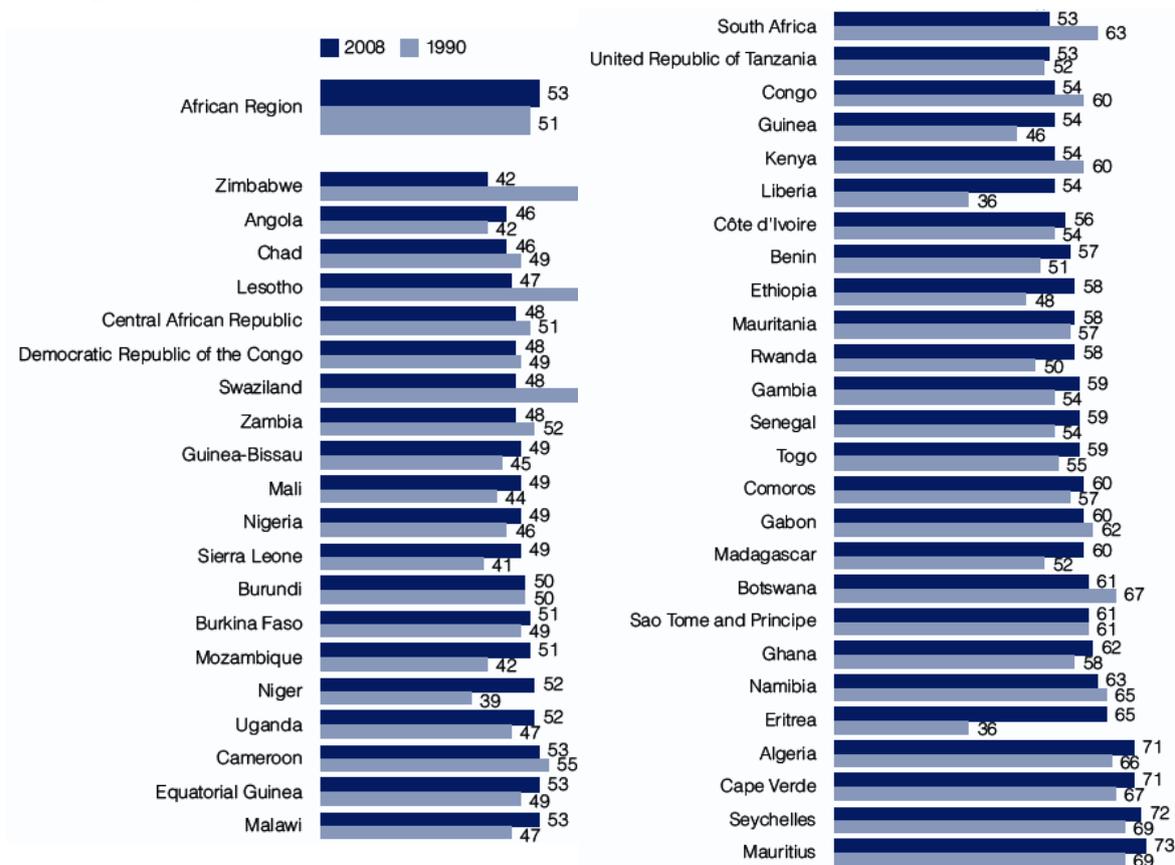
Africa continent (in 2012) has actually doubled its average rate of reduction in child mortality from 1.2 percent a year in 1990-2000 to 2.4 percent in 2000-2010.¹²⁶

Yet unfortunately, estimates on child mortality, like for other health indicators, could be not so accurate since fully functioning registration systems still represent a big challenge in Africa. Indeed the majority of surveys completely lack information about health status of rural and remote areas where, according to UNPD 2012, live most disadvantage children.

¹²⁵ The Declaration of Alma Ata was adopted at the International Conference of Primary Health Care, in Almaty (Kazakhstan) on 6-12 September 1978.

¹²⁶ UNDP (2012). *Assessing progress in Africa toward the Millennium Development Goals, Emerging perspectives from Africa on the post-2012 development agenda, MDG Report 2012*, New York, UNDP Publishing, p.56.

Fig. 5.1 Life expectancy at birth in years in the African Region, by country, 2008 and 1990



Source: WHO, *Atlas of health statistic (2011)*

Malaria, along with pneumonia, diarrhoeal diseases, pre-term complications and birth asphyxia are still the major causes of under-five mortality of which proportion is still increasing because of the lack of highly cost-effective interventions (e.g, preventive and curative programs for mothers and babies and early post-natal home visits) which governments cannot bear. Countries such as Sierra Leone, Democratic Republic of Congo, Somalia and Central African Republic, all either in conflict or recovering after conflict or ranked as having highest perceived levels of corruption¹²⁷, have also the highest rates of infant mortality (above 100 deaths per 1.000 live births in 2010).¹²⁸ Again Somalia

¹²⁷ TRANSPARENCY INTERNATIONAL, (2010). *Corruption Perception Index 2010*, Transparency International Publishing.

¹²⁸ UNDP (2012). *Assessing progress in Africa toward the Millennium Development Goals, Emerging perspectives from Africa on the post-2012 development agenda, MDG Report 2012*, New York, UNDP Publishing, p.61.

together with Chad with an average below of 50 percent, report the lowest immunization rates against measles in comparison to the rest of the countries.¹²⁹

Disproportionately high maternal mortality rates are symptomatic of a weak health system unable to provide skilled personnel and facilities to face emergencies and post-partum care. Also for this indicator, some African countries have reached a good progress in MDG 5, especially those able to improve the proportion of women delivering helped by skilled health staff or to provide population with more information about contraception (as for the case of Rwanda). Yet many others, characterized by institutional weakness, due in turn to conflicts, have higher maternal mortality likelihood. As a matter of fact, in 2008 the countries with highest maternal mortality ratio (MMR) were all eight in conflict or just recovering from a conflict.¹³⁰ This evidence is illustrative of the importance of adequate infrastructures (not limited to health institutions but also transportation, communication and roads) and services. A fragile or corrupt country is not able to provide similar services since it requires at first a rebuilding of all fundamental infrastructures (from transportations, to health and training of medical professional).

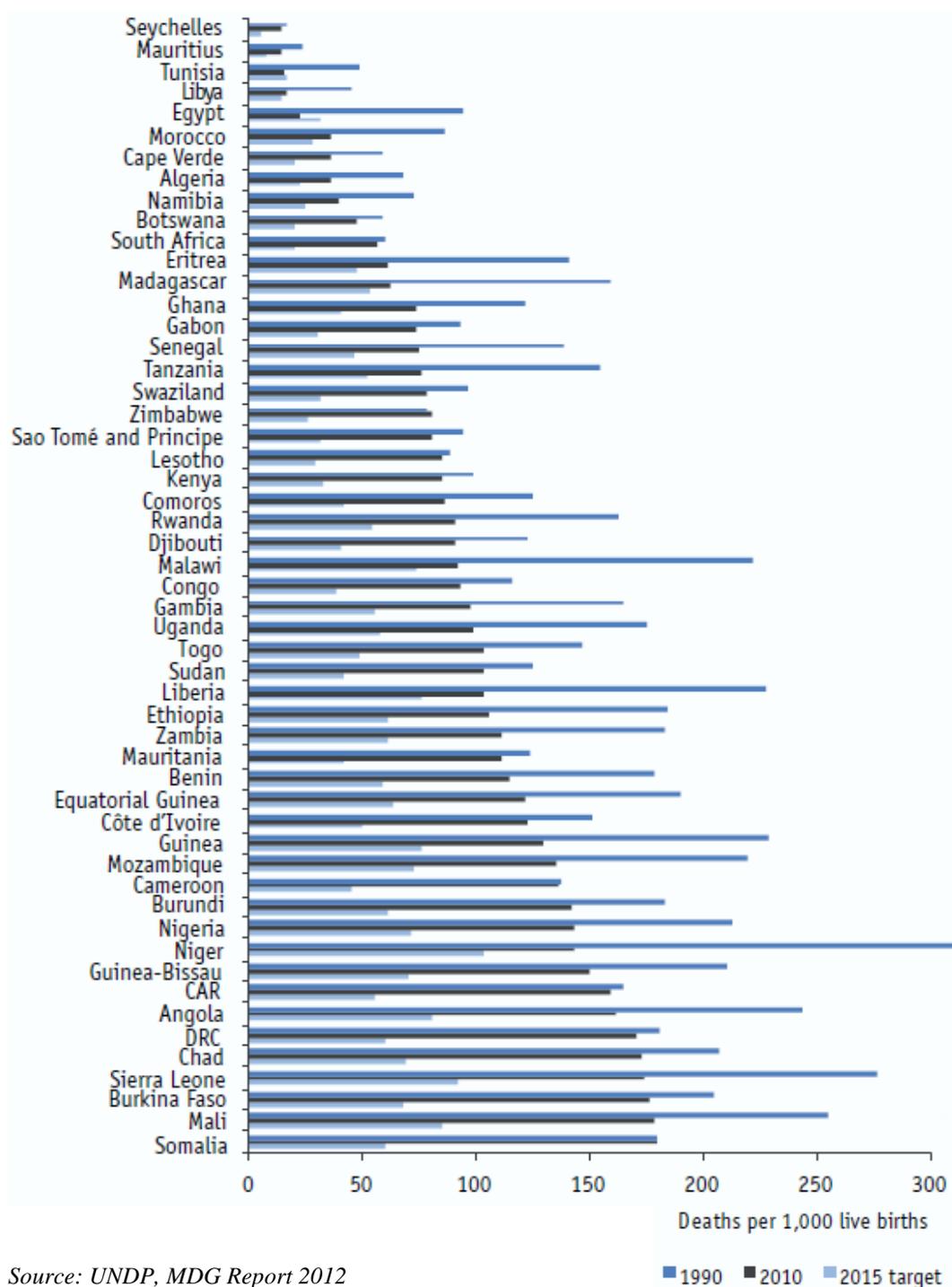
Hence, “an analysis of the data for 1995–2008 bears out the fact that the percentage increase in the proportion of births with a skilled health attendant is correlated with the percentage decrease in the MMR [Fig. 5.3]. In sum, a 1 per cent increase in this proportion is associated with a 0.21 per cent decline in maternal mortality”.¹³¹

¹²⁹ *Ivi* p.62

¹³⁰ Burundi, Central Africa Republic, Chad, Democratic Republic of Congo, Guinea-Bissau, Liberia, Sierra Leone and Somalia. UNDP (2012), *Assessing progress in Africa toward the Millennium Development Goals, Emerging perspectives from Africa on the post-2012 development agenda, MDG Report 2012*, New York, UNDP Publishing, p.68

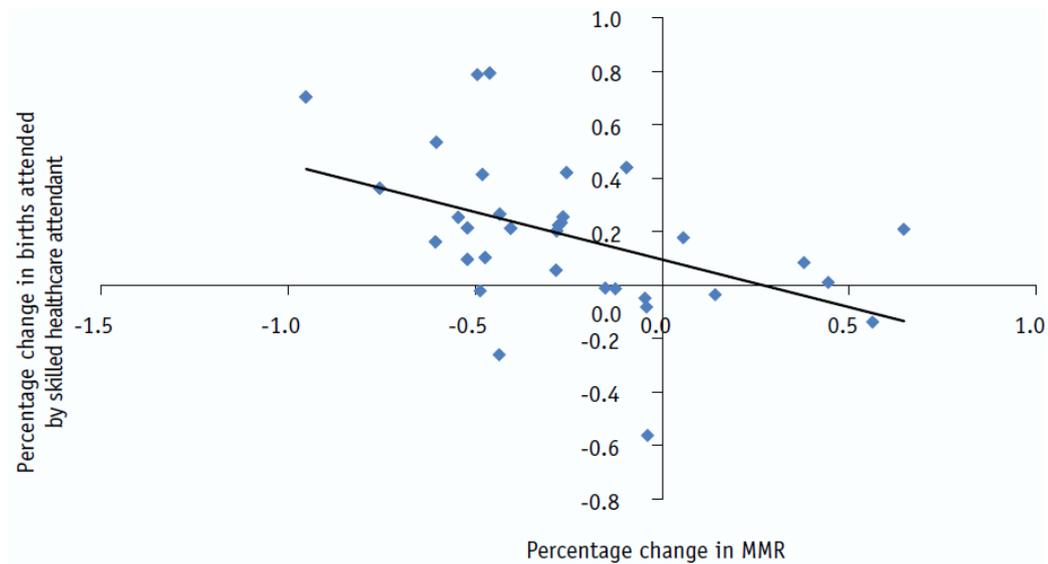
¹³¹ *Ivi* p. 69

Fig. 5.2 Progress in reducing the under-five mortality rate, 1990, 2010 and 2015 target



Source: UNDP, MDG Report 2012

Fig. 5.3 Correlation between % change in proportion of births with a skilled health attendant and % change in MMR, 1995–2008



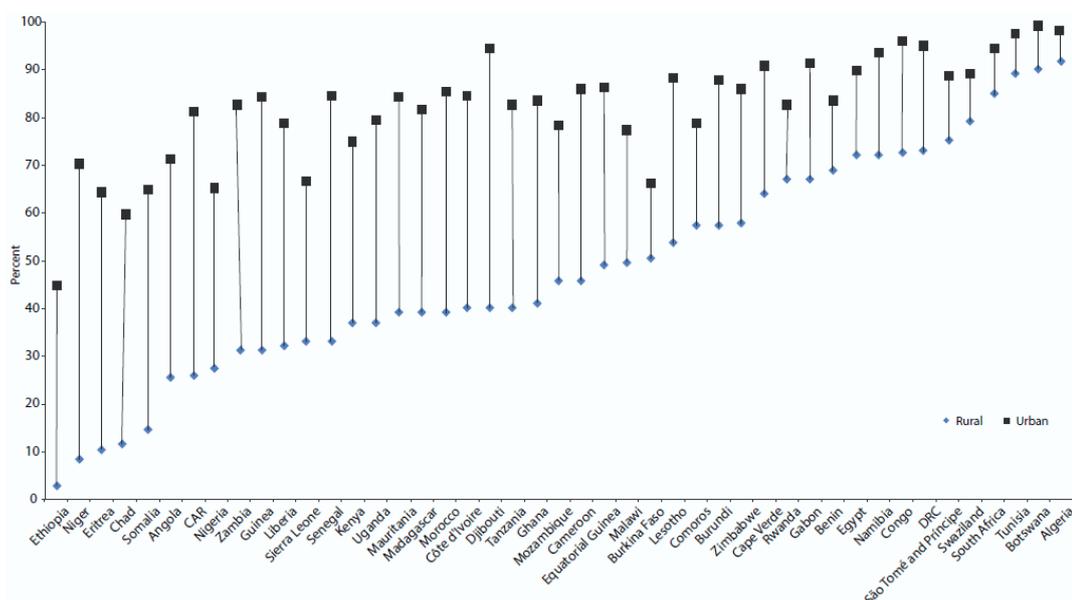
Source: UNDP, MDG Report 2012

But wide inequalities lie also within a country since access to skilled birth attendants enlarges even more the gap between rural and urban women. The latter are almost twice as likely as the other to deliver helped by skilled personnel, as illustrated in Fig. 5.4¹³². Countries as Niger presents a wide spatial discrepancy: 71 percent of urban women deliver with a skilled health attendant, while in rural areas only 8 percent of women have this opportunity.

Women could be prevented to give birth attended by skilled staff because of the high opportunity cost that this would entail: they may have to pay for the transport till the nearest skilled clinic where they are not even sure about having the right care, or even they are forced to pay bribes in order to have the expected attention.

¹³²Ivi p.70

Fig. 5.4 Share of women giving birth with a skilled health attendant in Africa, urban versus rural



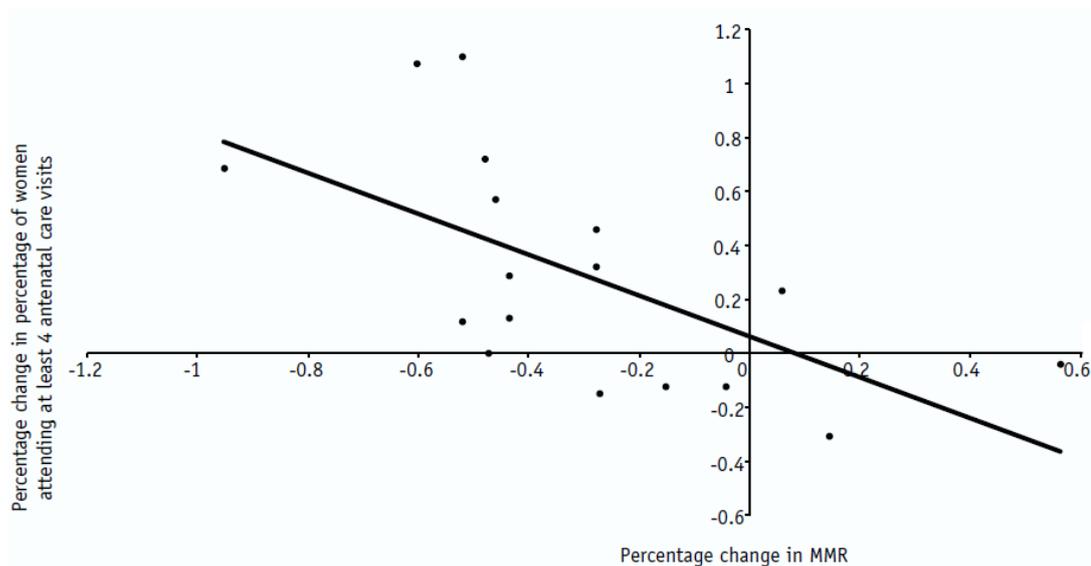
Source: UNDP, MDG Report 2012

Maternal mortality is also strictly correlated to antenatal care coverage: four or more visits (as recommended by WHO) guarantee a reduction in MMR (maternal mortality ratio); however the majority of African women usually attends only a visit which is free. The rest of recommended antenatal visits are skipped by African women due to high costs that actually they should pay out of pocket even when it should be imperative for governments provide them with at least four free high-quality antenatal visits. Fig. 5.5 shows the correlation between antenatal care coverage and MMR.

Health situation in Africa is challenged also by the concern of communicable diseases like tuberculosis, malaria and more recent HIV/AIDS for which African continent in 2010 accounted for 68 percent of all people living with it. Heterosexual transmission of HIV is the predominant mode in Africa. Among adults, the most infected are women (57%) but young girls are those who pay more the cruelty of this disease as vulnerable victims of sexual violence or of commercial sex.

Considering current low condom use during high-risk sex among young people, mother-to child HIV/AIDS transmission remains too high.

Fig. 5.5 Correlation between change in percentage of women attending at least four antenatal check-ups and percentage change in MMR, 1995–2008



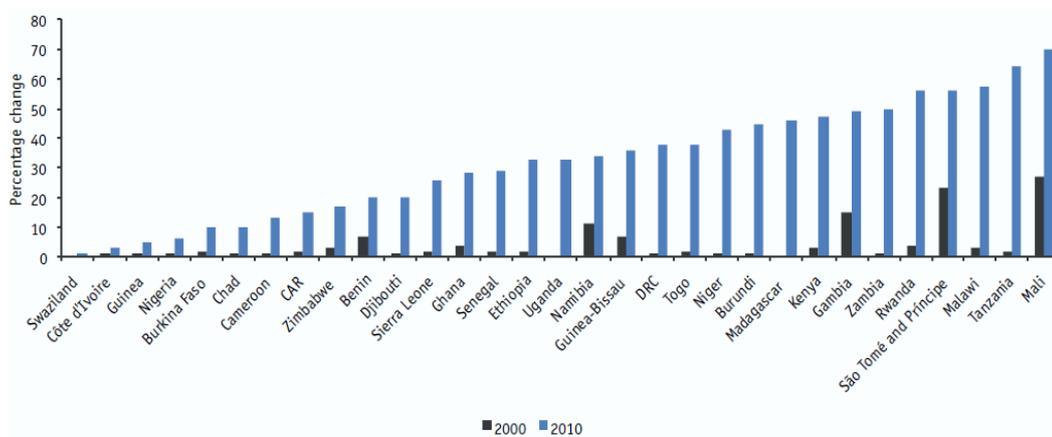
Source: UNDP, MDG Report 2012

Studies have demonstrated that “when mothers took a triple antiretroviral drug regimen during pregnancy and breastfeeding, the risk of HIV transmission was almost halved compared with women who took two drugs only”.¹³³ Yet, even if antiretroviral (ARV) medicines help to lower the level of HIV in the blood, postponing the spreading of other infections, their price proves to be still too high for poor African population. As a matter of fact, HIV/AIDS mother-to-child transmission is still challenging since it requires a double commitment for agencies which have to identify before, nearly all pregnant women living with HIV.

Even worse is the concern of infant antiretroviral prophylaxis coverage which among countries, varies significantly but still remains stagnating. The most powerful opportunity to challenge HIV among mothers and children in Africa would be to provide combined programs of prevention and treatment for all people living with HIV however, these projects implicate an economic burden that not all governments are ready to support.

¹³³ UNAIDS, (2011). *How to get to zero: faster, smarter, better*. World AIDS Day Report. UNAIDS Publishing, p.40.

Fig. 5.6 Change in share of children under-five sleeping under insecticide-treated bednets, circa 2000 and 2010



Source: UNDP, MDG Report 2012

Little progress reached in reversing the incidence of malaria and TB instead, is due to more active political commitment which, creating a strong partnership, is mobilizing even more resources also thanks to the countless vertical funds.

Nevertheless, despite the incremented usage of nets among households with access to them (88 percent) and among more vulnerable groups such as children under-five years of age (Fig. 5.6) and pregnant women, insecticides treated nets access remains well below the target of universal coverage.¹³⁴ As a matter of fact, in Kenya the large employment of a simple but effective means such as ITN have significantly improved the health of pregnant women and children; but the results are even more evident in Eritrea thanks to the free of charge distribution of these nets. This demonstrates how domestic governments, even if having low national incomes per capita, can contribute to reach more progresses just willingly giving priority to health improvement.

In comparison to MDG 4 and MDG 5, Africa's progress in eradicating HIV/AIDS, malaria and TB is encouraging since among other reasons, great support has been given by vertical funding in relieving health budgets of several African countries from the burden of these interventions.

¹³⁴ WHO, (2013). *World Malaria Report 2010*, WHO Global Malaria Programme, WHO Publishing.

Unfortunately, given the unpredictability of future vertical funds, it should be mandatory for African governments to find valid alternatives to boost domestic resources in order to keep on maintaining this encouraging successes.

5.3 Health financing in Sub-Saharan Africa

Even if countless maternal, child and HIV projects have been developed, political commitment from the majority of African countries has resulted insufficient to make a difference to the lives of mothers and their children and all ill people.

Governments are aware of the seriousness of this issue but are prevented from allocating adequate resources to healthcare by mere political reasons. These same political reasons are those obstacles that hinder donors' support in its way to help reducing the toll of maternal/child deaths and diseases in Africa.

In 2001 African Heads of States through the Abuja Declaration have committed themselves to adopt all necessary strategies in order to avoid missing MDG 4, MDG 5, MDG 6. They pledged to allocate 15% of their annual national budget to the improvement of the health sector. In addition, they ask for the commitment of developed countries encouraging them to keep their promise to allocate 0,7 percent of their Gross National Product (GNP) as Official Development Assistance (ODA).

Yet, several interlinked reasons advocate that for African countries it is critically fundamental to increase their health budgets: health is not only a human right but also a prerequisite for economic growth and human development.

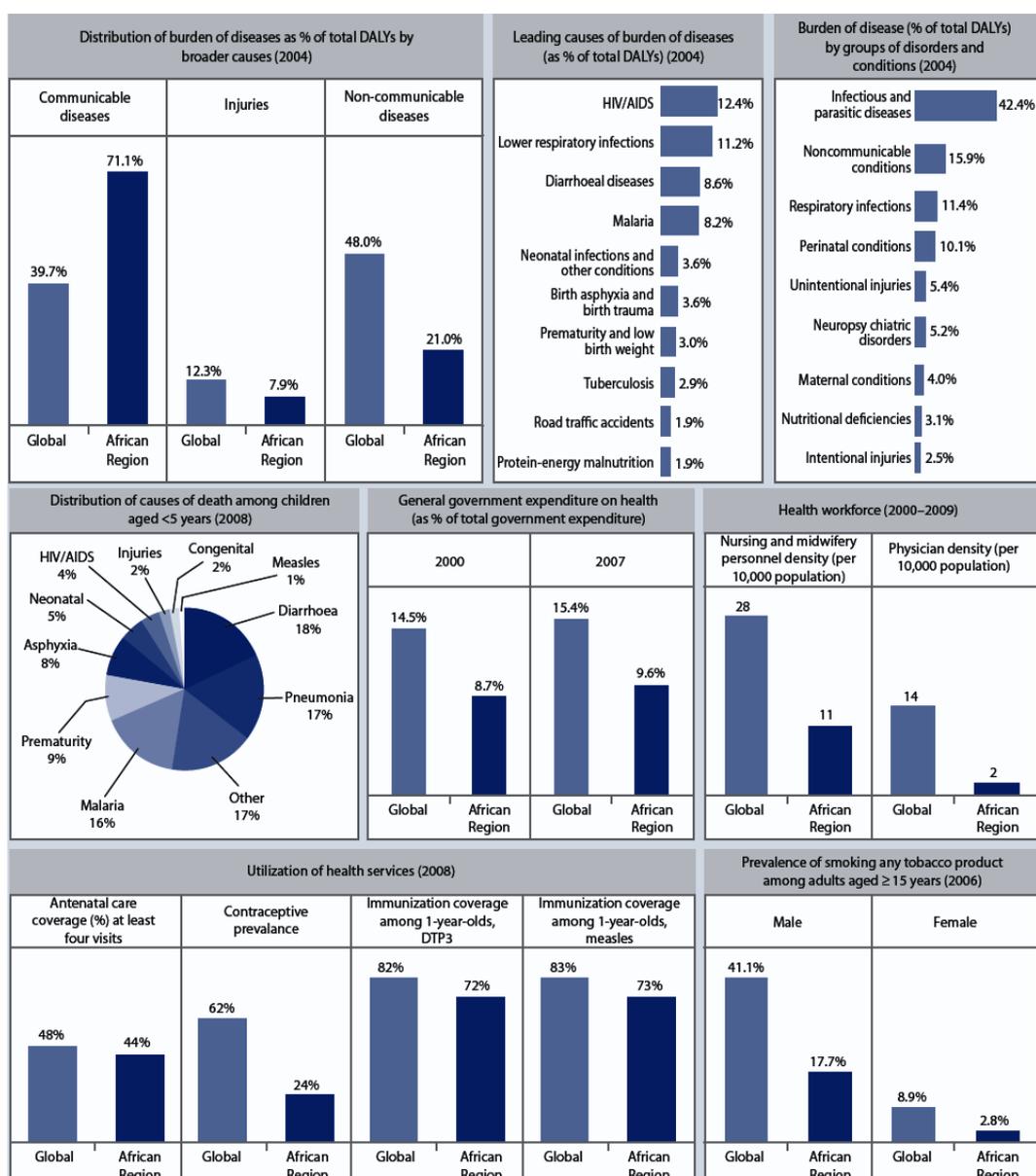
Often it is argued that building health systems in Africa is prohibitively expensive. But, nevertheless it holds true that in order to improve health, external aid cannot substitute the required reliable funding that a health system should aim to have within its country's own resources.

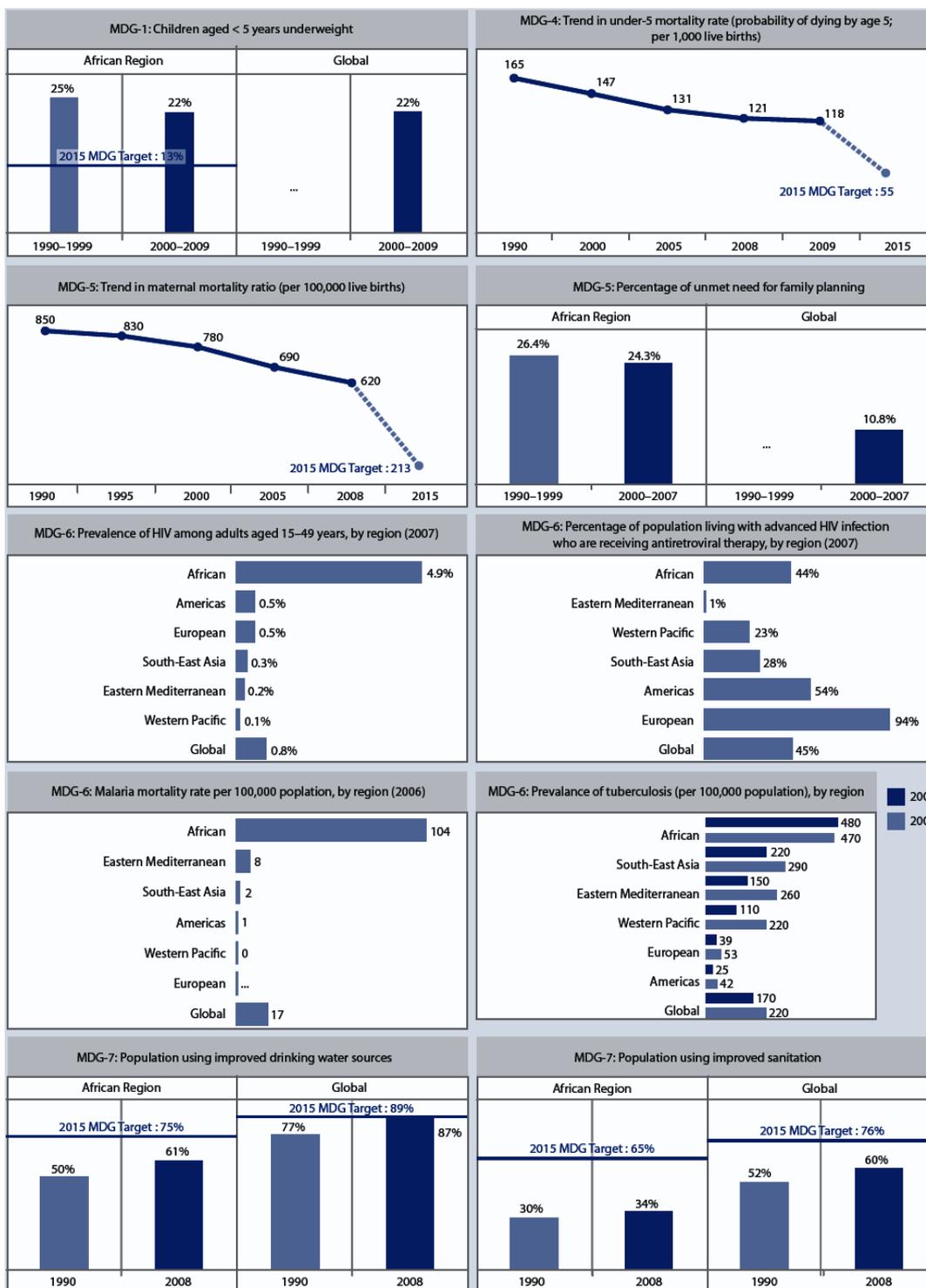
Fig.5.7 Overview of Progress on the Health-related MDGs in the African Region

Selected indicators**			
		African Region	Global
Population size (in thousands)	2008	804,865	6,737,480
Population living in urban areas (%)	2008	37	50
	2000	34	47
	1990	29	43
Life expectancy at birth (years), both sexes	2008	53	68
	1990	51	64
Adult mortality rate (probability of dying between 15 and 60 years per 1000 population)	2008	392	180
	1990	371	210
Per capita total expenditure on health (PPP int. \$)	2007	137	863
	2000	86	568
Gross national income per capita (PPP int. \$)	2008	2,279	10,290
	2000	1,506	6,940
	1990	1,319	4,862



All data sources are given in the African Health Observatory at www.aho.afro.who.int





Source: WHO, Atlas of health statistic (2011)

Box 5.1 Ten Years after the Abuja Declaration

In 2001, at the time of Abuja Declaration, in African Union countries governments expenditure on health from domestic resources generally averaged about US\$ 10 swinging from a minimum of US\$ 0.38 to a maximum of US\$ 380. This accounted for 44 percent of the total health expenditure on health (in the African Union). Instead, donors belonging to the OECD were already spending on average 0.4 percent of their GNI.

Yet, according to the WHO Report on the Abuja Declaration, “funding targets are being missed, both domestically and in terms of international assistance [...] and part of the explanation can be found in the lack of financial resources available to them [the health MDG]”. Even if twenty-seven countries have implemented their allocation to health since 2001, only two, Rwanda and South Africa have achieved the target of “at least 15 percent”. But unfortunately, the contribution of twelve countries have remained unaltered during these years while seven countries have reduced their allocation on health improvement. In “ODA for health” terms, the situation is better since recipient countries have shown a tripling increasing of contributions (from US\$ 5 in 2002 to US\$ 13 pro capita in 2008), even though the financial crisis has forced donors to reduce their disbursements. After ten years since the Abuja Declaration, most African countries are not yet on track in the achievement of health MDGs. Till now, they have reached less than 50 percent of the gains required to reach the Goals, among which the progress toward MDG5 (maternal health) is still particularly too slow.

Source: WHO (2011), The Abuja Declaration: ten years on

Table 5.1 Abuja Declaration and Health MDG Status Indicators, after 10 years

	2009**>2000 health share of total spending of government as a source		2009**=2000 health share of total spending of government as a source		2009**<2000 health share of total spending of government as a source		Number of countries
	per capita>33US\$	per capita=<33US\$	per capita>33US\$	per capita=<33US\$	per capita>33US\$	per capita=<33US\$	
	Seychelles (MIC)**	Eritrea	Algeria (MIC)	Madagascar			
		Rwanda	Egypt (MIC)				
			Tunisia (MIC)				
			Cape Verde				
On track health MDGs	1	2	4	1	0	0	8
Off track health MDGs	7	17	2	5	0	7	38
	Botswana (MIC)	Burkina Faso	Mauritius (MIC)	Dem Rep Congo		Benin	
	Gabon (MIC)	Burundi	Namibia (MIC)	Ethiopia		Central African Republic	
	South Africa (MIC)	Cameroon		Kenya		Gambia	
	Swaziland (MIC)	Chad		Niger		Guinea	
	Angola	Comoros		United Republic of Tanzania		Malawi	
	Sao Tome and Principe	Congo				Mauritania	
	Lesotho	Côte d'Ivoire				Togo	
		Djibouti					
		Ghana					
		Guinea Bissau					
		Liberia					
		Mali					
		Mozambique					
		Nigeria					
		Senegal					
		Uganda					
		Zambia					
Number of countries	8	19	6	6	0	7	46

Source: WHO (2011), *The Abuja Declaration: ten years on*.

5.3.1 General government expenditure on health

The total health expenditure functions as a measure to account a country's total level of funds (public, private and external resources) available in order to demonstrate the importance of health care in the overall economy of that same country.

Still today 22 of the 45 countries have a total health expenditure well below the minimum level of US\$ 44, recommended by the High Level Task Force on Innovative International Financing for Health Systems in 2009.

Table 5.2 Trends in total health expenditure per capita in current US\$

Year	Less than US\$ 20	US\$ 20–US\$ 44	More than US\$ 44
2001	Benin, Burkina Faso, Burundi, Central Africa Republic, Chad, Comoros, DRC, Eritrea, Ethiopia, Gambia, Ghana, Guinea Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Niger, Nigeria, Rwanda, Togo, Uganda, Tanzania (24 countries)	Angola, Cameroon, Congo, Côte d'Ivoire, Guinea, Lesotho, Mauritania, Senegal, Sierra Leone, Zambia (10 countries)	Algeria, Botswana, Cape Verde, Equatorial Guinea, Gabon, Mauritius, Namibia, Sao Tome and Principe, Seychelles, South Africa, Swaziland (11 countries)
2005	Burundi, Central African Republic, DRC, Eritrea, Ethiopia, Gambia, Guinea, Liberia, Madagascar, Malawi, Mozambique, Niger, Rwanda, Tanzania (14 countries)	Angola, Benin, Burkina Faso, Chad, Comoros, Congo, Côte d'Ivoire, Ghana, Guinea-Bissau, Kenya, Lesotho, Mali, Mauritania, Senegal, Sierra Leone, Togo, Uganda, Zambia (18 countries)	Algeria, Botswana, Cameroon, Cape Verde, Equatorial Guinea, Gabon, Mauritius, Namibia, Nigeria, Sao Tome and Principe, Seychelles, South Africa, Swaziland (13 countries)
2010	Central African Republic, DRC, Eritrea, Ethiopia, Madagascar, Niger (6 countries)	Benin, Burkina Faso, Burundi, Chad, Comoros, Gambia, Guinea, Kenya, Liberia, Malawi, Mali, Mauritania, Mozambique, Sierra Leone, Togo, Tanzania (16 countries)	Algeria, Angola, Botswana, Cameroon, Cape Verde, Congo, Côte d'Ivoire, Equatorial Guinea, Gabon, Ghana, Guinea-Bissau, Lesotho, Mauritius, Namibia, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, South Africa, Swaziland, Uganda, Zambia (23 countries)

Source: WHO, (2013), *State of health financing in the African Region*.

The previous table simultaneously shows the progresses made by some countries in improving their health expenditures. As Rwanda, for example, now (in 2010) allocates more than US\$ 44, even though 5 years before it belonged to those corrupt states that allocated less than US\$ 20 pro capita.

Governments in Africa are constrained in their capacity to finance health because of their low total national health expenditure .

In 2009, the most recent year for which data are available and reliable, the percentage of GDP spent on total health expenditure, which encompasses public funds, private funds and donor funds¹³⁵, of the 46 WHO African Region countries

¹³⁵ “Public funds consist of mainly funds from central government revenue, regional and municipal government revenue and return on assets held by a public entity. The private funds compose of essentially

averaged to 6.5 percent. Since the GDP is the combination of consumption, investment, government spending and net exports (exports minus imports), it is potentially vulnerable to shifts of these variables; therefore, if GDP decreases, the health expenditure will follow it; as it happened between 2008-2009 due to the global financial crisis.

On average general government expenditure on health was 9.6 percent of total government expenditure in 2009, but it is worth recalling that this percentage varies significantly across countries. In general most governments have increased their contribution for health after 2001 Abuja Declaration however, by 2009 only Botswana, Rwanda, Togo and Zambia have reached this target; having respectively annual per capita total spending on health US\$581, US\$52, US\$41 and US\$63, anyway above the minimum US\$ 34 per capita per year recommended by the WHO Commission for Macroeconomics and Health in 2001. Yet, due to difficulties in collecting direct taxes or contributions, the great majority of funding for health in Africa derives directly from a government capacity to manage adequately budget allocation which ultimately depends to a large extent on political choices. Those governments with a strong will to improve health status of their countries will be disposed to mobilize financial resources for health, despite their challenging macroeconomic reality. However, the more widespread reality in Africa continent shows that despite a real need of implementing health funding, the question of inefficient and non transparent use of resources is still too common.

5.3.2 Domestic funds for health

Generally, the ability of a country to improve its economic growth raising public financial resources through the taxation and revenues processes delimits government expenditures and determines its capacity to deliver fundamental services. Several African countries have shown a poor capacity in raising public revenues since the same informal nature of their economies makes tax collection

employer funds, household funds and funds from non-profit institutions serving individuals. The rest of the world funds (or donor funds) include bilateral grants, multilateral international grants and funds from funds contributed by institutions (including foundations) and individuals (diaspora) outside the country” in SAMBO LG, KIRIGIA JM, OREM JN, (2013), *Health financing in the African Region: 2000–2009 data analysis*, International Archives of Medicine, 6:10, p.2.

even more difficult. As a matter of fact, poor performances, poor accountability and poor management of tax system represent a further problems for many African countries.

Being health among the main sectors to which public expenditure is allocated, it is easy to understand the reason why it is so strictly interlinked with general government revenue generation. Some African countries have implemented good new stratagems in public revenue collecting just to raise additional funds to spend in health; Gabon's experience has been an example that many other countries should emulate. In 2009 it imposed a 1.5 percent levy on post-tax on money transfers and additional 10 percent tax on mobile phone operator in the country in order to reduce those economic barriers that prevented more vulnerable people from accessing healthcare.¹³⁶

Other mechanisms, even if not directly for improving health expenditure, have been adopted by African countries to raise general government revenue base; innovative tax and levy mechanisms associated with tobacco, alcohol, environmental pollution, petroleum products, currency transactions, indirectly could positive affect the capacity of government to finance health services.

Health advocates expect that these additional revenues would be addressed more to health expenditure, but usually they are actually not, since their inadequate use prevent them to contribute in improving the health sector.

Because of this misuse of additional public revenues along with a wide limited capacity of African countries to raise them, it is very difficult, especially for countries in challenging macroeconomic situations, to address sufficient amount of financial resources to health. It is in this precise context, that external funding for health becomes of fundamental significance.

5.3.3 External funds for health

Hence, African countries are strictly dependent on external resources (10.2 percent of the total health expenditure in 2009); there is countries as Malawi or as more recently Burundi and Tanzania, that registered a significant increase in

¹³⁶ WHO, (2013), *State of health financing in the African Region*, WHO Regional Office for Africa Publishing.

donor funding which has accounted for more than 40 percent of the total health expenditure between 2001 and 2010. (Fig. 5.8)

Many concerns have been listed regarding this reliance on donor funding as supporter of important health interventions; indeed, during the 61st session of the WHO Regional Committee in Yamoussoukro, Cote d'Ivoire, it has been reminded “ that external resources should only play a catalytic role, and the bulk of funding for health should be mobilized from domestic sources”.¹³⁷

Yet, this dependence could be often risky due to the high volatility of external aid and its selectivity in prioritizing a project according to donor's will even if not corresponding to the priorities of the recipient country. Indeed, alignment of aid flows and harmonization to national priorities are among the commitments stated in the Paris Declaration on Aid Effectiveness in 2005.

But, it holds also true that the recipient country could in turn nullify the benefit coming from an external fund just through a misuse of it, as it is recurring in Africa.

5.3.4 Private funds

Private households are the largest financiers of health care. Indeed, household's direct out-of-pocket spending (such as user fees to public, non-governmental, and private health service providers) on health constitutes a 61,6 percent of private expenditure. (Fig. 5.9)

But, pressure to abolish them is increasing since out-of-pocket spending actually “keep[s] the poor in poverty and push the near poor below the poverty line. Leive and Xu undertook a study in 15 countries in the African Region that revealed that on average 30% of all households financed OOPS health expenditures by borrowing and selling assets. The implications of this finding are even dire when viewed in the light of the fact that 52.3% of the population of the African Region live on less than one international dollar a day”.¹³⁸

¹³⁷ Ivi, p.17

¹³⁸SAMBO LG, KIRIGIA JM, OREM JN, (20103), *Health financing in the African Region: 2000–2009 data analysis*, International Archives of Medicine, 6:10, p.10.

Several countries in Africa have been evidently inefficient in the use of resources; in order to achieve national and international health development targets, not only they should increase funding but also they should be more equitable in financing and accessing healthcare. In addition, inadequate legal and regulatory frameworks have even more reinforced the governments inefficiency in the management of health subsystem.

The fact that the average of health funds (government, private and external) has evidently increased over the years but the health outcomes are reluctant to show up, gives rise to the suspect that health resources are not well employed. As a matter of fact, according to the World Health Report 2010¹³⁹ approximately 20-40% of health resources are wasted through inefficiency.

5.4 Governance matters

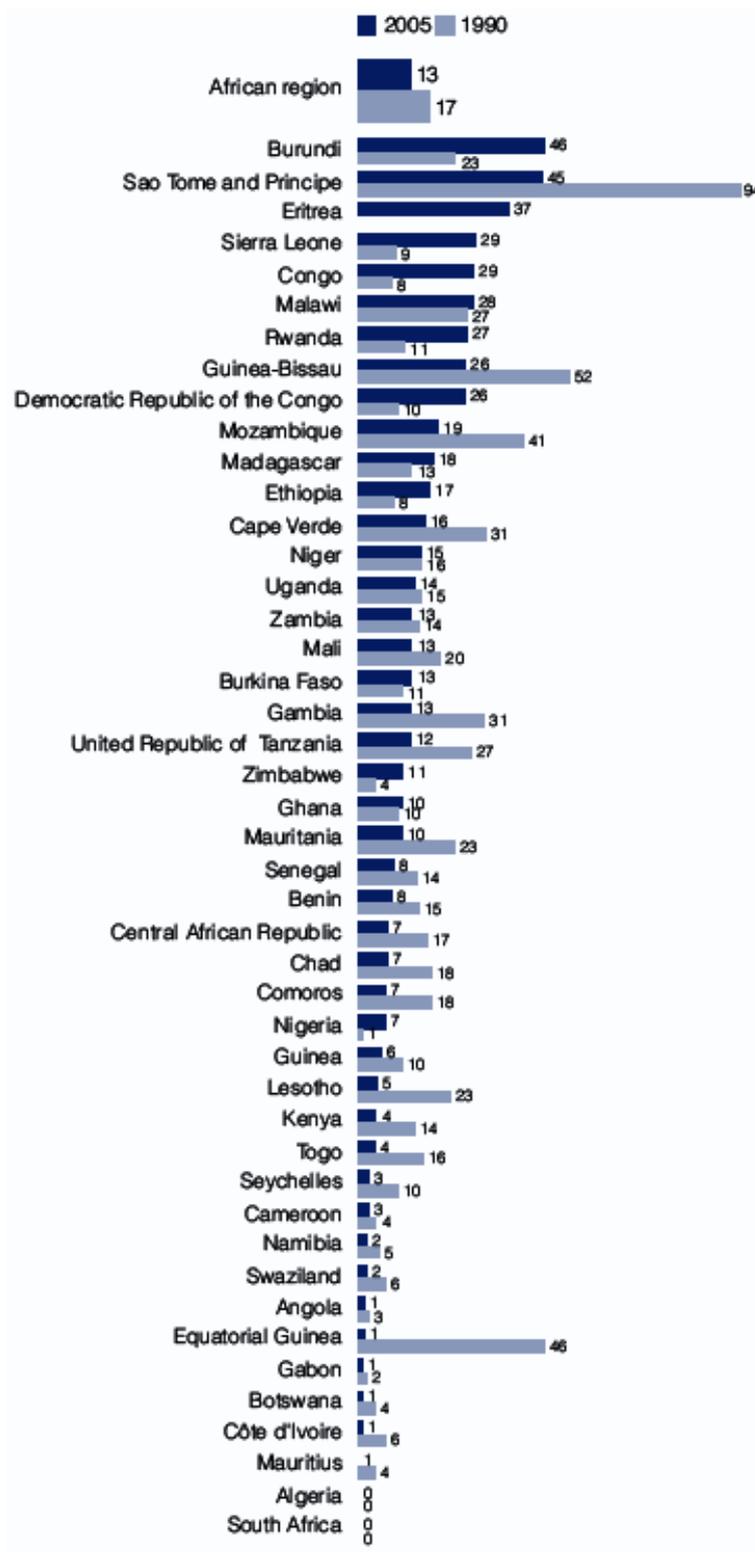
The ineffectiveness of increased public spending on health outcomes reflects evidently several weak institutional capacities, from leakage in public spending to poor budget management. All along they are regarded as the reasons why African governments hardly are able to translate public spending into effective services.

In the last half-century we have developed a better understanding of what helps governments function effectively and achieve economic progress. In the development community, we have a phrase for it. We call it good governance. It is essentially the combination of transparent and accountable institutions, strong skills and competence, and a fundamental willingness to do the right thing. Those are the things that enable a government to deliver services to its people efficiently.

Paul Wolfowitz, World Bank President, Jakarta, April 11, 2006

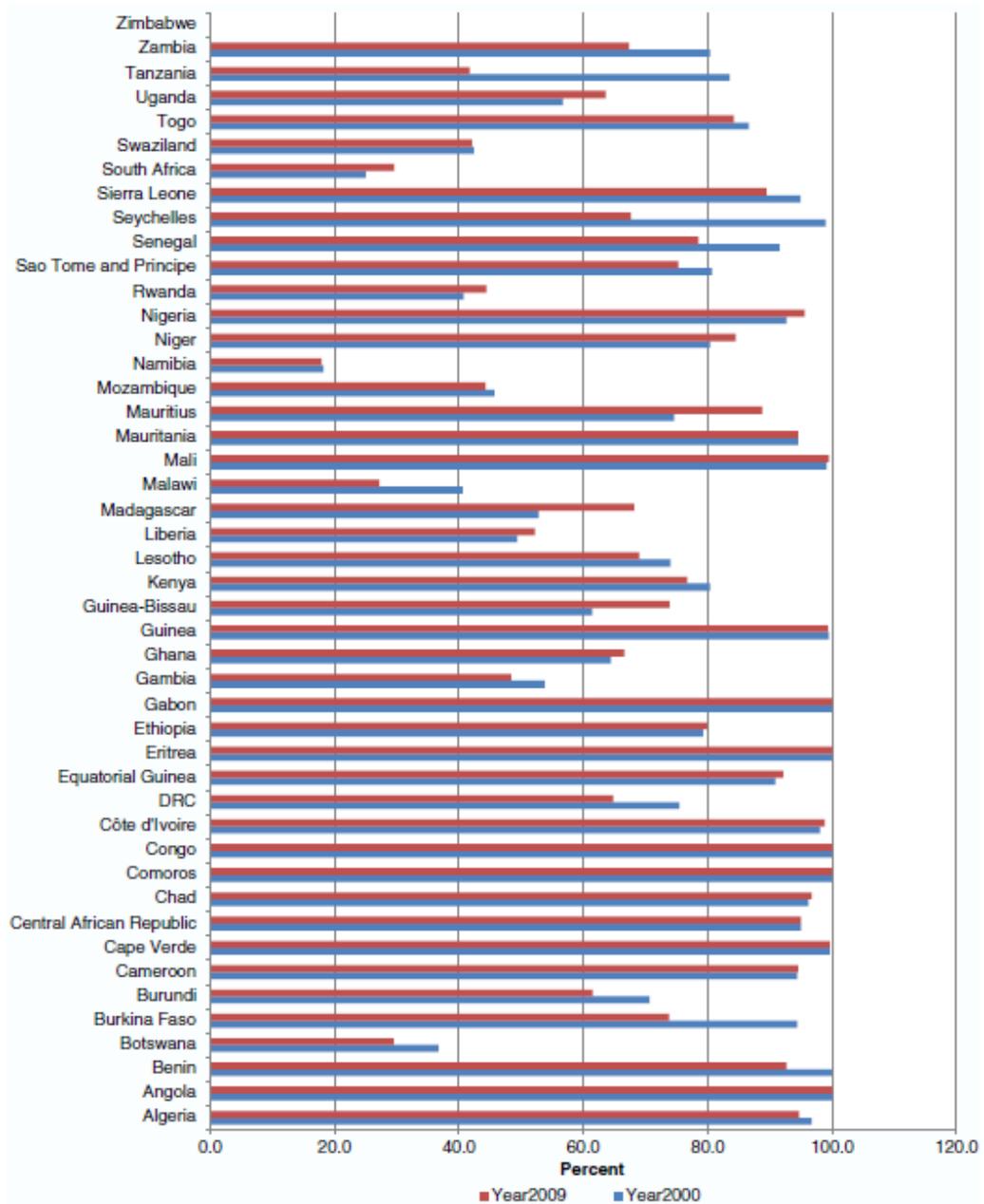
¹³⁹ WHO, (2010), *World Health Report 2010 Health systems financing: the path to universal coverage*. Geneva, WHO Publishing, p.15.

Fig. 5.8 Official development assistance received as percentage of GDP in the African Region, by country, 2005 and 1990



Source: WHO, Atlas of health statistic (2011)

Fig. 5.9 Out-of-pocket expenditure as % of private expenditure on health.



Source: Health financing in the African Region(2013)

Recently, the assumption that the role of good government influences even more a country's development effectiveness has been stressed and analyzed in detail.

On the basis of empirical evidence of weak links between public spending and good health development results, it has been wondered if it would mean that governments (mostly in developing countries) are spending on unproductive activities instead of on health services.

Several studies have generally demonstrated that a close correlation elapses between improved government and better development outcomes; but specifically, there is also grounded evidence that public health spending is more effective in improving health status in countries with good governance.

Pritchett¹⁴⁰, in his no more recent work of 1996, using the meaningful statement that "a dollar's worth of public spending often does not create a dollar's worth of capital, especially in developing countries" tried to give an empirical demonstration to the missed relationship between public investment and good performances. Among his potential findings, he underlined that it could mean that "public capital has been created effectively but used badly". The bad use of public capital according to Pritchett, includes a series of inadequate behaviours adopted by governments, such as corruption and patronage.

Further evidence supporting this theory, comes from a study that analyzes Uganda's public expenditure through the tracking of the percentage of budgetary allocation actually given to 250 primary schools. The survey has recorded that the percentage on average received by the schools under analysis amounted to only 13% of the budgetary allocation for non-wage expenditure. It takes no notice of the remaining amount (moving from the finance ministry to the facilities) which most likely disappeared or was employed for purposes far from primary school education.¹⁴¹

Similarly, Burnside and Dollar (2000)¹⁴² have tried to find an interaction among foreign aid, growth and economic policies. Actually, they didn't find a relevant

¹⁴⁰ PRITCHETT L.(1996). *Mind your P's and Q's: the cost of public investment is not the value of public capital*. Policy research working paper 1660. Development Economics Research Group, World Bank, Washington, D.C, WB Publishing, pp.1;12.

¹⁴¹ ABLO E, REINIKKA R.(1998). *Do budgets really matter? Evidence from public spending on education and health in Uganda*. Policy Research Working Paper 1926. Development Economics Research Group. World Bank, Washington, D.C. WB Publishing.

¹⁴² BURNSIDE C, DOLLAR D.(2000). *Aid, policies and growth*. American Economic Review 90 (4).

influence of aid on growth; however, more importantly, they recognized that the impact of foreign aid on growth is more positively consistent in countries with good policy environment. They compare the example of Ghana to that of Zambia; Ghanaian aid receipts are the coherent representations of this country's policy performance: aid increases as it (the country) improves. On the contrary, during the period under analysis Zambia policy performances keep on worsen despite aid increase. This demonstrates a missing direct correlation between aid and policies; but, regarding government consumption as a function of the institutional political variables that affects policy index, the authors state to have "95% confidence that the derivative of growth with respect to aid is a positive function of policy [...]" there is robust evidence that aid has a positive effect on growth in an environment of good fiscal, monetary, and trade policies".¹⁴³

As the influence of governance on development has been studied in detail by a sizeable empirical literature, many surveys have circumscribed the analysis range in order to deepen the correlation between good governance and better health development, through the exploitation of child (under-five years) and infant mortality indicators, considered the widest and the best indicators of health status. Among them, it is worthy of mention the contribution gave by Kaufmann et al in 1999¹⁴⁴. After having identified six aggregate indicators (voice and accountability, political instability and violence, government effectiveness, regulatory burden, rule of law, and graft) from the corresponding six basic governance concepts; they have studied the strong causal relationship between better governance and better health development through a cross-section of more than 150 countries, referring to the period 1997-1998.

The first government cluster ("voice and accountability") chosen by the authors refers to the political processes, the civil liberties, the political rights and the citizens' participation to the political processes, as well. "Political instability and violence" cluster reflects the idea that the quality of a government strictly depends on the sudden changes in government that in turn can affect the continuity of policies, but even worse the society. Through "government effectiveness" the

¹⁴³ *Ivi*, p.30

¹⁴⁴ KAUFMANN, D, KRAAY, A, ZOIDO-LOBATON, P.(1999). *Governance matters*, World Bank, Development Economics Research Group, Washington, D.C., WB Publishing.

authors wanted to measure the capacity of government to produce and implement good policies. While, the cluster of “regulatory burden” is already easily understandable. The last two clusters refer to the respect of the citizens and to the behaviour adopted by the government institutions; in particular, the last indicator “graft” refers to the perception of corruption. Associating these clusters to three development outcomes such as per capita incomes, infant mortality and adult literacy, the authors have found that improvement in governance significantly affects development outcomes. Specifically good governance has a strong negative impact on infant mortality.

The findings underlined by Kaufmann et al. resembles what the Department for International Development¹⁴⁵ has stated in its paper on the importance of building the capability of the state to govern in ways that improve development: “countries attract more investment and achieve higher rates of per capita growth when the state improves its effectiveness. A state which applies rules and policies predictably and fairly, ensures order and the rule of law. The government must be able to guarantee the provision of basic services. And it must have the capacity to make policies, to finance and implement them, and to monitor the outcomes. Government must ensure that the state fulfils its responsibilities to its citizens; that citizens and the private sector fulfil their responsibilities to the public good; and that the state accounts for its policies and performance. These relationships work best where roles and responsibilities are agreed and performed predictably. Law, regulation and custom set out the rules and in successful states are enforceable (‘the rule of law’”).

In order to improve the health of its population, every country (rich or not), decides to invest some public amounts in health expenditure. According to its “spending capacity” a country is supposed to spent in public health from less than 1 percent to more than 8 percent of its GDP, in the ways it considers to be suited to its needs.

One more time, the differences in the efficacy of public spending in improving health performances due to the quality of governance, are demonstrated through

¹⁴⁵ DEPARTMENT FOR INTERNATIONAL DEVELOPMENT (DFID), (2001). *Making government work for poor people building state capability*. Strategies for achieving the international development targets. London. DFID Publishing.

empirical data. Rajkumar and Swaroop have given further proof of the assumption that public spending, governance and specifically child (under-five) mortality are interlinked.

Considering a sample of 228 observations of 91 developed and developing countries over three different years (1990, 1997, 2003), the authors have let the total public health expenditure interacting with two measures adopted for governance (corruption and bureaucratic quality) in addition to other standard non-health-related variables such as ethno-linguistic fractionalization, the percentage of Muslim population, the percentage of educated females aged 15 and above, the percentage of population living in urban areas, the Gini coefficient and the percentage of under five population. Corruption index measures “corruption within the political system”, while bureaucratic index assesses “the soundness of institutions and the quality of the civil service”.¹⁴⁶

From the interaction among the indicators and the variables chosen by the authors empirically results that: “spending interacted with corruption has a significant coefficient of $-.09$ (with a t-statistic of -3.11). Among other regressors, ethno-linguistic fractionalization is positively and significantly correlated with child mortality. In countries where more adult women are literate, child mortality is lower. Countries with a higher percentage of population under five age have higher child mortality rates”.¹⁴⁷ This demonstrates that public expenditure has positive impact on reducing child mortality rates when regulated by well-functioning government institutions able to translate public spending into effective services.

In the current circumstance of meeting the most hardly achievable health-related MDGs these results are of relevant importance for understanding the reason why many African countries lag behind in reaching better health outcomes.

Increasing the public spending on health will be not enough for most of them since their average level of governance is often rated ineffective (weak), therefore corrupt.

¹⁴⁶ RAIKUMAR AS, SWAROOP V. (2007). *Public Spending and outcomes: Does governance matter?* Journal of Development Economics 86 (2008), pp.96-11.

¹⁴⁷ *Ivi*, p.101

A greater investment in public health in Africa will be vain without improved governance.

5.4.1 Corruption perceptions indicators

Nowadays it is well known that corruption represents a significant determinant in preventing countries from succeeding in their development. Hence, increased attention on it has been accompanied by the creation of a multiplicity of international databases and indicators useful to measure not only corruption, but also the role of governments in countries' development.

Nevertheless, compared to other fields of international development, corruption is often a concept too difficult to assess due to the lack of information, usually scarce and hardly available. As a matter of fact, the first attempts of creating a corruption assessment system proved to be fragmentary and incomplete. Therefore, it was through more focused attention on standardization and systematization, that it has been acknowledged that corruption could be measured. According to Kaufmann (2006)¹⁴⁸, corruption can be assessed in three ways:

- a) "By gathering selected views of significant stakeholders";
- b) "By tracking countries' institutional profiles";
- c) "By thorough audits of particular projects";

Actually, within the pool of indicators, the minority of them is based on objective measurements, while the majority derives from subjective assessments. The latter referring to a "perception" of corruption of significant actors (such as foreign investment executives or simply citizens), may include more general questions or ideas. Less frequent objective measurements on the contrary, reduce too much the assessment to the mere real corruption experiences.

Yet, strong criticism on these previous trends of indicators has brought to another stream of more adequate "aggregate indicators".

¹⁴⁸ KAUFMANN D, KRAAY A, MASTRUZZI M, (2006), *Measuring corruption: myths and realities*. World Bank Publishing, p.2.

Table 5.3 Examples of international databases on governance

Indicators/Databases	Institutions
Governance	
- CPIA (Country Policy and Institutional Assessment) - Governance Matters I-V - ICRG (International Country Risk Guide) - IEF (Index of Economic Freedom) - CPI (Corruption Perceptions Index)	World Bank Kaufmann, Kraay & Mastruzzi/World Bank Political Risk Services Group The Heritage Foundation Transparency International
Democracy	
- Political Rights, Civil Liberties & Freedom Rating - Polity I-IV (Polity's institutionalised democracy index) - Bollen's Index (Bollen's liberal democracy Index)	Gastil/Freedom House Gurr/University of Maryland (CIDCM) Bollen/University of North Carolina/(ICPSR)
Other indicators	
- ELF (ethnolinguistic fractionalization) - World Values Survey (trust, well-being, etc.)	Roeder/Dept. Political Science, University of California, San Diego Inglehart/WVS Association, Institute for Social Research, University of Michigan

Source: Document de travail DIAL (2006)

Currently, the two main international corruption indicators are the Corruption Perceptions Index (CPI), developed by the NGO Transparency in 1995 and the World Governance Indicators (WGI) developed instead, by Kaufmann's team of the World Bank in 1996. The importance of the latter is due to the fact that it is not strictly a corruption indicator since, as previously mentioned, it assesses also other six governance aspects: control of corruption, voice and accountability, political stability and absence of violence, government effectiveness, regulatory quality, and Rule of Law. The CPI remains the most employed for measuring large-scale corruption even if it still bases on perceptions of corruption by experts. Among Kaufmann's indicators, CPI is directly comparable to the Control of Corruption Indicator (CCI), even though the CCI is more exhaustive as it measures "the exercise of public power for private gain, including both petty and grand corruption and state capture."¹⁴⁹ Yet, despite some small differences in their design, both indicators have a common denominator: primary sources (opinions of experts and business men but also testimonies from households).

¹⁴⁹ KAUFMANN D, KRAAY A, ZOIDO-LOBATÓN P, (1999). *Aggregating Governance Indicators*. Policy Research Working Paper 2195. World Bank, Development Economics Research Group, Washington, DC, WB Publishing.

5.5 Financial deficits worsen child mortality trends

Under-five mortality (U5MR), the probability to die before fifth birthday and infant mortality (IMR), the probability to die before first birthday have been usually used to assess children's wellbeing. As already mentioned, the choice of infant and child mortality rates is due to their status of sensitive indicator of the availability, the utilization and the effectiveness of health care. They are commonly employed to compare health-care systems and for monitoring population and health programs.

In relation with the overall substantial progress toward achieving MDG4, which has recorded a drop of 47% (corresponding to a drop from 90 deaths per 1.000 live births in 1990 to 48 in 2012), actual situation in Sub-Saharan Africa still describes the highest rates of child mortality, with under-five mortality rates of 98 deaths per 1.000 live births (more than 15 times the average for developed countries), although a timid reduction increasing from 0.8 percent in 1990-1995 to 4.1 percent in 2005-2012.¹⁵⁰

It is also the only region where the number of live births and child population are expected to increase even more over the next two decades; as a matter of fact, by 2050, 40 percent of all live births and 37 percent of the world's children under five are expected to live in Sub-Saharan Africa. Therefore, following this trend, this will signify that the number of under-five deaths in Africa may stagnate or even increase without any significant progress.

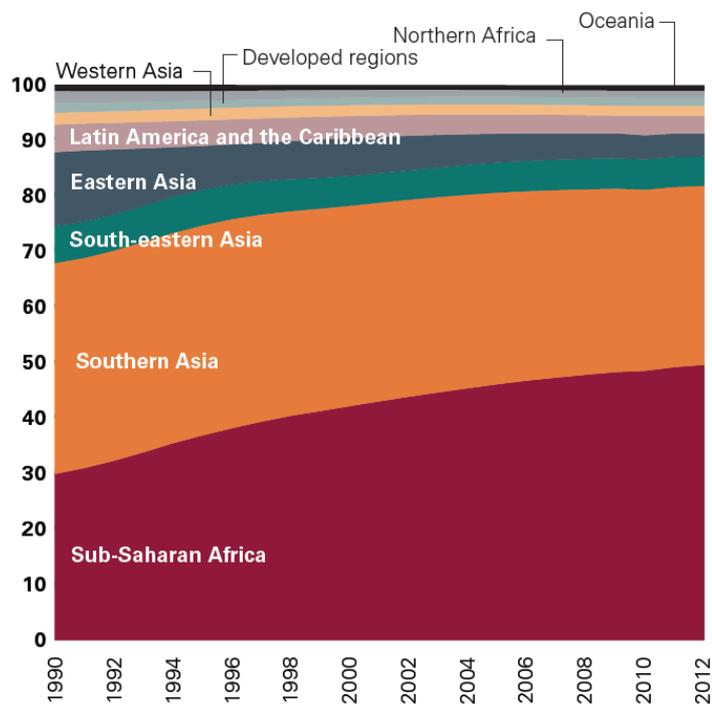
¹⁵⁰ UNICEF, WHO, WB, UN (2013). *Levels and trends in child mortality, Report 2013*. New York, United Nations Children's Fund Publishing.

Table 5.4 Levels and trends in the under-five mortality rate, by Millennium Development Goal region, 1990–2012 (deaths per 1,000 live births, unless otherwise indicated)

Region	1990	1995	2000	2005	2010	2012	MDG target 2015	Decline (percent) 1990–2012	Annual rate of reduction (percent)		
									1990–2012	1990–2000	2000–2012
Developed regions	15	11	10	8	7	6	5	57	3.8	3.9	3.8
Developing regions	99	93	83	69	57	53	33	47	2.9	1.8	3.8
Northern Africa	73	57	43	31	24	22	24	69	5.4	5.3	5.5
Sub-Saharan Africa	177	170	155	130	106	98	59	45	2.7	1.4	3.8
Latin America and the Caribbean	54	43	32	25	23	19	18	65	4.7	5.1	4.4
Caucasus and Central Asia	73	73	62	49	39	36	24	50	3.2	1.6	4.5
Eastern Asia	53	46	37	24	16	14	18	74	6.1	3.7	8.0
Excluding China	27	33	31	20	17	15	9	45	2.7	-1.2	5.9
Southern Asia	126	109	92	76	63	58	42	54	3.5	3.1	3.9
Excluding India	125	109	93	78	66	61	42	51	3.3	3.0	3.5
South-eastern Asia	71	58	48	38	33	30	24	57	3.9	3.9	3.8
Western Asia	65	54	42	34	26	25	22	62	4.4	4.4	4.5
Oceania	74	70	67	64	58	55	25	26	1.4	1.0	1.7
World	90	85	75	63	52	48	30	47	2.9	1.7	3.8

Source: Child Mortality Report 2013

Fig. 5.10 Nearly half the world’s under-five deaths were concentrated in Sub-Saharan Africa in 2012



Source: Child Mortality Report 2013

Moreover, Sub-Saharan Africa, having the highest neonatal mortality rate (32 deaths per 1,000 live births in 2012), accounts for 38 percent of global neonatal deaths. Children dying before 28 days of life, suffer from diseases and conditions easily preventable and treatable through interventions really cost-effective when distributed according to the interventional level. Malaria, measles, diarrhoea, respiratory infections, and AIDS are among the major diseases behind high under-five rates in Africa; yet, there is empirical evidence that around 67 percent of neonatal mortality could be reduced through the employ of high coverage of preventive and treatment packages delivered through hospitals, peripheral health centres and at the family and community level.

All these preventive programs should be managed by African healthcare systems that still today are fragile and fragmented. Although the increase in spending in the 1960s and in the 1970s, the health systems, as organized today, are not adequately addressing the increase burden of diseases. Moreover, recent reductions in health budgets not only have nullified previous progresses in healthcare but also have weakened even more African governments' capacity to face the growing health crisis. African health systems are neither robust nor flexible enough to manage new service delivery's scenarios that new and re-emerging diseases have created.

The lack of healthcare facilities and shortage of skilled healthcare staff, available drugs and equipment, hide other barriers hindering the achievement of the MDG4. In Africa, these obstacles are often of financial nature; they are economic constraints due to governments' inefficiencies in providing adequate health expenditure policies necessary to build human capital.

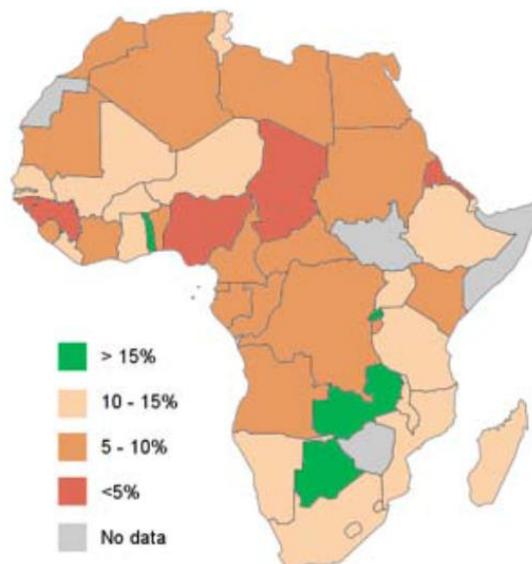
It is a given that African health systems face huge financing deficits. Compared to high income countries in which spending on health care exceeds US\$ 2,000 per person per year, in Africa per capita annual spending on health averages between US\$ 13 and US\$ 20. That is extremely low, noting that WHO considers US\$ 34 per person per year a minimum to provide a population with basic treatments and care for the major communicable diseases and early childhood and maternal illnesses. Compared to the global average of 5.4 percent of GDP, Africa spends on

average 2.5 percent of its GDP, barely reaching the needed to provide basic care.¹⁵¹ (See Fig. 5.11)

Even after 2001 Abuja Declaration, during which the heads of states of African Union committed themselves to allocate 15% of their national budget to health, the majority of African countries has not kept the promises.

More than 50 percent of African population does not have access to health facilities; high rates of maternal, child and infant mortality and low level of immunization are symptomatic of African governments' neglect of the centrality of health expenditure.

Fig. 5.11 General government health expenditure as % of general government expenditure, 2010



Source: The state of healthcare in Africa (2012)

Funding for health services is often considered a principal constraint for governments to be good managers of health systems in their countries.

Uganda's persistent dramatic rate of child mortality in spite of the significant economic growth the country has achieved over the last decade, provide us even more with direct evidence of the impact of government public expenditure on health and in particularly on MDG 4.

¹⁵¹ KPMG Africa Limited, (2012). *The state of healthcare in Africa*, KPMG Publishing.

In the past two decades Uganda has recorded a unprecedented significant and constant growth, even though all its numerous constraints. This period of uninterrupted growth has coincided, even if not all times, with poverty reduction. The 56,4 percent of population below poverty line in 1992/1993 fell to 33,8 percent in 1990/2000, but increased to 38,8 percent in 2002/2003 and recently has fallen again to about 31,1 percent.¹⁵² However in absolute numbers Uganda is still lagging behind because of high population growth rate (of 32 percent), which is implemented by the disproportionate contribution of rural areas. Thereby, government expenditure on health has increased as well, from 3.46 percent per capita in 1995 to almost 9 percent per capita in 2006. In 2007, the total government allocation amounted to 1.8 percent of Uganda GDP.¹⁵³

Table 5.5 Progress of Uganda on the MDGs

MDGs that are likely to be attained, with continued good policies
MDG 1 Eradicate extreme poverty
MDG 3 Promote gender equality and empower women
MDG 6 Combat HIV/AIDS
MDG 7 Ensure environmental sustainability
MDG8 Develop a global partnership for development
MDG that may be achieved with intensified efforts
MDG 2 Universal primary education
MDG for which strengthened policies, institutions and funding are necessary
MDG 1 Hunger
MDG unlikely to be met, even with improved policies, institutions and funding
MDG 4 Reduce child mortality
MDG 5 Improve maternal health

Source: ODI (2010)

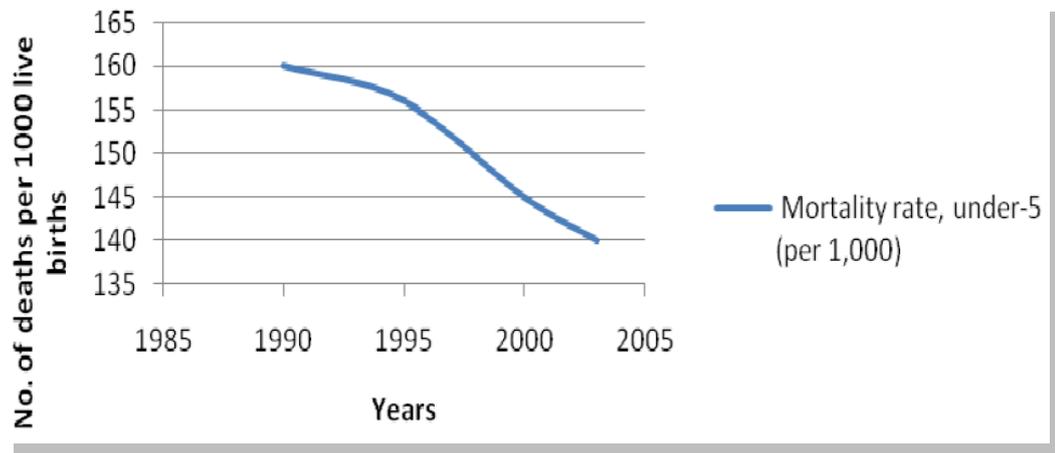
Yet, the economic growth and the consequent implementation of government expenditure on health have not translated into a significant reduction of under-five mortality. According to the analysis of Okella (2009) on previous infant and child mortality trends, it must be underlined that a rapid decrease during 1960s and 1970s of these indicators has actually been recorded, respectively from 224/1000 births in 1960 to 170/1000 live births in 1970. But it stopped during the 1990s:

¹⁵² OVERSEAS DEVELOPMENT INSTITUTE-ODI, (2010), *Uganda Case Study for the MDG Gap Task Force Report*, London, Overseas Development Institute publishing.

¹⁵³ *Ibidem*

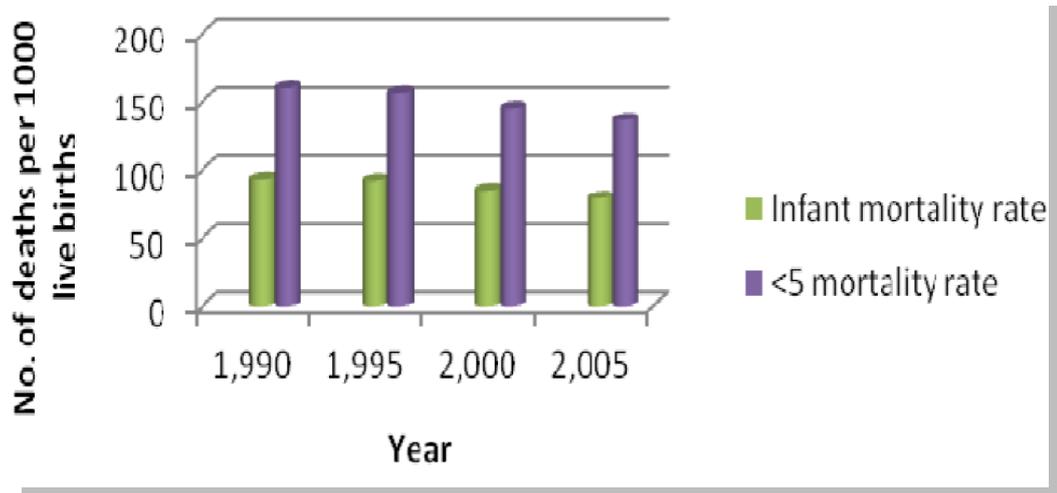
from 160/1000 live births in 1990 it declines only to 134/1000 live births in 2006, still remaining among the highest in Africa and not neglecting that the average annual GDP growth rate over this period has been estimated at 6.6 percent.¹⁵⁴

Fig. 5.12 Child Mortality trend in Uganda (per 1000)



Source: *The determinants of persistent child mortality trend in Uganda (2009)*

Fig. 5.13 Infant and under-five mortality rate in Uganda (5 year interval)



Source: *The determinants of persistent child mortality trend in Uganda (2009)*

¹⁵⁴ OKELLA N L, (2009). *The determinants of persistent child mortality trend in Uganda*, A Thesis submitted to Maastricht Graduate School of Governance in partial fulfilment of the requirement for MSc in Public Policy and Human Development (MPP).

Yet, it is evident that child mortality decreases more slowly than GDP growth's pace; as a matter of fact "child mortality should have been reducing at an inversely corresponding rate with economic growth"¹⁵⁵; but this has not been the case for Uganda.

According to Deaton, who confirms that "if countries are growing, the health of their inhabitants will look after itself"¹⁵⁶, the fact that Uganda keeps a critical rate of child mortality, even though an increase of its economy, helps to reconsider which could be high child-mortality rates' factors. Deaton recognizes beside broader social factors (e.g, the importance of education and literacy), direct determinants as infectious diseases such as malaria and measles which kill one in five Ugandan children under the age of five years. Yet the immunization, adequate prenatal care and birth attendance by skilled health personnel can lead to lower child mortality rates.

But a developing country as Uganda unfortunately is, does not have the capacity to deliver those health services essential for eradicating such diseases, since the resources allocated by the government to healthcare most often are limited, therefore insufficient.

Ugandan government expenditure, with its US\$ 9 per capita in 2007 (corresponding to about 9 percent of its budget)¹⁵⁷ has been stable over the years, although country's economy has improved and its annual population rate of 3.2 percent since 1990 constantly increases.¹⁵⁸

To be met MDG 4 requires an average reduction in the rate of under-five deaths of 5% each year, but till government's resource allocation prioritizes other sectors, it will be hardly reached.

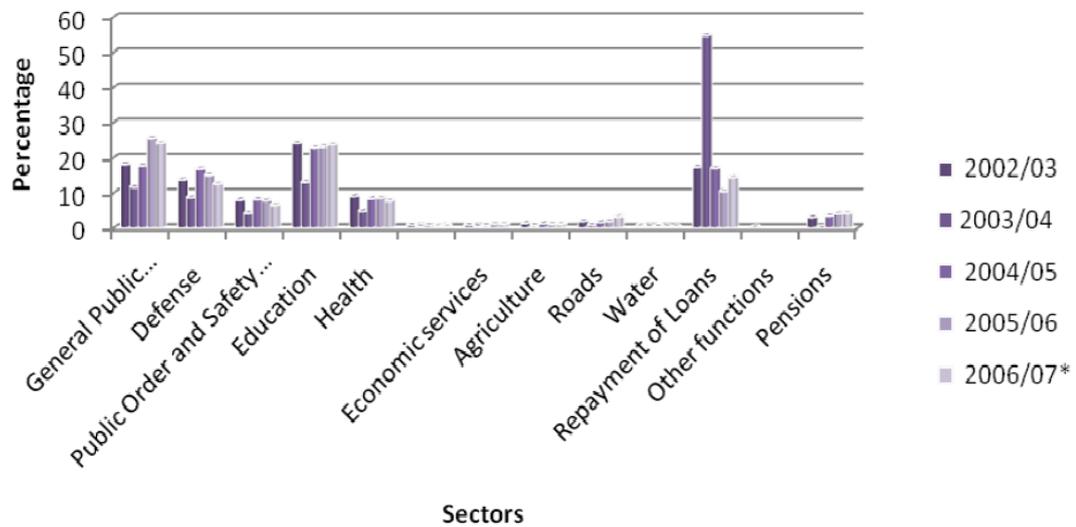
¹⁵⁵ Ivi, p.9.

¹⁵⁶ CUTLER D, DEATON A LLERAS-MUNEY A (2006). *The determinants of mortality*. Journal of Economic Perspectives 20(3), p.110.

¹⁵⁷ OVERSEAS DEVELOPMENT INSTITUTE-ODI, (2010). *Uganda Case Study for the MDG Gap Task Force Report*, London, Overseas Development Institute publishing, p.10

¹⁵⁸ OKELLA N L, (2009). *The determinants of persistent child mortality trend in Uganda*, A Thesis submitted to Maastricht Graduate School of Governance in partial fulfillment of the requirement for MSc in Public Policy and Human Development (MPP), p.35.

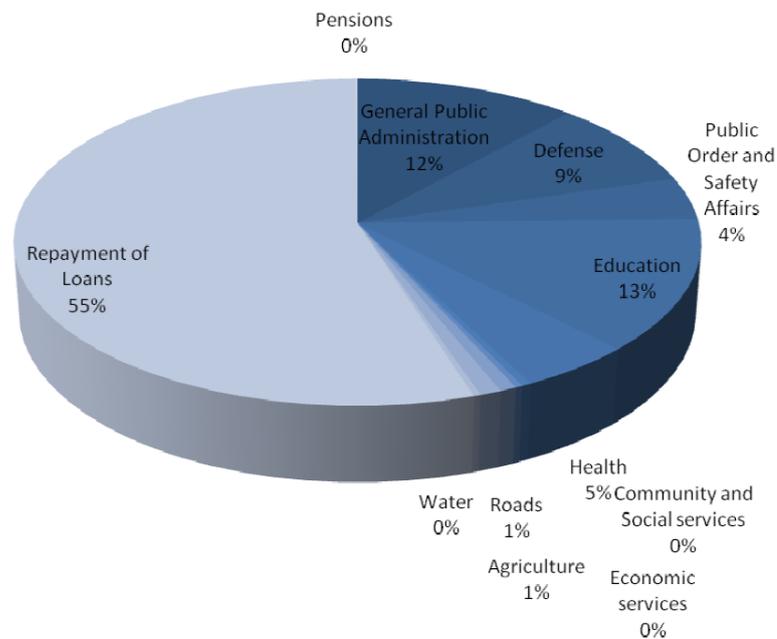
Fig. 5.14 Uganda's sectors expenditure



Source: *The determinants of persistent child mortality trend in Uganda (2009)*

As illustrates in Fig. 5.15 among others, a significant portion of national budget is addressed to debt servicing especially in 2003/2004 when more than half of the entire country's expenditure was spent for it, as depicted in Fig.5.16.

Fig. 5.15 Expenditure by sector 2003/2004



Source: *The determinants of persistent child mortality trend in Uganda (2009)*

Yet, not surprisingly, defence funding as well, deprives health sector of its due resource allocation and helps explaining the persistent high child mortality rate in Uganda.

5.6 Arms shoots down health development

“Dr. Walter Odhiambo, a surgeon from Kenya, tells the story of a 17-year-old Congolese boy whose jaw was shattered by a bullet. The son of a diamond prospector, he was shot by rebel soldiers who thought he had diamonds. It took him one year to raise the money from friends and family to have it treated. During this time, he kept his disfigured mouth covered. He travelled 3,000km to Nairobi for the operation to insert a steel plate into his jaw, which took nine hours and cost \$6,000. The cost of the operation is equivalent to a year of primary education for 100 children, or full immunisations for 250 children, or 1.5 years of education for a medical student”.¹⁵⁹

This is a direct evidence of the fact that medical expenses are one of the most obvious direct costs caused by armed violence; the burden of these expenditures contributes to prevent African countries from their development efforts to escape from poverty.

The previous report, though showing only a small part of the human impact of armed violence, omits the indirect human costs of health and livelihoods due to economic and social disruption. As a matter of fact, it has been estimated that at global level, every day around 1.000 (direct) victims of the use of small arms are counted; instead, the amount of indirect casualties of nine African conflicts is 14 times greater than that of people died (directly) during the conflict. Just mentioning the appalling amount of casualties counted by the Democratic Republic of Congo (DRC) in the period of time between 1998 and 2006: 4.8 millions of persons, corresponding to the 90 percent of the total number of deaths, have lost their lives during and after the conflict because of preventable infectious diseases, malnutrition and neo-natal/pregnancy conditions.

¹⁵⁹ IANSA, OXFAM, SAFEWORLD, (2007) *Africa's missing billions*, Briefing Paper 107, pg. 15

According to the Oxfam Briefing Papers (2007), compared to peaceful countries, African conflict-affected countries have on average:

- 50 per cent more infant deaths;
- 15 per cent more undernourished people;
- Life expectancy reduced by five years;
- 20 per cent more adult illiteracy;
- 2.5 times fewer doctors per patient;
- 12.4 per cent less food per person.

The same estimation has pointed out that the total annual amount lost by Africa because of armed conflict, is around US\$18bn corresponding to the 15% of annual African GDP. This represents one and a half times average African spending on health and education combined.

Significant resources that Africa is wasting in solving conflicts' consequences, could give instead, consistent contribution in the alleviation of the HIV and AIDS epidemic, in the improvement of prevention and treatment projects for TB and malaria and in building of more hospitals; positively affecting millions of people. Indeed According to the World Health Organisation, nursing large numbers of patients with gunshot wounds in Africa "has a draining effect on basic health care and diverts much-needed resources from other health and social services"¹⁶⁰, just considering, for example, that in a country with per capita government expenditure on health of US\$ 5, like Burundi, each firearm injury costs to the health system US\$ 163.

Hence, money spent for such avoidable causes is money that Africa can ill afford to lose since it is essential for improving country's development. Yet, among the countless reasons of African slow development, it is what fuels armed conflicts, e.g, arms transfer, that prevents the continent even more from attaining health-related MDGs.

¹⁶⁰ FLESHMAN M. (2001). *Small arms in Africa: Counting the cost of gun violence*, Africa Recovery, Vol. 15 No. 4, December 2001, p.1 (quoted in IANSA, OXFAM, SAFEWORLD, (2007). *Africa's missing billions*, Briefing Paper 107, pg. 13).

Since states have the complete right to acquire conventional arms for legitimate self-defence, arm acquisition, if complying with international standards and laws, can provide a useful contribution in safeguarding a country's stability and security. On the contrary, irresponsible arms transfers forcing the defence, reduce government funds fundamental for development, wasting them through inappropriate or corrupt arms acquisitions.

Even after the ceasefire, in 2006, that should have put an end to the long Burundian civil war, criminal and political armed violence still continues in the country. It has been recorded that in 2008, at least 100.000 small arms were still in illegal circulation brought from neighbouring countries. According to a civilian defence policy, during the conflict arms were distributed by the Burundian armed forces to local councils in order to reach general population. Simultaneously, rebel factions of National Council for the Defence of Democracy (CNDD) and National Liberation Force (FNL) also provided those parts of population under their control with arms illegally purchase from the Mai-Mai militia in the DRC and the former Rwandan armed forces. Therefore, large quantities of arms from Tanzania were shipped across Lake Tanganika to areas such as Makamba, Ruyigi, and Bururi where there were widespread complicity, corrupted officials and weak government control.

In 2007 Oxfam estimated the total economic cost of the conflict in Burundi amounting to US\$ 5.7bn.¹⁶¹

Burundi owes its awful health situation to the devastating impact of this armed conflict and to the corrupted activities lying beneath. Its performances in attaining MDG 4 and 5 (reduce child mortality and improve maternal health) are among the worst in the world. According to World Health Organization's statistics, more than one in every 100 babies and one in every 200 mothers dies in childbirths. A definite factor to this has been the destruction of health infrastructures and services during armed conflict but the violence threat and the long, unsaved distance to reach them, hold women back from moving in order to receive adequate medical treatments, as well.

¹⁶¹ IANSA, OXFAM, SAFEWORLD, (2007). *Shooting down the MDGs. How irresponsible arms transfers undermine development goals*, Briefing Paper 120.

When spending on arms transfers goes beyond the actual needs of ensuring a country legitimate self-defence, this leads to a drain of those resources fundamental for social development. In Africa the overspending on security sector rather than in favour of other areas, lays behind the missed realisation of social and health rights of large part of the population.

Unfortunately, the management of military budget is ministered often by weak government institutions unable to arrange a fair national security strategy. They act through nontransparent procedures which encourage even more pandemic corruption but together prevent richest countries and organizations from helping fragile states by means of substantial funds. In 2006, SIPRI and Africa Security Dialogue and Research (ASDR)¹⁶² has monitored the processes of budgeting for defence of eight African countries between 1999 and 2005 (Ethiopia, Ghana, Kenya, South Africa, Mali, Mozambique, Nigeria and Sierra Leone), assessing them through seven principles: (1) comprehensiveness, (2) contestability, (3) predictability, (4) honesty, (5) discipline, (6) transparency and (7) accountability, within the stages of formulation, approval and implementation of the military budget. It has been noted that all countries, with the exception of South Africa and Sierra Leone (but only since 2003), miss effective strategic defence plans secondary to the absence of realistic defence policies. Having a defence policy is a warranty of transparency and accountability for a country even though it does not necessarily mean that the government will put it into practice. It is exactly the absence of “financial discipline” in military spending, that leads governments in Africa to perform extra-budgetary expenses or to exploit other social, especially health sector’s budgets when an urgent security situation has revealed. As a matter of fact, until 2003 Ethiopia disproportionately allocated consistent budget to defence at the expense of health and other public sectors; while Kenya was an example of those countries with regular overspending of the defined military budget.

Military-related corruption suffered by Nigeria is due to the countless non-transparent and inadequately controlled military spending of its military-dominated government, of which low levels of transparency impede to know the

¹⁶² OMITOOGUN W, HUTCHFUL E.(2006), *Budgeting for the military sector in Africa. The process and mechanisms of control*. SIPRI Book, Oxford, Oxford University Press.

real amount of wasted resources. An authentic example comes from the signing in 2005 by the Ministry of Defence (MoD) of a contract of US\$ 74.5 million for refurbishment, training, and logistical support related to Nigeria's G.222 military transport planes, as they were not included in the negotiations. The MoD was actually criticized by the Air Force since any procurement decision was (still is) usually left to the military hierarchy. As a matter of fact, the expenditures on major military procurement deals are often not adequately reported in Nigeria's national budget. Just considering that in 2000 and 2001 any defence expenditure was registered; only afterward it was included. Nigeria is not the only example of exclusion of arms procurements from military budget; this practice is widely current in African countries: "when the military budget is presented to the parliament it rarely contains allocations for arms procurement, and when allocations are included it is not specified that they are for purchasing weapon, appearing under general headings (e.g. 'other expenditures')"¹⁶³. Ethiopia as well, is an example of country that regularly purchases weapons and rarely details its procurement in military budget. The main problem related to the missed recording of this defence spending is the impossibility in tracking the real military expenditure. The even reverse progress towards health-related MDGs of South Africa with underweight children, child mortality and improved sanitation's rates deteriorating even more since 1990, is direct consequence of an arms' deal. It has been signed in 1999 by the government and a number of major European arms suppliers for the acquisition of a range of major weaponry (advanced fighter jets, trainer aircraft, corvettes and submarines). The equipment purchased initially for R29b (US\$ 4.8 billion) but actually amounting to R66m (US\$ 9.1 billion), was considerably more advanced than the real needs and with little relation to the identified military missions. Yet, even if South Africa is one of the few African countries in possess of a transparent military planning and budgeting as mentioned above, even such reliable (at least on paper) processes can lose their efficacy when affected by corruption.

¹⁶³ PERLO-FREEMAN S, PERDOMO C. (2008). *The developmental impact of military budgeting and procurement – implications for an arms trade treat*, OXFAM Publishing, pg. 19.

Unfortunately, “this arms deal continues to cost South Africa an average of R4bn (US\$ 530 million) a year, but correcting reported infrastructure shortfalls in South African schools would cost R3bn (US\$ 398 million) a year for ten years, while the annual cost of making up backlogs in the free provision of water services has been estimated at R3.2bn (US\$ 425 million)”.¹⁶⁴

Table 5.6 Military and social expenditure priorities, select countries, 1999–2003

Income group/ Sector ^b	1999	2000	2001	2002	2003	Average, 1999–2003
<i>Low-income countries</i>						
Military	2.7	2.7	2.5	2.5	2.3	2.5
Education	3.4	3.5	3.8	4.0	4.0	3.8
Health	1.8	2.0	2.0	2.2	2.2	2.1
<i>Middle-income countries</i>						
Military	1.9	1.9	2.0	1.9	1.9	1.9
Education	4.8	4.5	4.7	4.6	4.7	4.7
Health	3.3	3.3	3.4	3.4	3.4	3.4
<i>High-income countries</i>						
Military	2.1	2.0	2.0	2.0	2.0	2.0
Education	5.5	5.4	5.6	5.7	5.9	5.6
Health	5.8	5.8	6.1	6.2	6.4	6.1

^a The countries covered are those for which data are available for at least 2 of the 3 sectors throughout the 5-year period, totalling 82 of the 167 countries in the SIPRI Military Expenditure Database. The coverage is uneven between income groups: 24 high-income countries of a possible 37 countries; 45 middle-income countries of a possible 81; and 13 low-income countries of a possible 49 countries in the SIPRI database. In addition, although data were available for Eritrea (a low-income country), it has nevertheless been excluded as a statistical outlier.

^b The data on education and health expenditures refer to general government expenditure, including central, regional and local government. Data on health expenditure include social security contributions and funding from external resources.

Source: Freeman et al.(2008)

Hence, the general concern is that in the long term excessive expenditure on defence and specifically on arms trade will come at the expenses of health funds, so essential for the human development of African society.

Table 5.6 presenting data on the average proportion of national GDP invested on defence and health by country income groups for the period 1999-2003, provides

¹⁶⁴ IANSA, OXFAM, SAFEWORLD, (2007) *Shooting down the MDGs. How irresponsible arms transfers undermine development goals*, Briefing Paper 120, pg.14.

us with further evidence that low-income countries give priorities to military spending over health. Moreover, as the income level increased, the proportion of GDP addressed to health spending increased, as well; while low-income countries have spent on average 5.9 percent of GDP on health, middle and high-income countries spent 8.1 and 11.7 percent respectively.

More importantly, the reported data demonstrate that health expenditure is a lower priority than security in low-income countries, such as Africa. Therefore, the general concern is unfortunately even more attested by empirical evidence that confirms that health sector could improve if military expenses were reduced.

5.7 The paradox of plenty

Nigerian petrodollars account for more than 83 percent of federal government revenue, more than 95 percent of export earnings and about 40 percent of Nigeria's GDP.¹⁶⁵ In order to reach the state, these amounts of money largely pass through the Nigerian National Oil Company (NNPC)¹⁶⁶ which usually exports 57 percent of total crude oil. The proceeds are deposited in the Central Bank of Nigeria (CBN) supposed to be shared by the three levels of government on a constitutional formula according to which, 48.5 percent is for the Federal, 24 percent is for the states, and 20 percent belongs to the local governments. The remaining 7.5 percent is address to special funds. The Federal Government has even stated that oil proceeds in excess of US\$ 20 per barrel should be destined to a special development account; unfortunately, this commitment has not been kept.

Indeed, lack of accountability and transparency's tools let the petrodollars being wasted. Human Rights Watch (2002) reports that "little of the money paid by the

¹⁶⁵ GARY I, KARL TL, (2003). *Bottom of the barrel, Africa's oil boom and the poor*, Report, Catholics Relief Services Publishing.

¹⁶⁶ "The Nigerian National Oil Company (NNPC) was created in 1977 as a vehicle for partnerships with foreign oil companies and is now a holding company for a diverse set of subsidiaries". GARY I, KARL TL, (2003), *Bottom of the barrel, Africa's oil boom and the poor*, Report, Catholics Relief Services Publishing.

federal government to state and local governments from the oil revenue is actually spent on genuine development projects”.¹⁶⁷

As a result, in Nigeria more than 70 percent of the population live with less than a dollar a day, 43 percent has not access to healthcare systems and clean water and infant mortality rate averages around 138 deaths per 1.000 live births every year, still among the highest in the world.

Congo as well, belongs to the long list of corrupt African states whose populations are indirectly paying the consequences of budgets mismanagement.

Petroleum dependence together with civil war have exacerbated even more corrupt Congolese fiscal system, already unable to face oil price shocks and the exhaustible nature of its oil resources.

Indeed, revenues of more than US\$ 2.5 billion oil exports ought to provide 3 million Congolese people with a stable basis for beginning their long way towards development; weak government and its too strictly dependence on petrodollars, however obstruct this project. As evidence, the 70 percent of the population live on less than US\$ 1 per day and about 35 percent have no access to clean water. The revenues have not been sufficient to reduce infant mortality, which remains unusually high (128 deaths per 1.000 live births in 2008), maternal mortality (580 deaths per 100.000 live births) and tuberculosis incidence which averages around 660 deaths per 100.000 population; so distant from the 2015 MDG target of 138.¹⁶⁸

The health status of Congo is due once again to resources squandering in ever increasing military expenditures “necessary” for facing civil war. Hence, that same civil war was fought also for political reasons relative to petroleum issues which directly involved the French oil company Elf-Aquitaine which in turn supported president Nguesso arms and militias’ funding in exchange future access to oil.

Therefore, in Congo as well, mismanagement of budget allocations has hindered adequate health expenditures for the purchase of medicines and the building of

¹⁶⁷ Ivi, p. 26.

¹⁶⁸ WHO, (2011). *Health situation analysis in the African region. Atlas of health statistics*. WHO Regional Office for Africa Publishing.

health structures fundamental for avoiding population to be deprived of their own health right.

Africa hosts eight oil exporters: Nigeria, Angola, Gabon, Equatorial Guinea, Cameroon, Chad, the Democratic Republic of Congo and Sudan.

Solely African governments have the legal honour to select the international company operating within their territories. They directly decide the share of benefits to address to it and the amount of proceedings to destine to the state. African governments ultimately choose how and to whom the share of oil revenues must be allocated seemingly for the benefit of the whole country. Unfortunately, since these government institutions belong to the so called “fragile states”, they are often inexperienced and completely lack accountability. As a matter of fact, being so weak, they become strictly depend on oil proceedings as the main source of revenues and foreign exchange, as well as their main power. But they seem to not understand that the more they spend, the more they need oil revenues.

The population of these oil rich countries believe that oil will improve their development (e.g, more jobs, more education, better healthcare) but they ignore that actually, it brings only more dissatisfaction and consequently more violence. Indeed, it has been demonstrated that in countries depending on oil exportations, poverty has increased over the past two decades instead of being tackled as government institutions are particularly vulnerable to policy failure.

Hence, the significant oil revenues generated by oil’s boom, when well arranged (see the case of Norway), could offer the right opportunity to improves the lives of millions of people through increased expenditures in health, education, and other social services. But, when these revenues are managed by governments lacking transparency and accountability, it is highly unlikely that they will improve population’s condition. On the contrary, they actually worsen country’s development.

This means that these development problems around petroleum are not relative to the resource itself, but depends on the quality of public policies through which governments “sow” their oil revenues.

The impossibility to avoid the temptation of lavish spending has let the country garnering the title of “world’s largest per capita importer of champagne”¹⁶⁹. Unfortunately, the several attempts made to trace oil monies expenditures have been unsuccessful, although the long series of scandals Gabon have experienced, including money laundering linked to French politicians, party financing and allegations of hidden oil. As any deposit has never been made in the Fund for Future Generations created “to capture 10 percent of budgeted oil revenues as well as 50 percent of any windfall revenues for future use”¹⁷⁰, so nothing has been made to improve health sector which in Gabon is characterized of a great gap between mediocre health outcomes and consistent public spending in health. General Gabonese government expenditure on health (in 2007) corresponds to about 14 percent of the total government expenditure but the results made in reducing infant and maternal mortality¹⁷¹ are still too far from attaining the corresponding health MDGs.

¹⁶⁹ SCHISSEL H, *Champagne: Top of the Pops*, West Africa 3 June 1985 (quoted in GARY I, KARL TL, (2003), *Bottom of the barrel, Africa’s oil boom and the poor*, Report, Catholics Relief Services Publishing, p. 29).

¹⁷⁰ GARY I, KARL TL, (2003). *Bottom of the barrel, Africa’s oil boom and the poor*, Report, Catholics Relief Services Publishing, p. 29.

¹⁷¹ Under-five mortality rate in 2008 averages 69 per 100.000 live births against the 31 of the MDG target. Maternal mortality ratio in 2008 averages 260 per 100.000 live births against 65 of the MDG target. WHO, (2011). *Health situation analysis in the African region. Atlas of health statistics*. WHO Regional Office for Africa Publishing

CHAPTER 6: QUIET CORRUPTION: UBIQUITOUS IN AFRICAN HEALTH SECTOR

... “don't let corruption kill development – highlights one of the biggest impediments to the world's efforts to reach the Millennium Development Goals”.¹⁷²

“in Nyassa a health centre worker removed antibiotics from his workplace to send them across the border to Malawi, in exchange for ... shoes, TV sets, video sets, hi-fi sets, etc. He opened his own shop in town on account of his dishonesty.”¹⁷³

“My son was vaccinated with water because we were too poor to pay the health worker the extra fee.”¹⁷⁴

“The Government has this morning formed an anti-corruption squad to look into the conduct of the anti-corruption commission, which has been overseeing the anticorruption task-force, which was earlier set to investigate the affairs of a Government ad hoc committee appointed earlier this year to look into the issue of high-level corruption among corrupt Government Officers.”¹⁷⁵

6.1 Introduction

The annual global health spending is approximately US\$ 3 trillion. Yet, while high income and OECD countries spend on average from 7 percent to more than 12 percent of their GDP on health, in low-income countries health spending ranges from 4 percent to 5 percent of GDP.¹⁷⁶

¹⁷²UN Secretary-General's speech on the International Anti-Corruption Day, 9 December 2009.

¹⁷³FERRINHO P, OMAR MC et AL, (2004), *Pilfering for survival: how health workers use access to drugs as a coping strategy*, Human Resources for Health, 2:4, p.2.

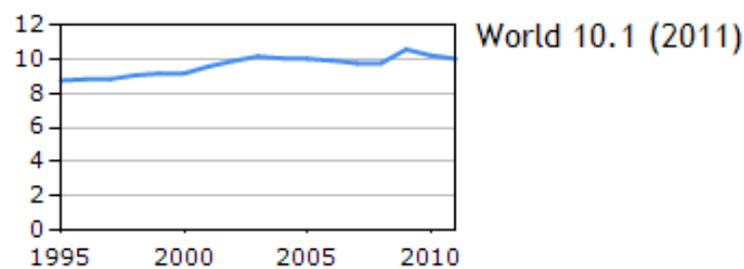
¹⁷⁴CMI (2008), *Corruption in the health sector*, U4 Issue 2008:10, Anti Corruption Resourcing Centre Publishing, p.25.

¹⁷⁵Statement issued by Kenya's Attorney General (quoted in KAUFMANN D, (1998). *Revisiting Anti-Corruption Strategies: Tilt Towards Incentive-Driven Approaches?* In United Nations Development Programme (ed.) *Corruption and Integrity Improvement Initiatives in Developing Countries*, New York, p.64).

¹⁷⁶DFID (2010). *How to note. Addressing corruption in the health sector*. DFID Practice Paper. DFID Publishing.

In order to guarantee universal and equitable access to health services, according to human rights' dictation, resources, considered a sufficient part of public revenues, are earmarked by governments and external supporters to health sectors globally and at country level.

Fig. 6.1 Global average of total (GDP) health expenditure



Source: World Bank Search. Available from:

http://search.worldbank.org/data?qterm=global+ANNUAL+HEALTH+SPENDING&topic_exact=Health

These same resources “offer lucrative opportunities for abuse and illicit gain”¹⁷⁷ that goes under the larger definition of corruption.

It represents “a concern in all countries, but it is an especially critical problem in developing and transitional economies where public resources are already scarce”.¹⁷⁸

Usually, literature underlines a direct relationship between corruption and African development just limiting its debate to the so called “big-time corruption”¹⁷⁹. It refers to that vice belonging mainly to the government highest figures and which notably hides behind administrative and political corrupted practices. But most often it takes no notice of that form of corruption more silent and more lethal

¹⁷⁷Ivi, p.3.

¹⁷⁸VIAN T. (2002). *Corruption and the Health Sector*, U.S. Agency for International Development (USAID) and Management Systems International (MSI), p. 1 (quoted in ANTI CORRUPTION RESOURCES CENTRE, (2008). *Corruption and the Health Sector*, U4 ISSUE, Volume 10, Anti Corruption Resources Centre Publishing, pg.4.

¹⁷⁹WORLD BANK (2010), *Silent and lethal. How quiet corruption undermines Africa's development efforts*. Africa Development Indicators. World Bank Publishing, p. 1.

which penetrates African health sector directly. Exactly it takes the name of “quiet corruption”.

Compared to other sectors, health is usually defined as one of the most corrupt. Its vulnerability to corruption seems to be due first of all to its complexity but also to its “uncertainty, asymmetry of information and the large number of actors” involved (in it).¹⁸⁰

The uncertainty refers to the impossibility to predict the number of people who will fall ill because of which disease; consequently, it will be challenging decide on the needed medical treatments. This uncertainty together with a complete lack of reliable information (supposed to be equally shared between health providers and patients but also between suppliers and providers) leaves too much discretion to unmonitored health providers who finally tend to abuse of their position in several different ways. Frequently it happens that doctors prescribe drugs to patients who assume them thinking that they will improve their conditions however, doctors prescribe those specific medicines just because pharmaceutical companies have offered them certain incentive to do so.

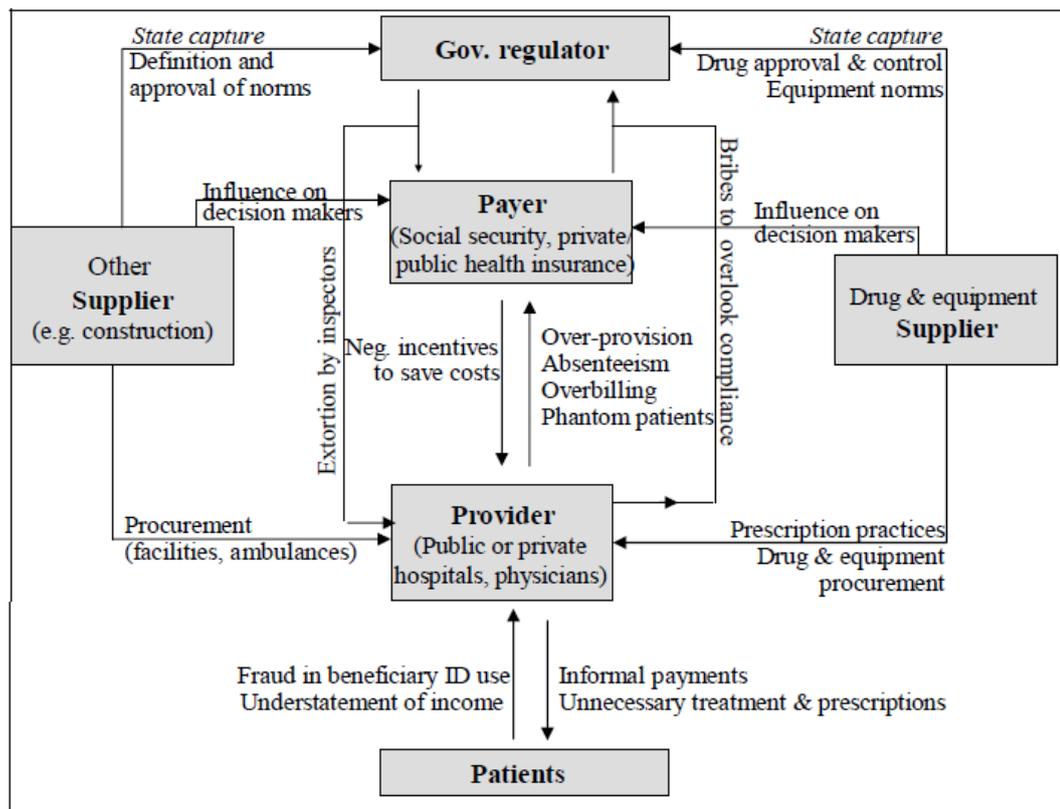
The same unmonitored health providers (from government health regulators to health suppliers) are those who most frequently not carry out their duty since they are absent. Moreover, the decentralization of health service delivery and the unknown potential conflicts of interest among medical suppliers and higher health policy makers make it more difficult holding in check health sector’s quality. Figure 6.2 provides us with a scheme with the core areas of health sector and corruption risks.

In the health sector, many abuses¹⁸¹ such as illegal fees, absenteeism, theft and inadequate medical supplies procurement, are not only a crime but also simultaneously a cause and a consequence of “insufficient health budgets” that “combined with burgeoning health problems such as the global HIV-AIDS pandemic, have led [finally] to an acute shortage of health workers, shortage of

¹⁸⁰ DFID (2010), *How to note. Addressing corruption in the health sector*. DFID Practice Paper. DFID Publishing, p.3.

¹⁸¹ Processes with higher inherent risk of corruption: 1)provision of services by medical personnel; 2)human resources management; 3)drug selection and use; 4)procurement of drugs and medical equipment; 5)distribution and storage of drugs; 6)regulatory systems; 7)budgeting and pricing. In ANTI CORRUPTION RESOURCES CENTRE (2008). *Corruption and the Health Sector*, U4 ISSUE Volume 10, Anti Corruption Resources Centre Publishing, p.5

Fig.6.2 Core areas of health sector and corruption risks



Source: DFID (2010), *How to note. Addressing corruption in the health sector.*

drug and medical supplies, inadequate or non-payment of health workers salaries, poor quality of care, and inequitable health care services in many low income and transition countries”.¹⁸²

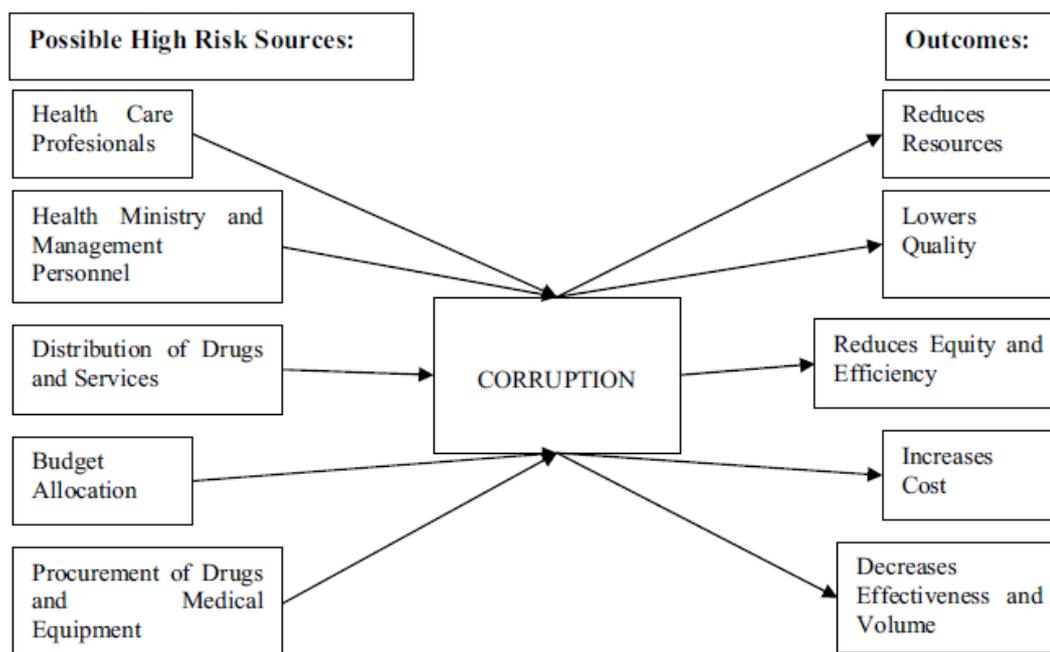
It is curious noting that till now corruption in health sector has been often omitted or hardly reported just through anecdotal descriptions lacking of empirical data (willingly) by the same professional literature.

A dated article published in *The Lancet* in 1978 touches on corruption in Kenyan health sector just reporting that two officials of the ministry of health have been bribed to buy from a company so large quantitative of medicines to cover nation’s needs for ten years even though some of those drugs would have expired in few years.¹⁸³

¹⁸² ANTI CORRUPTION RESOURCES CENTRE (2008). *Corruption and the Health Sector*, U4 ISSUE, Volume 10, Anti Corruption Resources Centre Publishing, p.4

¹⁸³ FERRINHO P, VAN LERBERGHE W. (2005). *Managing health professionals in the context of limited resources: a fine line between corruption and the need for moonlighting*. World Bank Publishing.

Fig. 6.3 Corruption in the health sector: risk areas and consequences



Source: Corruption and the Health Sector, U4 ISSUE 2008

The inclination of professional literature to omit more eloquent information about corruption in health sector and its consequences on health development seems to be justified by the will to avoid to make public integrity weakness of countries governments.

Indeed, corruption in the health sector reflects more general problems of poor governance and public sector accountability: “corruption thrives where transparency, accountability, and participation are weak, where public sector and financial management capacity are low, and where public decision making has been compromised by conflicts of interest and political interference. Conversely good governance can discourage corruption”¹⁸⁴.

Since individual beliefs are so accustomed to eroding public services values and social norms, it is not surprising that an environment that seems to normally accept and even justify dishonest practices in health sector has been created in Africa.

¹⁸⁴ DFID (2010), *How to note. Addressing corruption in the health sector*. DFID Practice Paper. DFID Publishing, p.5.

Behind “lower” health corruption stays a general dissatisfaction of health providers; as Ferrinho¹⁸⁵ reports as real evidence, a Mozambican nurse in 1999 was paid just 10-15 % more of what it had been paid 15 years before. It is worth remembering that low salaries received by health staff are in turn direct consequence of government budget leakage. In such context, “demotivation”, “lack of commitment” and low productivity of health providers seem to be almost justified by patients. But, what is felt to be even more justifiable is their dishonest coping strategies: “many clinicians combine salaried public sector clinical work with a fee for service private clientele. Others resort to absenteeism or predatory behaviour, asking under-the-counter payments for access to ‘free’ services or goods and/or misappropriating drugs or other supplies and referral of public sector patients to private practices”¹⁸⁶.

But being weak governance the main characterization of African countries, together with a deep-rooted culture of acceptance of corrupt health processes, it will be hard to eradicate corruption from the entire African health sector.

As already shown, the achievement of MDGs is directly linked to good governance conditions. In Africa, specifically corruption and weak governance help understand the reason why the allocations of significant resources have not translated into better health outcomes, fundamental in the attainment of health-related MDGs.

“When public money is stolen for private gain, it means fewer resources to build schools, hospitals, roads and water treatment facilities. When foreign aid is diverted into private bank accounts, major infrastructure projects come to a halt. Corruption enables fake or substandard medicines to be dumped on the market, and hazardous waste to be dumped in landfill sites and in oceans. The vulnerable suffer first and worst”¹⁸⁷. These are the words chosen by the UN Secretary-General Ban Ki-moon on Anti-corruption Day (9 December 2009) in order to stress the danger led by corruption on development and on the global efforts to reach MDGs.

¹⁸⁵ FERRINHO P, VAN LERBERGHE W. (2005), *Managing health professionals in the context of limited resources: a fine line between corruption and the need for moonlighting*. World Bank Publishing.

¹⁸⁶ *Ivi*, p.5

¹⁸⁷ UN Secretary-General’s speech on the International Anti-Corruption Day, 9 December 2009.

According to Ban Ki-Moon, “the vulnerable” as children, women and the poor are those most affected by the heavy burden of corruption, given that they can be even denied access to health care when they cannot afford to pay those “additional” costs required for benefitting of health assistance. Direct evidence of this disadvantage comes from Burkina Faso where one of the main cause of high maternal mortality rate is due to corruption by health suppliers. The informal fees they require to guarantee health services cannot be paid by pregnant women. Another important report from the International Monetary Fund shows the clear negative effects these dishonest practices have on infant and child mortality: corruption not only lowers the immunization rate of children but also prevent population from using public health services.

6.2 Quiet corruption

Quiet corruption although smaller in monetary terms than “big-time” corruption, concerns more directly common vulnerable households since they interact more with health services but at the same time, they are also the least likely to know how to get redress when health suppliers abuse their position.

Being an abusing of public office for private gains, even if involving lower level officials and routine public services; petty corruption like big-time corruption weakens services as well. But contrary to the more “noisy” and blatant corruption at political level, quiet corruption with its low capability to attract public attention is even more ubiquitous. Therefore lasting and danger effects fall back more on poor people than on others. Indeed, poor people have to pay additional costs (bribes) even to receive just basic public health services, while rich households are disposed to pay bribes in order to receive specialized health treatments.

The Report on Africa Development Indicators 2010 expresses properly the concept of quiet corruption through the iceberg analogy (Fig.6.4): big-time corruption is just the “tip of the iceberg” while, quiet corruption is less evident but more widespread; it embraces a large number of beneficiaries (from health providers, doctors to nurses) and consequently brings about long-term effects.

Fig. 6.4: Big corruption is only the “tip of the iceberg”



Source: WORLD BANK (2010) Africa Development Indicators 2010.

As usually happens in Africa, a mother to whom quiet corruption has denied high quality antenatal care, might give birth to an underweight child “who will likely suffer a series of health setbacks during childhood that potentially magnify the immediate effects of the poor antenatal care”.¹⁸⁸ Yet, this represents just a part of a longer significant chain of direct and indirect consequences led by quiet corruption. In front of these injustices, families’ mistrust of poor quality health system increases so much that several households begin to renounce to their health right and abandon health system leaving public health facilities underutilized.

¹⁸⁸ WORLD BANK (2010), *Silent and lethal. How quiet corruption undermines Africa’s development efforts*. Africa Development Indicators 2010. World Bank Publishing, p.3.

In some regions of Uganda, decreasing services' utilisation, "sometimes caused by financial inaccessibility and sometimes by poor perceived quality", ¹⁸⁹ lowers health staff attendance; as a consequence, opening hours of health care facilities are reduced. "The hours worked were very low reflecting the fact that most units were open only for 2 to 3 hours in the morning and had informally arranged shift systems which required at most one qualified health worker to be on duty at any one time. Given the low utilization levels described above, one qualified worker was usually sufficient to deal with the workload." ¹⁹⁰

Again, the pervasiveness of quiet corruption could be explained by the same analogy of the iceberg in the sense that being an entire unique bigger concept (a bigger piece of ice), big corruption and quiet corruption are intertwined and mutually reinforcing. Within a corrupt environment, even if "quiet corrupt" such as those of low-level officials, everybody committing corruption may justify himself in his same mind through the consideration that also his superiors are involved in big-time corruption routinely. Therefore big-time corruption in turn, wasting available resources and avoiding to regulate adequately health system incites low-level bribers to act in thievishness.

Big-time corruption drives corruption at the level of service delivery, which again reinforces big time corruption; in this sense this represents the mechanism that has made quiet corruption becoming ubiquitous in African health system, ruining it.

Hence, "African health systems falls into a permanent vicious cycle in which every misconduct is tolerated"¹⁹¹ till it will be eradicate from African political economy.

¹⁸⁹ "In the average facility there were less than 20 outpatients per day. In some facilities there were also significant numbers of ante-natal care patients and there is usually a busier immunization day. Nevertheless this level of utilization was less than expected of the smallest rural unit and most units could and did manage the workload with only one qualified health worker despite the expected staffing levels being much higher". MCPAKE B, ASIIMWE E, MWESIGYE F, OFUMB M, STREEFLAND P, TURINDE A (2000), *Coping Strategies of Health Workers in Uganda*, p. 146. In FERRINHO P, VAN LERBERGHE W. (eds.), (2000). *Providing Health Care under Adverse Conditions: Health Personnel Performance and Individual Coping Strategies*. Antwerp: ITG Press.

¹⁹⁰ MCPAKE B, ASIIMWE E, MWESIGYE F, OFUMB M, STREEFLAND P, TURINDE A (2000), *Coping Strategies of Health Workers in Uganda*, p. 148. In FERRINHO P, VAN LERBERGHE W. (eds.), (2000). *Providing Health Care under Adverse Conditions: Health Personnel Performance and Individual Coping Strategies*. Antwerp: ITG Press.

¹⁹¹ WORLD BANK (2010). *Silent and lethal. How quiet corruption undermines Africa's developments efforts*. Africa Development Indicators 2010. World Bank Publishing, p.5.

6.3 Budget leakage hurts health

Recently Mozambique has recorded a rapid improvement in health facility infrastructures and in health sector staff as well. Even if it translated into good improvement of services' outputs, it has not reached the significant hoped growth. Still persist notable problems in service delivery such as shortage of drugs or equipment and missing staff's integrity, ignoring as well which processes allocate resources among districts or among facilities.

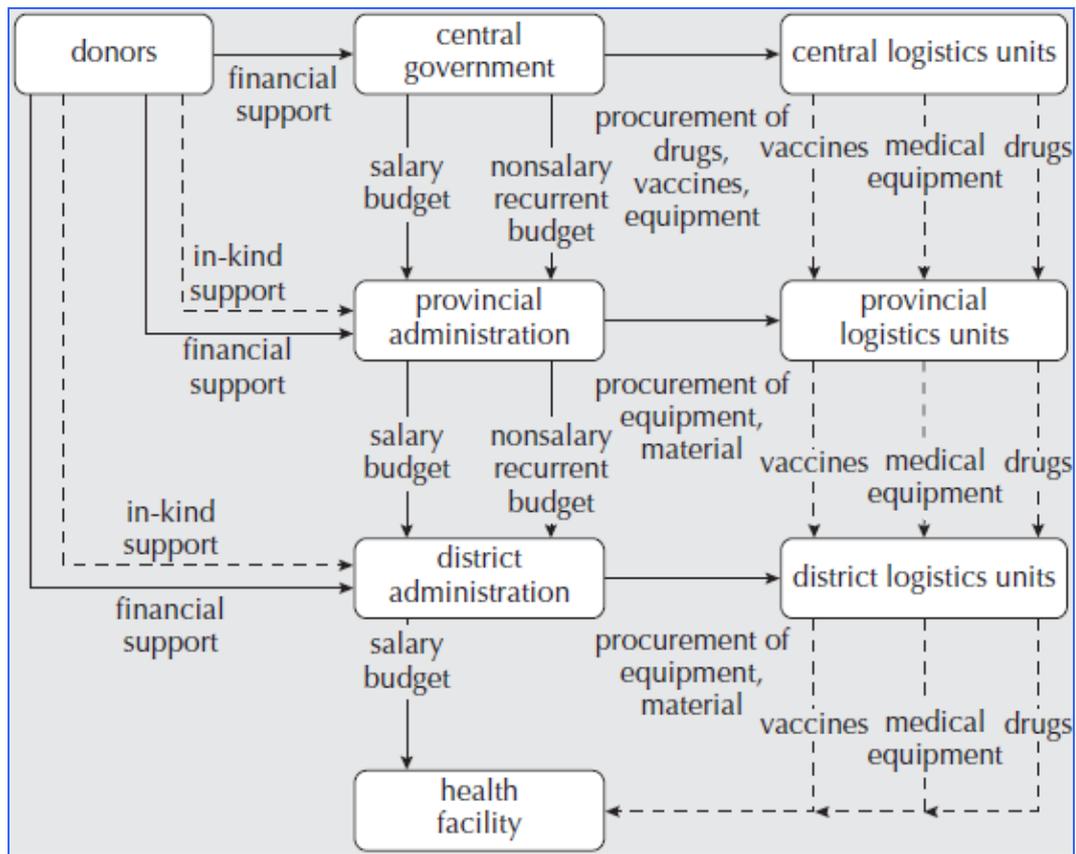
In most developing countries, public health facilities do not received every month the concern budget to adequately spend. Usually, the financial and in-kind resources they receive, pass through multiple channels governed by different, administrative and recording procedures.

Every step of this broader system presents potential risk of leakage: salary payments usually distributed to staff in cash or directly into bank accounts are strictly arranged by governmental institutions; nevertheless, government administrators can anyway leak them just creating fictitious health workers (ghost workers) and getting then, the salary payments supposed to belong to these fake workers. Yet, leakage of salary payments could take place also at facility levels, specifically when (paid) staff do not work regularly. Medical supplies are procured at the central and regional level before being distributed to facilities; again expenditures on drug may leak during procurement process but also during the distribution phase through theft or routine disposal (such as the expiration date). External financing from NGOs or other development agencies is subjected to leakage as well, especially at the higher levels.

In order to understand why the resources supposed to be employed in district health services did not reach the facilities actually delivering the services, an Expenditure Tracking and Service Delivery Survey (PETS)¹⁹² has been implemented in 2002.

¹⁹² "Public Expenditure Tracking Surveys (PETS) or Quantitative Service Delivery Surveys, collect data from health facilities, but also from the administrative units at local and central government levels that are charged with the financing and administration of the facilities. A central aim of these surveys has often been to determine whether funds allocated by governments to health service delivery reach the facilities that are supposed to deliver the services" in AMIN S, DAS J, GOLDSTEIN M. (2008). *Are you being served? New tools for measuring service delivery*, Washington, World Bank Publishing, p.173.

Fig. 6.5: Financial and resources flows to primary facilities



Source: WORLD BANK (2008), *Are you being served? New tools for measuring service delivery*.

The survey, analyzing the delivery of health service in relation to district recurrent budgets, human resources and drugs (and other supplies), has disclosed a different feature of the concept of leakage. “Leakage is generally thought of as the difference between a resource allocation or entitlement for a particular facility for a given period and the amount of resources actually received by the facility during the relevant period”.¹⁹³

Unfortunately, there are no severe allocation rules to apply for budget division. Most often, it happens that resources allocation is determined at the central level which allows for discretion among local providers.

Consequently, “the absence of hard allocation rules complicates the conceptualization and measurement of leakage”.¹⁹⁴

¹⁹³ Ivi, p.176

¹⁹⁴ Ibidem

Excepting the amount allocated to salary payments which strictly depends on the grade of a staffer; the resources budgets to district facilities in Mozambique are merely indicative, unbind from severe allocation rules, therefore vulnerable to changes over the year. The same consideration has been recorded also for drugs and other medical supplies. Since drugs can be distributed to health centres as prepackaged kits (on the base of an historical estimation of patients' volume) or even as individual drugs (as facilities have requested), "administrators at the provincial and district levels may exercise considerable discretion over the distribution of drugs".¹⁹⁵

But this has not been the case for Mozambique because the survey has found that "in 25–30 percent of the districts, the number of received drug kits, according to district records, did not correspond to the number of kits distributed according to provincial records. Similarly, the total value of individual drugs distributed to districts according to provincial records was more than the corresponding value of the drugs actually received according to district records in 60 percent of the districts; the difference ranged from 10 to 90 percent. Although these findings represent strong evidence of leakage, the data also suggest that a few districts received *more* drugs than that the provinces claim to have distributed. It is, therefore, possible that the observed discrepancies are driven by poor recordkeeping rather than irregularities".¹⁹⁶

Similarly for human resources, it cannot be asserted that money was lost along the way, since "staff were fewer in district and facilities than how many were actually present"; but in the opposite situation (of supposed ghost workers) this hypothesis of leakage may not be rejected.

Hence, the survey has demonstrated that in the specific case of Mozambique, the inconsistencies between government budget allocations and health outcomes originate from government's weakness in management and control systems rather from blatant fraud or malfeasance. However, as already empirically demonstrated, weak government, impeding efficient and equal distribution of resources, prevents

¹⁹⁵ AMIN S, DAS J, GOLDSTEIN M. (2008), *Are you being served? New tools for measuring service delivery*. Washington, World Bank Publishing, p.181.

¹⁹⁶ *Ivi* p. 183

in turn the improvement of health status of Mozambique and its path toward meeting health-related MDGs. (See Box 6.1)

The case of Mozambique demonstrates that not always leakage means corruption since sometimes (but not so often) leakage of money also can be due to administrative bottlenecks and to legitimate reallocations. Actually, budget allocation for health represents an important “function” for governments in order to equally distribute resources in more efficient and useful health services and programs; however, it is a process that requires great capability and complete reliability by governments.

Yet, the great majority of African countries, classified as fragile, completely lack not only governments’ financial and technical capacity to carry out this commitment but also the transparency in tracking and recording such resources allocations. Institutions are weak, budget management is often undemocratic and opaque therefore few room is left to public participation. Hence, being the resources unchecked and unrecorded, they can be easily dispatched to more politically and financially favourable sectors.

Monitoring the relationship among resources allocation and actual spending at the facility level, Reinikka and Svensson in 2003¹⁹⁷ have observed that in many African countries financial stocks are not designated in compliance with planned budget decisions. Precisely, Ugandan and Tanzanian local councils have exploited for private gains large parts (actually 41%) of funds coming from the central government. As well in Ghana, only the 20 percent of non-wage public health expenditure, corresponding to the portion untouched by the leakage passing through ministries and districts levels, is actually used in service delivery centres. Based on these considerations, leakage and resources misallocations experienced by Chad help to understand why several previous researches have never found a significant relationship between health financing and health outcomes.

¹⁹⁷ REINIKKA R, SVENSSON J. (2003). *Survey techniques to measure and explain corruption*, World Bank. World Bank Publishing.

As Devallade ¹⁹⁸ states, corruption not only reduces the total amount at disposal for public expenditure, since large part of it is already stolen during the planning of budget distribution, but also affects the distribution of the amount left.

As a matter of fact, it is corruption that diverts resources towards public expenditure such as defence, fuel and energy, public services and order or culture, disadvantaging social sectors among which health.

The study of 2004 in Chad provides us with the concrete evidence of the detrimental effects leakage has on health services.

During the period under analysis, health situation in Chad were even worse than what would be expected at the equivalent level of GDP (US\$ 304 per capita). Under-five mortality rate was 200 per 1.000 live births. Maternal mortality was among the highest in the African continent (around 1.100 for 100.000 live births). The determinants of mortality were, but unfortunately are still widely diffuse, infectious diseases and parasites. According to the authors, the missing decrease in the incidence of these diseases still persists “despite significant increases in the budgetary resources allocated to health”¹⁹⁹.

Effectively, in 2003 regional administrations were supposed to receive 60 percent of Ministry of Health’s allocation (an increasing of 24% over the previous year), but the real amount got by the regional delegations was about 26% of the official budget.

Local health centres in turn, received about 1% of the original non-wage recurrent budget (comprising medical materials and medications) officially allocated by the Ministry of Health to the regions.

Since in Chad medications costs amount to 75% of total health expenditure per patient, and in rural areas it reaches even the 85%, they represent an important barrier to health service access. More often the population, not sure that its resources could be enough for paying a visit or a drugs prescription, prevented from addressing to health centres.

¹⁹⁸ DELAVALLADE C.(2006), *Corruption and distribution of public spending in developing countries*. Journal of Economics and Finance, 30:2.

¹⁹⁹ GAUTHIER B, WANE W. (2006). *Leakage of Public Resources in the Health Sector: An Empirical Investigation of Chad*. Policy Research Working Paper 4351. World Bank Publishing, p.3.

Box 6.1: Key findings beyond leakage

Nonwage recurrent budget	<p>There are delays in execution: in many districts, the initial budget transfer, due in January, occurred only in March or April, and monthly replenishments were frequently delayed by several months.</p> <p>Delays and other problems resulted in low budget execution among districts; the average execution rate was 80%, and some districts executed only 35% of the original allocation.</p> <p>There are dramatic disparities in district health spending per capita; these disparities may not be adequately accounted for by differences in population or differences in infrastructure.</p>
Drugs	<p>There are delays in drug distribution, and there is evidence of stock-outs.</p> <p>Individual drugs compose a large share of the drugs used in health centers and health posts, even though drug kits are supposed to be adequate.</p> <p>Despite the explicit aim of a needs-based distribution of drugs to facilities, there were considerable discrepancies in the number of tablets distributed per patient for six tracer drugs (for example, between 1.1 and 16 aspirins were distributed per patient episode).</p>
Human resources	<p>Delays in salary payments (60% of staff reported that they had received their salaries late “often” or “almost always”).</p> <p>Absenteeism (19% of staff were not present at the time of the visits).</p> <p>Low levels of health worker satisfaction existed, particularly in rural areas (75% of staff in rural facilities wanted to transfer).</p>
User fees	<p>Despite the existence of a national policy, the fees for consultations and medicines vary considerably across provinces, districts, and facilities; similarly, the rules on exemptions in payments for consultations and medicine vary greatly across districts and facilities.</p> <p>A sizable share of the revenues from user fees are not recorded by facilities (68% of the total consultation fees and 80% of the payments for medicines, based on a comparison of expected total facility receipts, given patient volume, payments reported by patients, and revenue reported by facilities).</p>

Source: *Are you being served?* (2008)

The repercussions of this opaque process on health services are severe. These have been shown by the authors examining “the effect on medication prices and showed that leakage has a negative and significant impact on the prices of medications sold by health centres. Health centres that do not receive public support tend to charge significantly higher mark-ups on medications than centres that receive public resources”²⁰⁰ . Disadvantaged by high cost of health treatments, once again, the poor are forced to renounce to health. For this reason, the authors state that if the resources budget would correspond to the official amount supposed to reach regional facilities, the number of patient seeking for health care would double.

6.4 Aid effectiveness: a perspective by donor’s and recipient’s side

Aid is a tool that could be instrumental in addressing the health challenge faced by fragile states, but the reality of this century shows that every single attempt resulted almost ineffective. There is a blatant disparity between population enjoying luxuries, amusements and consequently high quality social services and those 1.3 billion people still living in poverty, denied their basic needs and human rights.

Support from the donors all along has represented a fundamental part of financing for diverse sectors in Africa. Specially Sub Saharan Africa’s health sector heavily relies upon sizeable donor funding.

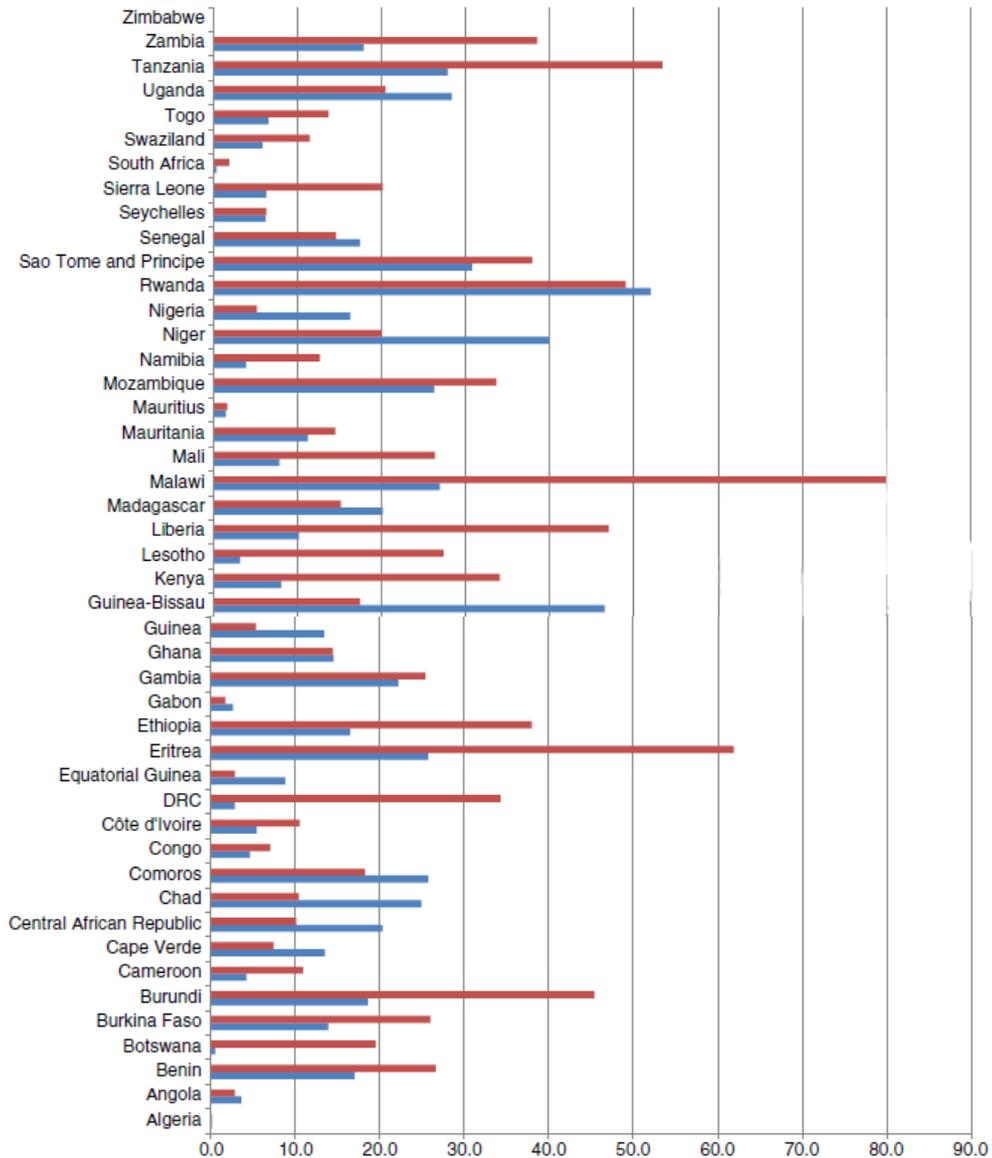
Total official development assistance (ODA) to sub-Saharan Africa has historically accounted for approximately 20 percent of total global ODA. Over the past two decades, ODA for health has been steadily increasing and in 2012, reached a high of US\$ 45 million.²⁰¹

Unfortunately, even if the volume of development aid constantly rises, health outcomes still remain unsatisfactory because of several political bottlenecks which hamper the adequate permutation of aid in qualitative services’ provision.

²⁰⁰ *Ivi p.27*

²⁰¹ OECD Web Site, Aid statistics, *Statistics on resource flows to developing countries*.

Fig. 6.6 External resources for health as % of total expenditure on health



Source: *Health financing in the African Region: 2000–2009 data analysis.*

In this instance, also donors, raise several concerns.

Aid flows are usually forced by volatility over time; this same volatility often prevents recipient countries to plan long-term projects implicating recurrent costs (for example hiring additional staff) since most often, donor funding is no more available once the project ends.

In the long run health outcomes in Africa can be affected also by donors' free will to sustain a country more than another. The political nature of donor countries and their foreign policy considerations stay behind their choice of helping more the so

called “donors darlings”, such as Madagascar, Malawi, and Mozambique, for which external assistance actually covers up to 50 percent of total health expenditures, than countries such as Guinea-Bissau, Togo, and Zimbabwe, in which external assistance accounts for approximately 7 percent of total health expenditures.²⁰² This can be explained only by the relative political stability of the recipient country which helps attracting more aid and it motivates donors to think about programs and projects that aid can sustain. However, often it happens that the same aid is employed in sustaining diseases programs which do not respond to the disease priorities of the recipient country government’s overall plan, as it occurred in Rwanda. Donors allocated US\$ 46.6 million for HIV/AIDS in 2005, when the country had a 3 percent prevalence rate, and only US\$ 18.3 million for malaria, which was the biggest cause of mortality in this country.

Another important concern that lies among donors and recipient countries is related to the limited capacity of many Sub-Saharan countries to absorb large amounts of donor funds and make effective use of them in financing health sector. Indeed, in the instance of the GAVI Alliance for Immunization Services Support (ISS)²⁰³, an evaluation of the program made by the same GAVI has shown that “the availability of strong technical assistance to support the National Immunization Program and a well-organized, functioning Inter-Agency Coordinating Committee were present in countries that were most successful in allocating and using funds”.²⁰⁴

Hence, the strategic allocation of funds is strictly related to not fully developed absorptive capacity of recipient countries because of “human capacity constraints, weak budgeting and planning processes, local political interference, and excessive donor requirements for reporting and monitoring and evaluation”²⁰⁵.

²⁰² USAID, (2008). *Health financing in Africa today: challenges and opportunities*. Africa’s Health in 2010 Academy for Educational Development Publishing.

²⁰³ “GAVI is an alliance involving multiple partners from the private and public sectors, dedicated to improving health and saving the lives of children through the support of widespread vaccine use. During the first phase of GAVI (2000-2005), GAVI provided support to immunization programs in the form of ISS (Immunization Service Support) cash contributions, in-kind support for the introduction of new vaccines, and in-kind and cash contributions for injection safety” in CHEE G, HIS N, CARLSON K, CHANKOVA S, TAYLOR P. (2007), *Evaluation of the first five years of Gavi immunization services support funding*. GAVI Alliance Publishing, p. IX.

²⁰⁴ USAID, (2008), *Health financing in Africa today: challenges and opportunities*. Africa’s Health in 2010 Academy for Educational Development Publishing, p.28

²⁰⁵ *Ibidem*.

Box 6.2 How absorptive capacity constraints can limit the effectiveness of donor financing

Months behind	No. countries
0	1
>0-6	18
>6-12	11
>12-18	8
>18-24	5

The difficulties countries are demonstrating in drawing down on their Global Fund to fight AIDS, Tuberculosis, and Malaria allocations also show the problem of their absorptive capacity. An analysis by Aidsplan in January 2008 indicates that of the 43 Global Fund grant recipients in sub-Saharan Africa, only one (Rwanda), was on schedule with its grant disbursements. The table shows that, on average, sub-Saharan Africa countries were 8.6 months behind schedule and, since Round I in 2002, only 46 percent of approved funds have been disbursed as of January 2008.

Source: USAID (2008)

On the contrary, fungibility²⁰⁶ of aid funds and the extent to which it actually reaches the populations seems to be a concern related most of all to recipient countries.

Usually, once it is received, aid can be voluntarily employed by recipients in other domestic sectors needing major priority; in this context, as for the case of government spending management, fungibility cannot be regarded as “bad” given that fund transfer takes place only for government’s decision according to what it considers to have the priority.

However, the impacts that donor funding directly have on under-five mortality and indirectly on maternal mortality (by increasing the impact of governmental health expenditures on this outcome) can be largely explained by “bad” fungibility of donor funding. Just considering the extent to which a recipient country, diverting the fund received for a specific purpose to another sector, would be hard-pressed in that event that its donor country suddenly decreases or completely cuts its support. The recipient country will be forced to quickly re-allocate resources to fill the gap, subtracting from other sectors.

²⁰⁶ “Diversion of funds to public expenditures other than those for which the aid is intended, including tax reduction or debt repayment” in GOTTRET P, SCHIEBER G. (2006), *Health financing revisited. A practitioner’s guide*. The International Bank for Reconstruction and Development /World Bank, Washington, World Bank Publishing, pg.145 (quoted in USAID, (2008), *Health financing in Africa today: challenges and opportunities*. Africa’s Health in 2010 Academy for Educational Development Publishing, p.27).

Assessing the impact of funding resources, coming from UNICEF and from the United Kingdom's Department for International Development (DFID) on maternal and child mortality rates, the case of Nigeria offers useful evidence with regards to the pervasiveness of corruption in Nigerian weak institutions.

“Nigeria has one of the highest child mortality rates in the world, recent data from the United Nations sources show the under-five mortality rate in Nigeria for 2010 is 142 per 1,000 live births. Infant mortality rate is 88 per 1,000 live births, and Neonatal mortality rate, 40 per 1,000 live births, with a concurrent increase in the number of live births. Annual number of births and deaths of under-5 in thousands were 6332, 861 respectively as at 2010”²⁰⁷.

“In the last ten years, a total commitment of \$6,277,010,522 has been made to Nigeria as ODA. Of this amount, only about 50% has been disbursed. Instructively, 54 per cent of the total ODA disbursements went to the health sector with almost all donors contributing on one platform or the other. Leading in the total ODA disbursements is UNICEF – providing 41 per cent or \$1,346,093,278. Of this amount, UNICEF disbursed a total of \$578,737,141 (43 per cent) to the health sector [...] The second highest contributor to ODA disbursements in Nigeria over the last decade is DFID, providing 17 per cent or \$559,981,950. Of this amount, \$84,100,000 was spent in the health sector during the period under review [1995-2007].”²⁰⁸

Despite the commitment of UNICEF and DFID, which actually has led to some timid improvements at least in reducing under-five mortality rate as described in Fig 6.7; under-five and maternal mortality reduction in Nigeria still remain too slow to register any substantial results in the long way of MDG 4 and MDG 5 attainment.

²⁰⁷ ADEOMI M. (2012). *Achieving MDG 4 in Nigeria: a shot in the dark?*, Health Desk.

²⁰⁸ OKOLI U. (2009), *Development Aid and Nigeria's Poverty Challenge: Millennium Development Goals 4 and 5 in Focus*, A dissertation presented to the Faculty of Arts in the University of Malta for the degree of Master in Contemporary Diplomacy, p.57,58.

Fig. 6.7 Trends in Maternal and U5 Mortality Ratios (1995 – 2007)

	Maternal Mortality Ratio (MMR)		Year	U5 Mortality Ratio (U5MR)
1995	1,100		1995	230.0
2000	800		2000	207.0
2005	1,100		2005	194.0
			2007	188.8

Source: OKULI U. (2009)

UNICEF and DFID report that their failure in improving Nigerian MDG 4 and 5 must be searched in the low coverage of effective interventions; for example, insecticide treated nets, fundamental in reducing malarial deaths by about 25 per cent, were used only by 2 per cent among the target group. Lack of access, inadequate coverage and poor quality of health care services as well as poverty and illiteracy all continue to deprive people of their health.

However, according to Easterly (2006)²⁰⁹, what stays at the top of the ladder of the defective Nigerian health system is: poor governance, weak policies and institutional development. Hence, maternal and child health situation in Nigeria remains a controversial and unresolved subject due to the laissez-faire and corrupt attitude of government that too often wastes not only the public amount but also succeeds in diverting the aid funds which fail to reach the really needy. There is large agreement in considering “high cost and ever increasing risk of doing business in Nigeria [...] a direct manifestation of institutionalised corruption²¹⁰ traceable in years of military dictatorship, political instability and poor governance”.

Therefore, development aid is “a double-edged sword”. Since its differential impact may depend upon the recipient country’s characteristics, it can be fundamental in improving economic and social progress in those recipient

²⁰⁹ EASTERLY, W. (2006). *The white man’s burden: why the west’s effort to aid the rest have done so much ill and so little good*. New York: Oxford University Press (quoted in OKOLI U. (2009), *Development Aid and Nigeria’s Poverty Challenge: Millennium Development Goals 4 and 5 in Focus*, A dissertation presented to the Faculty of Arts in the University of Malta for the degree of Master in Contemporary Diplomacy, p.64).

²¹⁰ UNICEF. (2004). *UNICEF Nigeria website* [online].

countries where the economic and political environment is healthy and sound. But, more likely external aid support could not be translated in positive effects since it is wasted through wrong resolutions of weak governance and political institutions of fragile states.

It is worth reminding that these assertions are not limited to Nigerian context but they hold true also for the entire African continent. Already two decades ago the World Bank stated that “the litany of Africa’s development problems is a crisis of governance” because “poor quality institutions, weak rule of law, an absence in accountability, tight controls over information, and high levels of corruption still characterize many African states today”.²¹¹

“The [same] Commission for Africa agrees, noting that without progress in governance all other development reforms and processes in Africa will have limited impact”²¹².

It is this same institutionalized corruption that nowadays makes Africa unattractive to investors. It is even more widespread the opinion that there is no sense in supporting with large amounts of money countries with poor policies, given that, most often development aid assistance not even reaches the really needy and consequently decreases its effectiveness. As a matter of fact, aid to sub-Saharan Africa has been falling steadily since 1990s.

Zambia represents one of the countless cases of donor funding for health subjected to corruption and to which donor support was frozen. Starting from 1990s aid effectiveness pooled through a Sector-Wide Approach (SWAs)²¹³ was here implemented.

Yet, development partners also in collaboration with the Ministry of Health, have several modalities to provide Zambia’s health sector with aid (it amounts to almost 50 percent of the Ministry of Health core budget): the vertical funds play also a leading role in aid funding which, according to internal decisions, is administered by NGOs and not directly by national financial management systems. It is worth mentioning that in 2007 Ministry of Health’s budget was

²¹¹ BRAUTIGAM D, KNACK, S. (2004). *Foreign aid, institutions, and governance in Sub-Saharan Africa*. Economic Development and Cultural Change, 52 (2), p. 255.

²¹² OKOLI U. (2009). *Development Aid and Nigeria’s Poverty Challenge: Millennium Development Goals 4 and 5 in Focus*, A dissertation presented to the Faculty of Arts in the University of Malta for the degree of Master in Contemporary Diplomacy, p.23.

²¹³ See www.who.int/trade/glossary/story081/en/ for more information about SWAs.

approximately US\$ 161 million, while in the same year, the Global Fund and PEPFAR's aid resources for Zambia amounted to US\$ 340 million.²¹⁴

But, in 2009 a decision taken by Ministry of Health to procure nine mobile hospital units from China without consulting the development partners supposed to pay indirectly for it, let the same development partners suspecting for the Ministry. Then, it was a check by the Anti-Corruption Commission that ascertained that US\$ 1.4 million was embezzled by high-level officials in the Ministry of Health. This sum was supposed to be spent to pay their consultancy for holding some workshops actually never taking place. This represented just one of the several irregularities found hereafter.

The World Bank's report on the inadequacy of public expenditure management in Zambia together with a scandal book reporting that between 1984 and 2004 the total sum corresponding of two-thirds of the total budget for 2006 was misappropriated, prevented development partners in providing further funds. According to Pereira, "Sweden and Holland delayed the release of funds to the expanded basket. Canada had already released its funds before the scandal broke and has requested that their funds not be used at present. The EC is in the process of consulting Brussels on the release of their SBS. The GAVI Alliance has delayed payment, though a different auditing issue was involved and will reconsider in September 2009. The Global Fund has announced a delayed release of funding and is awaiting the Office of the Inspector-General's decision".²¹⁵

Funds freeze had direct striking impact on health sector: several hospitals restricted their services since training, drug procurement, laboratory costs, operations, outreach activities, running costs are all costs strictly depending on Ministry of Health's budget. What is even worse is that: "the lack of funds also affects one of the most important and successful initiatives in the health sector: Child Health Week. This campaign reaches 2 million children²¹⁶ every year and offers free vaccination, weight monitoring and vitamin supplements".²¹⁷

²¹⁴PEREIRA J. (2009), *Zambia Aid effectiveness in the health sector*. Case Study. Action for the Global Health. Action for the Global Health Publishing.

²¹⁵ *Ivi*, p.10

²¹⁶ The actual health situation in Zambia. For MDG 4: "Child mortality: The observed declines in child mortality rates in Zambia are insufficient to reach MDG target 4.A. Under-five mortality dropped from 190.7 deaths per 1,000 live births in 1992 to 137.6 deaths per 1,000 live births in 2010, while infant mortality (death before a child's first birthday) reduced from 107.2 deaths per 1,000 live births in 1992 to 76.2 deaths per

Aid effectiveness should have the main function to improved health reality in African continent, but unfortunately, as Zambia together with several other evidences have demonstrated, it is sometimes turned into a political instrument. Recently, Zambian Government “put a huge billboard in front of a newly built hospital near Lusaka which reads ‘Your Government and your money have worked’, when in reality the hospital had been funded entirely by DPs. Reportedly, when people in the area complained about the lack of drugs to treat patients, the Government replied: ‘Look! We have been investing in infrastructure!’”²¹⁸

6.5 Pharmaceuticals misuses as coping strategies

“The porter was searched by the security people at the gate, and they found several medicines in his handbag”. “In Nyassa a health centre worker removed antibiotics from his workplace to send them across the border to Malawi, in exchange for ... shoes, TV sets, video sets, hi-fi sets, etc. He opened his own shop in town on account of his dishonesty”. “The nurse replaced prescribed post-op pethidine with Diclofenac or Aspergic. He sold the pethidine to drug addicts afterwards”. “My mother went to a public hospital and the doctor prescribed injectables. At the hospital pharmacy, the pharmacy technician told us that the injections were out of stock and referred us to one nurse in one of the wards. We went there and the nurse sold us the injections for 300.000,00 meticaais (approximately US\$ 20) ”.²¹⁹

For reasons of convenience, just few statements have been reported here; they give testimony of the misuse of pharmaceuticals for personal gains which only in Mozambique and Cape Verde take the shape of stealing, overcharging or informal payments.

1,000 live births in 2010. Similarly, neonatal mortality (deaths during the first 28 days after birth) has according to UNICEF reduced from 43 deaths per 1,000 live births in 1990 to 27 deaths in 2012”. UNDP (2013), *Millennium Development Goals, Progress Report Zambia 2013*, Lusaka, Zambia, UNDP Publishing, pp.30-31.

²¹⁷ *Ibidem*

²¹⁸ *Ivi p.18*

²¹⁹ FERRINHO P, OMAR MC et AL, (2004), *Pilfering for survival: how health workers use access to drugs as a coping strategy*, Human Resources for Health, 2:4, p.2.

Fig. 6.8 Misuse of pharmaceuticals for personal gains

Type of misuse
Stealing
Sale of prescription drugs without prescription
Prescription of necessary drugs
Sale of unnecessary large amount of drugs o individual patients
Unnecessary prescription of injectables
Prescription of expensive brand names in lieu of generic drugs, particularly in private practice
Substituting generics with brand name drugs
Under-the-table payments for supplying supposedly free drugs
Overcharging
Selling free samples

Source: FERRINHO (2005)

Hence, it is evident that in addition to the corruption of non-salary cash flows, the leakage of health goods is permeating the majority of African countries, as well. What is even more disconcerting is the institutionalization of this same phenomenon. The author indeed reports also the personal considerations of Mozambican and Cape Verde health workers who admit that misuse of pharmaceuticals is by now a common practice even recognized with the stipulation of informal contracts between private clinics and public health workers to ensure regular supply of certain kind of medicines. "Everyone knows that stealing of medicines and other medical supplies by health personnel is a common practice in our society", "I think this is happening all the time in our country ... Let me tell you, this type of things has been going on for a long time and it is not going to end all that easily". "Anyone going to the market or strolling down any street in town, can meet people selling medicines, usually not health workers, selling medicines. Other stuff such as IUD and other drugs find their way straight to private consulting rooms".²²⁰

²²⁰ *Ivi p.3*

Figure 6.9 Leakage of resources in health care

Country (year)	% of cash/in-kind resources leaked	Resource category
Kenya (2004)	38	Non-salary budget
Tanzania (1999)	41	Non-salary budget
Uganda (2000)	70	Drugs and supplies
Ghana (2000)	80	Non-salary budget
Chad (2004)	99	Non-salary budget

Source: WORLD BANK (2010) *Africa Development Indicators 2010*.

Mozambique in particular has designed a very well-organized system for drug stealing, the net of which extends to engage also non health related personnel, useful for a greater profit: "No one ever steals alone. There are always third parties involved. There is also a distribution circuit. This involves cooking the books to eliminate all evidence of stolen goods, bribing those in charge of supervision, reliable sales' outlets (at home, private pharmacies, in private clinics, in Dumbanengs [informal market outlets] etc.). Recently there is even talk of «contracts» between private clinics and public sector health workers to ensure the steady supply certain types of medicines. Medicines may even be carried across the border to neighbouring countries. These circuits may even be under the control of people not associated with the health care sector, but rather with the import/export business".

Nevertheless, Ferrinho in his revealing report takes no notice of the impressions of patients about the advantage taking by health workers of their common health system in which they trust no more. They would argue that they are one more time left behind; forced to pay for the long-term consequences of “missing moral and civic sense” of health workers who try to justify their behaviour saying that it is due to "serious lack of motivation", "the true reasons for these practices are the low salaries paid by the government", "economic reasons, and low salaries ... those are the reasons ... it is a means of surviving".²²¹ Once again this dishonest attitude takes place in an environment of weak government *laissez-faire*;

²²¹ *Ibidem*

everybody well- aware of not risking any punishment, keeps on exploiting “the ignorance of our people”²²².

According to the World Bank, each year 100 million people fall into poverty because of the cost of medical care. Sixty per cent of these costs are spent just on medicines. Just in developing countries the cost of pharmaceutical expenditures and drugs procurement amounts to 20-50 percent of public health budget; of the public procurement cost about 10-25 percent is lost because of corruption.²²³

In Africa, health-related MDGs will be hardly met since the health systems run so inefficiently also for this apparently “less invasive” form of corruption. It explains the reason why approximately 2 billion people lack regular access to medicines, the steady absorption of which would save the lives of 10 million people every years, according to WHO estimations.²²⁴

Another very important cause of unnecessary morbidity, mortality and loss of confidence in medicine and health system is the ever growing production of substandard and fake drugs. It represents a significant problem, pervading poorer countries, which till now has not yet run into an inflexible cooperating opposition of drug companies, governments and international organizations.

The reluctance of governments and pharmaceutical companies to inform health workers and public about drugs’ forgery is due to the fear of a potential harm to the detriment of their own brand-products, because consumers may begin to lose confidence in the brand name if they fear that the product may not be authentic.

However unfortunately, the silence with regards to this illegal affair results in intensifying counterfeit drugs sell in neighbouring countries or in shipping them even beyond; with the direct consequence of enlarging the effects these fake medicines have on unaware needy patients.

Substandard drugs, being drugs of poor quality or a total counterfeit, may indeed have little or no therapeutic value, causing illness and death from the same diseases supposedly being treated or when containing toxic substances. Further,

²²² *Ivi p.4*

²²³ ANTI CORRUPTION RESOURCES CENTRE (2008), *Corruption and the Health Sector*, U4 ISSUE, Volume 10, Anti Corruption Resources Centre Publishing.

²²⁴ WHO (2004) “*WHO Medicines Strategy: Countries at the Core 2004–2007*”.

those composed by “subclinical” amounts of active ingredients, even if appropriate, can encourage the spread of drug resistant pathogens. (Box 6.3)

Consequently, obstructing treatment successes and strengthening patient’s drug resistance, fake pharmaceuticals enable even more the spread of infectious diseases among global population.

Box 6.3 Medical risks associated with counterfeit drugs

Type of counterfeit drug	Associated medical risk
Perfect imitation-the same active ingredients and packaging as the real drug	Limited, assuming that the quality is good
Inadequate imitation-the same active ingredient but of insufficient quality and quantity	Reduced efficacy and, in the case of antibiotics, development of pathogen resistance
“Placebo”-looks like a real drug, but contains no active ingredient	Lack of efficacy
Poisons-contains harmful or poisonous substances	Physical injury or death

Source: WORLD BANK (2004. *Rising to the challenges*).

But another “indirect” very detrimental effect due to fake drugs, discloses when people have personal experience with these products, not benefiting from them. Patients begin to lose faith not only in brand names, but even worse they become reluctant in considering still fundamental taking drugs in order to treat their illnesses. In Africa, this could be particularly dangerous, since infectious diseases affect the great majority of the population. If ill people reject the treatment because of their own scepticism in these medications, they imperil the rest of population, remaining infectious.

A recent survey by WHO of seven African countries found that between 20 and 90 per cent of all anti-malarials failed quality testing. These included chloroquine-based syrup and tablets, whose failure rate range from 23 to 38 per cent; and sulphadoxine / pyrimethamine tablets, up to 90 per cent of which were found to be below standard (WHO 2007)²²⁵.

²²⁵ WHO (2007). *General information on counterfeit medicines*.

“If drugs contain too little of the active ingredient, not all the disease agents are killed and resistant strains are able to multiply and spread. As a result, patients receive too little medicine and die or are far sicker than would have been the case if they had received an adequate dose”.²²⁶

In Zambia, an increase in morbidity and mortality in people living with HIV/AIDS due to ARV drug resistance, treatment failure and adverse drug effects has been reported. As a matter of fact, a supposed AIDS treatment called Tetrasil was found to be a pesticide used to clean swimming pools. Surveys report that people affected by HIV/AIDS involuntarily substituted their right treatment with this fake drug.²²⁷

In Congo in 2003, bottles and blisters not packaged in carton boxes were labelled ‘Triomune’ (stavudine, lamivudine and nevirapine) and ‘Duovir’ (lamivudine and zidovudine), both of which belong to Cipla’s brand.

Actually, these bottles contained non-ARV pharmaceutical products and some tablets were composed of fluvoxamine (antidepressant) or cyclobenzaprine (muscle relaxant); patients were appealed to buy them because of their convenient cost.²²⁸

In 1995 Niger benefited from a conspicuous donation of 88.000 Pasteur Merieux and SmithKline Beecham vaccines from Nigeria in order to hack a dangerous meningitis epidemic; unfortunately, those vaccines found to be counterfeit lacking of any active product. Sixty thousands people could not benefit of a real preventive care since they were inoculated with fake medications.

According to WHO, the high vulnerability of pharmaceutical sector to this form of corruption derives from the specific features of the larger health sector, which in turn reflects general problems of governance and public sector accountability, common in fragile states.

The efficacy of a treatment strictly depends on the quality of regulations and standards in the production, distribution and prescription of it. When adequate supervision misses, the risk of production of fake drugs increases. Additionally, it

²²⁶ See *Quality analysis of first line- HIV/AIDS medicines dispensed in Lusaka urban district health facilities of Zambia*

<http://dspace.unza.zm:8080/xmlui/bitstream/handle/123456789/897/Main%20Document.pdf?sequence=1>

²²⁷ *Ivi*

²²⁸ RAVINETTO R. (2004). *Counterfeit ARVs in DRC*, EDRUG, (quoted in *Quality analysis of first line- HIV/AIDS medicines dispensed in Lusaka urban district health facilities of Zambia*).

is very hard to recognize a counterfeit product from the effective one since counterfeiters have high capacity and meticulousness in reproducing the trademark's form, colours and even the package (see Fig. 6.10 and Fig. 6.11). In fragile states, where there is a total lack of regulation and enforcement of medication distribution, the 25 percent of drugs are counterfeit or substandard.²²⁹

Fig. 6.10 How close fake malaria drugs mirror the real thing



Source: <http://pulitzercenter.org/projects/china-africa-developing-world-corruption-anti-malarial-drugs-health-aid>

Given the apparently identical aspect of both (legitimate and illegitimate) medications, it will be hard for the usual consumer verify in advance the quality of one rather than the other. He should need government regulations in recognizing the legitimate drug, but most often, “lack of political will and commitment to fight the scourge, weak legislation prohibiting counterfeiting of drugs, absence of or weak national drug regulatory authorities, weak drug laws enforcement and penal sanctions, shortage or erratic supply of drugs, high cost of medicines, ineffective cooperation among stakeholders, trade involving several

²²⁹COHEN JC, MRAZEK M, HAWKING L, (2007), *Corruption and pharmaceuticals: strengthening good governance to improve access*, in CAMPOS JE, PRADHAN S (2007), *The many faces of corruption*. Washington, World Bank Publishing.

intermediaries, inadequate skilled human resource to run the system and corruption and conflict of interest”²³⁰ leave him victim of a conspiracy against his health.

Fig. 6.11 How close fake drugs mirror the real thing



Source: <http://www.poverty-action.org/blog/harnessing-market-forces-fight-fake-drugs>

6.6 Inadequate human resources

The direct evidence reported in Box 6.4 tells us that behind the death of an average of six women every day in Burkina Faso, as a result of complications due to pregnancy or childbirth, lies also informal payments among other several causes.

Anxious and hesitating households frighten for childbirth complications or suffering for any other disease problems, are more vulnerable and even more likely to be victims of medical staff extortion. Illiterate patients have to confront unequally with “supposed” competent knowledgeable medical staff who take advantage of this missing informational equity in order to cheat them.

Informal payments having become so widespread, have created a parallel market for services within African public healthcare system, in which depending on the

²³⁰ WHO (2006) *Programmes and Projects, Bulletin of the World Health Organization*, Past Issues, 84(9): 685-764 (quoted in *Quality analysis of first line- HIV/AIDS medicines dispensed in Lusaka urban district health facilities of Zambia*).

context, informal payments range for bypassing a queue, for getting drugs and other medical supplies, for benefitting of small services or of major surgery. Gifts of appreciation are also considered in some way another form of bribery since they do not affect health service provision. They are indeed less damaging since they do not involve any element of payment for service, which on the contrary, acts as incentive to influence health worker suppliers' behaviour.

A study on informal payments in Tanzania has analyzed across rural/urban dichotomy, some significant statements of patients willing to pay informally health care service, overconfident of the better quality of them.

Tanzania patients are willing to pay also to reduce waiting time for receiving medications or for being visited. Medical staff helps them to bypass potential queue in return for money: "S/he takes the patient ... and tells her/him that 'I understand this doctor very well and I am sure s/he will help you, do you have money?', and then that staff comes and tells me that 'excuse me doctor, I have a relative outside, can you please help me?' By knowing that the patient is a relative of my colleague I will attend her/him ... That person has already taken the money from the patient and when s/he went outside to call the patient s/he might have told the patient 'I've already given the doctor his money so there's no problem' and so the patient come to me knowing that I took her/his money."²³¹

Health workers request unjustified payments even also for providing patients with services so expected as for example the employ of bedpan (in return of Tsh 1.000 every time he/she needs it) or medicines supposed to be free.

"When the pregnant women come from the clinic, they come even without some of the very key supplies needed. If such women go to the maternity ward, it becomes the happiest moments to the nurse, because she knows that that client is her source of income...It doesn't mean that the supplies are not there, but this is just a strategy of the health workers to gain an income"²³².

²³¹ Statement of a clinical officer from urban area quoted in MÆSTAD O, MWISONO A, (2007). *Informal Payments and the Quality of Health Care in Tanzania: Results from Qualitative Research*, CMI Working Paper WP 2007:5, Bergen: Chr. Michelsen Institute, p.4

²³² Statement of medical assistants from urban area quoted in MÆSTAD O, MWISONO A, (2007). *Informal Payments and the Quality of Health Care in Tanzania: Results from Qualitative Research*, CMI Working Paper WP 2007:5, Bergen: Chr. Michelsen Institute, p.5

Box 6.4 Testimony of unofficial payments

Mariam was 23 when she died in a hospital in Ouagadougou in April 2008, 13 days after delivering a stillborn baby. Mariam lived with her husband, Ali, a motorcycle mechanic, in Ouagadougou. Their first child died at six or seven months. During Mariam's second prenatal visit at a nearby CSPA, they learned that Mariam was expecting twins. A few days later, they were told that Mariam needed blood tests which cost 3,200 CFA francs (around US\$7). Ali told Amnesty International: "Actually, the personnel told us that the ones who did the exams were not there and I understood that we had to pay. I really wanted the exams to be done. As soon as I paid, my wife was able to do the tests." There were problems during the delivery. One baby was born (he survived), but the second didn't come out. Mariam was then transferred to a hospital where she spent three days. One week later, Mariam became dizzy and experienced severe headaches. Ali took her back to the hospital. He told Amnesty International: "Mariam was moaning and shaking a lot and several medical personnel told me I had to pay for products, I don't know which ones. I paid several sums amounting to more than 30,000 CFA francs (around US\$68.50)." The following day, Mariam was told that she could go home. Her husband said: "We were getting ready to leave, but Mariam said that she wanted to sleep: she slept from 7am to 7pm at the hospital. But once Mariam was awake, she was not well. She began to shake again and had to be taken back to the emergency ward." Her husband was again given a prescription and had to pay 4,500 CFA francs (around US\$10) for a box of gloves. "They opened them and gave me some. I was not given the other gloves. After waiting for two hours, I went to ask why the treatments had still not begun. I was told that there were sicker patients to treat first. I kept waiting and then asked why they were not taking care of my wife. I was told: 'You must first take care of your patient'. I then realized that I had to pay so that they would take care of my wife: I handed over 5,000 CFA francs (around US\$11.50) and then my wife was taken care of."

Ali was given another prescription but he could not find the product. "I asked a nurse for help. She offered to sell me the product that she herself had bought for her mother. She told me that the product cost 7,000 CFA francs (around US\$16) from a pharmacy and that she would sell me it for 4,720 CFA francs (around US\$11). I gave her 10,000 CFA francs (around US\$23) and she gave me back my change but it was too late, my wife did not use this product, as she had already died." In total, the delivery and the trips to the hospital cost Ali around 90,000 CFA francs (around US\$206).

Mariam's eldest brother said, "my sister died due to a lack of means and adequate treatment. The hospital, it is like a chamber of commerce. If you are poor, you are 'left'; if you can pay, you are treated."

Source: *Giving life, risking death*. Amnesty International (2009).

This is the disconcerting proof of an even more sophisticated practice to make patients pay additional unjustified costs for buying pretended missing drugs or supplies in private market. Drugs' issue is often exploit in order to cheat vulnerable patients who are encouraged to buy "better quality" medicines directly from private pharmacies run by clinicians rather than from the facility's outlets. Finally, through the strategy of reducing baseline quality of health treatment, health staff tempts patients to be more willing to pay since the message is clear: "unless you pay, the quality will be very low".²³³ A nurse from urban area reports that "if you go at the health facility you'll find a nurse with an angry look, who is just

singing without showing any sense of care. ... Without giving something to this nurse you won't be assisted".²³⁴

Even if it is a malpractice, these "cash or in-kind transfers to service providers in excess of official user fees" are expected to be at least "necessary" for benefitting from improved quality treatments, reduced waiting time, receiving drugs or hospitals meals and getting more and better attention.

But always more frequently, they are destined directly to the pockets of health staff rather than to contribute to the improvement of health facilities, infrastructures and supplies availability included.

According to Tanzanian testimonies, among all medical staff, doctors are those who typically get larger sums of money (in the form of up to Tsh 50.000 bribes) since they carry out longer and more perilous work, such as surgeries. But nurses as well, collect a significant amount of money through smaller bribes got during more frequent occasions they have to encounter patients. Bribes' amounts vary also across rural/urban dichotomy, according to which in rural areas patients are encouraged to pay smaller sums of money than in urban region. The same is for government/nongovernment dichotomy: in non-government hospitals corruption is less oppressive.

Keeping again Tanzanian health system as an example, it has been observed that this practice is so widespread among rural and urban health facilities that even when a health worker pays proper attention to a patient, just in order to guarantee

²³³ *Ivi, p.6*

²³⁴ *Ibidem*

higher service quality, he risks to be accused of being paid by the same patient. Uncommon behaviours adopted by medical staff to a patient, such as seeing him off-ward hour or seeing him more often just to be sure of having made the right diagnosis make people suspect of bribery.²³⁵

These suspicions are frequent also in outpatient facilities and impede clinicians' carrying out; they are forced to rush (and sacrificing medical examination's quality) in order to take care of all patients, avoiding to ask them to come back the next day otherwise they might be accused of having receive some bribes. A Tanzanian nurse from a rural context reports that: "...it's better to rush than tell them come back tomorrow, they may end up saying that the doctor wants something, that's why s/he has asked me to go back tomorrow".²³⁶

All these direct evidences have disclosed the extent to which even just unofficial payments affect the provision of health services and consequently people's health: since quality services are usually associated with corruption, those non-corrupt health workers are forced to lower service quality just to shy away from being accused of corruption.

But, quality service standard can be "artificially" reduced by the same health workers; most of all, at the beginning of the consultations (for example, receiving rudely the patient, proceeding slowly) as trick to show patients that paying more, they will also get more. According to some ethical standards, they indeed agree upon a threshold level of service to provide without bribes. Patients, ignoring the real level of the threshold, will be disposed to pay only for getting examinations of higher quality than that of the "artificial" standard.

As already said, these predatory behaviours seem to be symptomatic of a general dissatisfaction of health employees due to low earnings. Health workers justify their misconduct, indicating that their salaries are low relative to their expectations ("there's no material compensation. That's what's missing; it's really

²³⁵ "...when you devote time to take care of a patient, others think that you must have been bribed by that patient". Statement of a nurse from rural area quoted in MÆSTAD O, MWISONGO A, (2007). *Informal Payments and the Quality of Health Care in Tanzania: Results from Qualitative Research*, CMI Working Paper WP 2007:5, Bergen: Chr. Michelsen Institute, p.9.

²³⁶ *Ibidem*

not enough”²³⁷); consequently, they are “forced” to find copying strategies, even though cheating patients and that same corrupt public sector that does not satisfy them but, that is simultaneously too weak to be able to hold them in check.

As a matter of fact, weak accountability of public sector resulted to be one of the main causes of absenteeism among Rwandan and Ethiopian health workers who linger unpunished. The following statement of a nurse from rural Ethiopia helps understand the actual public health sector reality: “on disciplinary measures . . . ? There is no such thing in the public sector. If someone is not efficient, there is no punishment or feedback, and there is no encouragement for good and efficient health workers”.²³⁸ Since mostly in public health sector, misconduct is unpunished, health workers not fearing to be discovered, keep on being absent often because of their formal or informal second jobs in other clinics, pharmacies or in unofficial health care provision from their homes.

“Absenteeism is symptomatic of an unaccountable and ineffective government, and leads to contempt for government, its policies and practices, and compromises both access to and quality of health care services. Unproductive or absent workers who do not receive any punishment for substandard performance and whose promotion and pay remain the same as those with better performance, undermine morale and reduce output, which in turn leads to a spiral of overall poor performance. Accountability is meaningless or doesn’t exist without sanctions, and institutions suffer accordingly”.²³⁹

Hence, absenteeism is in turn a significant determinant of high infant mortality in Rwanda and in Ethiopia, which reaches 118 per 1.000 and 110 per 1.000 live births respectively.

Therefore, it has been demonstrated that even low rates of health staff absenteeism might affect significantly health outcomes when health facilities are unable to provide patients with alternative solutions when specialized health workers are absent. Specifically, in some rural antenatal care clinics in Kenya, during their first antenatal visit, pregnant women have the opportunity to have a HIV/AIDS

²³⁷ Statement of a doctor from urban Rwanda quoted in AMIN S, DAS J, GOLDSTEIN M. (2008), *Are you being served? New tools for measuring service delivery*, Washington, World Bank Publishing, p.279.

²³⁸ *Ibidem*

²³⁹ LEWIS M, (2006). *Governance and Corruption in Public Health Care Systems*, Working Paper 78, Centre for Global Development Publishing, p.20.

test. If HIV/AIDS positive, they are referred an HIV clinic within the same facility and provided with PMTCT (prevention of mother-to-child transmission of HIV) services. Yet, the absence of the nurse specialized in providing HIV testing and counselling services together with a missing adequate substituting solution which would provide the patients with the same service, might have important consequences on mother and child's health. It has been recorded that pregnant women "are more than 50 percentage points less likely to learn their HIV status during their pregnancy [...] yields the result that PMTCT nurse absence contributes to an additional 3.7 mother-to- child infections per 10,000 live births."²⁴⁰

Hence, reducing absenteeism in public health facilities could lower vertical HIV transmission by 0.5 to 1.5 infections per 1.000 live births.

Even though these are just micro-evidences, they are more specific and more helpful for giving a valid demonstration of the extent to which quiet corruption in Africa, translated in poor service delivery, affects directly and indirectly health status.

²⁴⁰ GOLDSTEIN M, GRAFF ZIVIN J, HABYARIMANA J, POP-ELECHES C, THIRUMURTHY H, (2013), *The Effect of Absenteeism and Clinic Protocol on Health Outcomes: The Case of Mother-to-Child Transmission of HIV in Kenya*. American Economic Journal: Applied Economics, 5(2), pp.60; 80.

CONCLUSIONS

The issue of health and of its determinants integrates entirely in the broader concept of development. This work has shown that the reflection on the concept of development enlarges when the plurality of non-economic dimensions previously neglected, are recalled from the theoretic analysis of it.

Its identification with economic development, conceived as economic growth, became the main conceptualization that has headed the analysis of social systems' evolution. Yet, debatable results coming from the use of this development model, has led to a redefinition of the concept of development no more limited to mere economic acceptations.

According to the consideration that wealth is not an aim in itself but a means through which we reach something else, human development should be conceived as enlargement of people's opportunities to choose and to live the life they prefer or, according to Amartya Sen, the enjoyment of freedoms for translating capabilities into functionings.

Health, defined as "not merely the absence of disease" but as "physical, mental and social well-being"²⁴¹ proves to be a fundamental prerequisite for society development. Health, along with education represent not only the discriminating criteria for societies' abilities to create development opportunities but also useful criteria to assess social costs.

According to Sen, health is indeed, a key element for determining individuals' substantive freedoms as human rights, but also an essential prerequisite for their social, politic and economic participation.

The centrality of health among the eight Millennium Development Goals, that world leaders committed to meet within 2015, has contributed to reach the development success of the MDG era and it will be also instrumental for even more achievement by the fixed target.

The analysis of general MDGs assessment points out that these Goals have been instrumental in making the international community aware of the importance of

²⁴¹ WHO, (1946), *Constitution of the World Health Organization*. WHO Publishing

improving global and national development policies and to let it being more incline to consider health fundamental in human development.

Indeed, the significant progresses achieved since 2000, not only on health indicators but also on other developmental issues, demonstrate the extent to which MDGs have brought increased resources, attention and action for more vulnerable groups like mothers and children. Through the means of MDGs, extreme poverty has been eradicated, children have access to primary education, women have gained more job opportunities and wider participation in political affairs, HIV/AIDS, malaria and TB have been considerably reduced and access to sanitation facilities has globally improved.

Politically and technically application of MDGs at national and global levels is very likely due to the easily understandable way in which they are expressed; their well-defined goals and targets have incited world leaders and civil society to commit more seriously in order to reach development, despite its ambitious agenda.

Nevertheless, I consider that it is nonsense claiming that the international community is globally reaching the Millennium Development Goals when fragile states are often excluded from the analysis and left behind. It holds true that these countries are the furthest away from MDGs achievement, accounting for 75 percent of the MDGs deficit worldwide.²⁴²

Hence, fragile states pose different challenges because of their “multi-faceted state-fragility”²⁴³. Even if there is no unique correct definition of this concept, general opinion agrees that state-fragility is essentially a dynamic process which resumes the imbalance between state functions and ability to deliver on the one hand, and societal expectations on the other²⁴⁴.

Community dissatisfaction in fragile states is due to the inconsistency of state institutions unable not only to legally manage political and collective activity

²⁴² OECD (2010), *Concepts and Dilemmas of State Building in Fragile Situations: From Fragility to Resilience*. OECD/DAC Discussion paper, Paris: OECD Publishing (quoted in UNITED NATIONS ECONOMIC COMMISSION FOR AFRICA, Sub-Regional Office for West Africa-ECA/SRO-WA, (2012), *Fragile States and development in West Africa*, ECA/SRO-WA Publishing, p.29).

²⁴³ MENACOL, A. R. (2010), *State-building for Peace – A New paradigm for international engagement in post-conflict fragile states*, RSCAS 2010/24, EUI Working papers (quoted in UNITED NATIONS ECONOMIC COMMISSION FOR AFRICA, Sub-Regional Office for West Africa-ECA/SRO-WA, (2012), *Fragile States and development in West Africa*, ECA/SRO-WA Publishing, p.15).

²⁴⁴ *Ibidem*

through the means of the rule of law, but also to guarantee adequate resources allocation and political participation. The study confirmed previous considerations according to which, if participation of society in political affairs, selection and control are not equally distributed in the political system due to institutions' weakness, state will be unstable and therefore it will show signs of fragility.

Related to the weakness of state institutions, economic factors, natural resources and violent conflicts too, are all external causes leading fragile-states lagging behind along their way towards the achievement of the Millennium Development Goals.

Fragile states' poor outcomes in health indicators reflect weak consistency of state institutions and inadequate governance. 41 to 51 percent of children dying before their fifth birthday; 33 to 44 percent of maternal deaths; 34 to 44 percent of people living with HIV/AIDS and 27 to 35 percent of people lacking safe drinking water are all consequences of lacking health services supposed to be provided by the government.

Considering the current health status of African countries, in particular those belonging to the Sub-Saharan region, I have tried to find a (in)direct correlation between weak institutions of the twenty-one African fragile states and their poor health outcomes.

Collected data confirm that despite hesitant progresses in reducing child and maternal mortality and in HIV/AIDS eradication, Africa is still the furthest in achieving health Millennium Development Goals by 2015. Conflict-affected or fragile countries as Sierra Leone, Democratic Republic of Congo, Somalia, Central African Republic and Nigeria with their highest rates of infant mortality (above 100 deaths per 1.000 live births in 2010)²⁴⁵ hardly would have contributed in redoubling child mortality reduction's rate in 2012.

A moderate group of African states whose institutions have been able to guarantee skilled health staff during delivery or to provide population with more reproductive health services, has reached a good progress in reducing maternal

²⁴⁵ UNDP (2012), *Assessing progress in Africa toward the Millennium Development Goals, Emerging perspectives from Africa on the post-2012 development agenda, MDG Report 2012*, New York, UNDP Publishing, p.61.

mortality. Nevertheless, maternal mortality remains the biggest concern of Africa's health development since, as evidenced by analyzed data, this indicator is symptomatic of country's weak (health) system. Most often governments cannot or even will not provide their population with not even the basic services and facilities, fundamental for facing any emergencies and for ensuring post-partum care, as recommended by the World Health Organization. Highest maternal mortality ratio in Africa is also due to inability of governments to overcome the unfading discrepancies between rural and urban areas, where women are almost twice as likely as the other to deliver helped by skilled personnel, as provided by the current discrepant maternal mortality ratio of a fragile state as Niger.

In comparison to MDG 4 and MDG 5, Africa's progress in eradicating HIV/AIDS is encouraging also thanks to external vertical funds; however, women and children again are the most vulnerable. Because of still low condom use, 57 percent of African women are infected through heterosexual transmission of HIV; as a consequence mother-to-child transmission remains too high to attain 2015 target.

Considering the multi-sectoral nature of health determinants, I found that a broad economic and political approach for the specific case of Africa, could be more useful in order to understand the causes of its poor health outcomes.

Precisely child mortality trends in Africa, as sensitive indicator of the availability, utilization and effectiveness of healthcare, reveal how financial deficits could affect health conditions in the continent.

In order to decrease the highest (worldwide) neonatal mortality rate (32 deaths per 1.000 live births in 2012), African governments should improve the delivery of better health services. Nevertheless, higher coverage of preventive and treatment packages and more skilled personnel entail higher costs that would in turn fall on the government spending for health which, unfortunately, does not belong to the priorities of the great majority of African governments. In order to attain MDG 4 by 2015, a fragile state as Uganda, should reduce under-five mortality rate of 5 percent every year but as long as government's resource allocation prioritizes general public administration or defense sector in addition to substantial loan repayment, high child mortality will persist.

Just for the reason of being severely conflict-affected, some fragile countries spend on arms' transfers well beyond the actual needs of ensuring legitimate self-defense.

Lack of governmental "financial discipline" in military spending, in countries as Kenya, Mozambique, Malawi or Nigeria proves to be the explanation of extra-budgetary spending and the consequent drain of health budgets. Hence, Nigerian military-related corruption could be a determinant factor of its highest rate of women dying from giving birth in the whole African continent.

Considering analyzed data, there is sound evidence that health outcomes are strictly related to health spending; therefore, when less military expenditure is made, increasing health allocations and relative improved health status are recorded.

Analyzed data have provided another highly interesting consideration: the debate on the relationship between corruption and African development normally focuses just on the consequences of more blatant "big-time corruption" but, it does not mention the long-lasting effects due to the so-called "quiet corruption" that penetrates directly African health sector.

Health sector is by definition one of the most corrupt due to its complexity but also to its "uncertainty, asymmetry of information and the large number of actors" involved²⁴⁶. Nevertheless, it reflects also governments' integrity; therefore those countries where health sector is highly corrupt are usually countries with more general problems of poor governance, weak transparency and public sector accountability. According to previous consideration, quiet corruption may be the reason why (general) resources allocations to health sector are not translated into better health outcomes in Africa.

Because of budget leakage for example, the remaining 26 percent (actually received by regional administrators, instead of the supposed 60 percent of the official budget coming from the Chadian Ministry of Health) cannot be enough to ensure wide immunization coverage to 200 (in 1.000 live births) children dying for measles and parasites. But, when aid effectiveness becomes a political instrument, there are higher risks that corruption might affect, even if indirectly,

²⁴⁶ DFID (2010), How to note. Addressing corruption in the health sector. DFID Practice Paper. DFID Publishing.p.3.

health outcomes. The case of funds freeze in Zambia, due to alleged corruption, may explain its high under-five mortality rate with 141 deaths in 1.000 live births in 2009.

Alarming maternal mortality rate of Burkina Faso (on average six women every day) shows how women are the most vulnerable victims of informal payments to medical staff in order to get better assistance during delivery. Children in Rwanda and in Ethiopia instead, are direct victims of widespread medical staff's absenteeism. As a matter of fact, quiet corruption in Africa does not necessarily involve (informal) money transfer, but may also exhibit in health workers' absenteeism. The testimonies reported in my thesis demonstrate that weak accountability of public sector leaves unpunished this malpractice which is commonly adopted in African health sector.

Health workers' misconducts such as bribes for bypassing a queue, for purchasing medications or for getting adequate assistance, absenteeism or pharmaceuticals counterfeiting are all justified by the same health workers as coping strategies in order to compensate for low salaries. Yet, considering the analyzed data, likewise patients, probably sharing the general dissatisfaction of health workers, justify and even accept these malpractices; the more vulnerable households in Africa are so accustomed to corrupt social norms, that it has been created a "routinely" corrupt social environment.

I have tried to give my modest contribution to the recognition that improving health conditions of African households is fundamental for the attainment of Millennium Development Goals by 2015.

Nevertheless, improving African governance is even more central for their realization. In fragile states where governance, accountability and transparency are weak or completely lack, more vulnerable people as children, women and poor pay heavier consequences with their own health and their own development.

My study has attempted to explain a deep-rooted obstacle like corruption, that threatens Africa's efforts to improve its development. Evidences of the nature and the impacts of ubiquitous "quiet corruption" complementary to more visible "big-time" corruption highlight the severity of their long-term consequences that

cannot be ignored neither by policy makers nor by the whole international community.

However, despite weak governance of African countries and deep-rooted culture of acceptance of corrupt processes, African corruption may be at least tackled. Indeed, major transparency and availability of information by governments could guarantee progresses in tracking absenteeism, funds leakage and informal payments. Implementation of anticorruption policies to be adopted by each country should limit misconducts in every sector and accordingly, beneficiaries should benefit not only of better health outcomes but more importantly of their own right to health.

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APPENDIX 1

A/56/326

Millennium development goals

<i>Goals and targets</i>	<i>Indicators</i>
Goal 1. Eradicate extreme poverty and hunger	
Target 1. Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	1. Proportion of population below \$1 per day 2. Poverty gap ratio (incidence x depth of poverty) 3. Share of poorest quintile in national consumption
Target 2. Halve, between 1990 and 2015, the proportion of people who suffer from hunger	4. Prevalence of underweight children (under five years of age) 5. Proportion of population below minimum level of dietary energy consumption
Goal 2. Achieve universal primary education	
Target 3. Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	6. Net enrolment ratio in primary education 7. Proportion of pupils starting grade 1 who reach grade 5 8. Literacy rate of 15-24-year-olds
Goal 3. Promote gender equality and empower women	
Target 4. Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015	9. Ratio of girls to boys in primary, secondary and tertiary education 10. Ratio of literate females to males of 15-to-24-year-olds 11. Share of women in wage employment in the non-agricultural sector 12. Proportion of seats held by women in national parliament
Goal 4. Reduce child mortality	
Target 5. Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	13. Under-five mortality rate 14. Infant mortality rate 15. Proportion of 1-year-old children immunized against measles
Goal 5. Improve maternal health	
Target 6. Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	16. Maternal mortality ratio 17. Proportion of births attended by skilled health personnel

<i>Goals and targets</i>	<i>Indicators</i>
Goal 6. Combat HIV/AIDS, malaria and other diseases	
Target 7. Have halted by 2015 and begun to reverse the spread of HIV/AIDS	18. HIV prevalence among 15-to-24-year-old pregnant women 19. Contraceptive prevalence rate 20. Number of children orphaned by HIV/AIDS
Target 8. Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	21. Prevalence and death rates associated with malaria 22. Proportion of population in malaria risk areas using effective malaria prevention and treatment measures 23. Prevalence and death rates associated with tuberculosis 24. Proportion of tuberculosis cases detected and cured under directly observed treatment short course
Goal 7. Ensure environmental sustainability^a	
Target 9. Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	25. Proportion of land area covered by forest 26. Land area protected to maintain biological diversity 27. GDP per unit of energy use (as proxy for energy efficiency) 28. Carbon dioxide emissions (per capita) [Plus two figures of global atmospheric pollution: ozone depletion and the accumulation of global warming gases]
Target 10. Halve by 2015 the proportion of people without sustainable access to safe drinking water	29. Proportion of population with sustainable access to an improved water source
Target 11. By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers	30. Proportion of people with access to improved sanitation 31. Proportion of people with access to secure tenure <i>[Urban/rural disaggregation of several of the above indicators may be relevant for monitoring improvement in the lives of slum dwellers]</i>

<i>Goals and targets</i>	<i>Indicators</i>
Goal 8. Develop a global partnership for development^a	
Target 12. Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Includes a commitment to good governance, development, and poverty reduction — both nationally and internationally	[Some of the indicators listed below will be monitored separately for the least developed countries (LDCs), Africa, landlocked countries and small island developing States] Official development assistance
Target 13. Address the special needs of the least developed countries Includes: tariff and quota free access for least developed countries' exports; enhanced programme of debt relief for HIPC's and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction	32. Net ODA as percentage of OECD/DAC donors' gross national product (targets of 0.7% in total and 0.15% for LDCs) 33. Proportion of ODA to basic social services (basic education, primary health care, nutrition, safe water and sanitation) 34. Proportion of ODA that is untied
Target 14. Address the special needs of landlocked countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)	35. Proportion of ODA for environment in small island developing States 36. Proportion of ODA for transport sector in landlocked countries
Target 15. Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	Market access 37. Proportion of exports (by value and excluding arms) admitted free of duties and quotas 38. Average tariffs and quotas on agricultural products and textiles and clothing 39. Domestic and export agricultural subsidies in OECD countries 40. Proportion of ODA provided to help build trade capacity Debt sustainability 41. Proportion of official bilateral HIPC debt cancelled 42. Debt service as a percentage of exports of goods and services 43. Proportion of ODA provided as debt relief 44. Number of countries reaching HIPC decision and completion points
Target 16. In cooperation with developing countries, develop and implement strategies for decent and productive work for youth	45. Unemployment rate of 15-to-24-year-olds
Target 17. In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	46. Proportion of population with access to affordable essential drugs on a sustainable basis
Target 18. In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	47. Telephone lines per 1,000 people 48. Personal computers per 1,000 people [Other indicators to be decided]

^a The selection of indicators for goals 7 and 8 is subject to further refinement.

Source: Road map towards the implementation of the Millennium Declaration, 2001 Resolution A/56/326.

Salute e sviluppo negli Stati Fragili. Focus sull' Africa

La salute, secondo l'Organizzazione Mondiale della Sanità, non è solamente assenza di malattia, bensì “stato di completo benessere fisico e psichico”. Pertanto, il significato intrinseco di tale concetto, e di riflesso dello stesso concetto di diritto alla salute è quello di garantire ad ogni individuo la possibilità di beneficiare di coperture e prestazioni sanitarie fondamentali senza alcuna discriminazione economica, di genere, razziale, culturale o geografica.

La salute, intesa come stato di completo benessere, ha però delle importanti implicazioni economiche che, così come influenzano il benessere di una famiglia, possono determinare il futuro di una intera popolazione.

Ad ogni individuo ed ad ogni famiglia, la buona salute offre la possibilità e la capacità di raggiungere il proprio sviluppo personale e di creare la propria sicurezza economica futura. La salute infatti, sta alla base della produttività lavorativa, della capacità di apprendere a scuola e dell'essere in grado di crescere non solo fisicamente ma anche intellettualmente.

La salute, assieme all'istruzione, rappresenta uno dei cardini fondamentali del capitale umano che sta alla base della produttività economica di ogni individuo.

Infatti, una popolazione che gode di buona salute contribuisce notevolmente alla crescita e allo sviluppo economico del proprio Paese, nonché alla riduzione della povertà. Al contrario, il peso economico causato dalla malattia si riscontra maggiormente nei redditi annuali ridotti di un'intera società, nel reddito dimezzato di un individuo e nelle stesse fragili prospettive di crescita economica.

Ogni investimento sanitario perciò, diventa non solo un'opportunità per migliorare le condizioni di salute della società, bensì anche un mezzo per raggiungere uno sviluppo economico adeguato e sempre crescente che permetta, soprattutto agli Stati classificati “fragili”, di sfuggire alla cosiddetta “trappola della povertà”. La povertà impedisce agli individui di

godere di un'appropriate assistenza sanitaria. Ciò comporta un peggioramento delle condizioni di salute (già causate da redditi estremamente bassi) di questi stessi individui, i quali, nella disperata ricerca di altra assistenza sanitaria, si impoveriscono ulteriormente riducendo la propria capacità produttiva.

Nel 2000 le Nazioni Unite decidono di lanciare la “nuova sfida del Millennio”, richiamando l'intera comunità internazionale a collaborare per ridurre drasticamente la povertà estrema nel mondo entro il 2015. Per realizzare questo ambizioso obiettivo del Millennio, viene riconosciuta alla salute un'importanza fondamentale e strumentale.

Un significativo miglioramento delle condizioni di salute della popolazione, in particolare “ridurre la mortalità infantile” (MDG 4), “migliorare la salute materna” (MDG 5), “combattere l'HIV/AIDS, la malaria e altre malattie” (MDG 6), è strumentale per il raggiungimento dei restanti cinque Obiettivi del Millennio. Tuttavia, nonostante l'impegno dimostrato sia dai Paesi Sviluppati, sia da quelli “bersaglio” di tale iniziativa, i più recenti bilanci relativi ai Paesi più poveri hanno dimostrato una situazione ancora piuttosto sconcertante.

Gli Stati classificati “fragili” generalmente caratterizzati da condizioni di salute di gran lunga peggiori rispetto ad altri Stati che presentano lo stesso grado di sviluppo, difficilmente raggiungeranno gli Obiettivi del Millennio riguardanti la salute entro il 2015.

Le pessime condizioni di salute in cui versano gli Stati Fragili sono il prodotto di un'inefficiente amministrazione del settore sanitario e della mancanza di servizi che spetterebbero di diritto alla popolazione: acqua potabile, servizi sanitari di base efficienti, assistenza medica competente, adeguate infrastrutture.

La scarsa qualità dei servizi sanitari forniti negli Stati Fragili, riflette la debolezza, nonché l'inconsistenza delle stesse istituzioni statali, incapaci non solo di amministrare legalmente l'attività politica in virtù dello stato di diritto, ma anche di garantire i servizi di base, quale la distribuzione delle risorse o la partecipazione politica. Il mio lavoro conferma infatti, delle

presedenti considerazioni, secondo cui la fragilità statale è essenzialmente un processo dinamico che comprende da una parte, lo squilibrio tra le funzioni dello stato e la capacità di compiere tale funzioni, e le aspettative della società, che, se non soddisfatte, possono provocare ulteriore instabilità e fragilità.

Sempre legati alla debolezza che generalmente caratterizza le istituzioni degli stati fragili, vi sono altri fattori che ostacolano il raggiungimento degli Obiettivi del Millennio da parte di questi stessi stati. Questioni di natura economica, così come il susseguirsi di conflitti armati o questioni legate alla distribuzione e allo sfruttamento delle risorse naturali presenti nel territorio, fungono da maggiore ostacolo allo sviluppo economico di questi numerosi stati fragili.

Limitando la mia ricerca solamente alle condizioni di salute di questi stati, l'inconsistenza e la fragilità delle loro istituzioni si riflette nell'alta percentuale (tra il 41 e il 51 per cento) di bambini deceduti prima del quinto compleanno, nell'altissima mortalità materna (tra il 33 e il 44 per cento) e nell'altrettanto significativa percentuale di persone affette da HIV/AIDS (da 33 a 44 per cento).

La lista fornita dall'OECD include 47 paesi fragili nel mondo, in cui vivono circa 1,5 miliardi di persone. Di questi 47 stati fragili, 21 appartengono al continente africano.

Analizzando pertanto, le attuali preoccupanti condizioni di salute in cui versano numerosi stati africani, in modo particolare localizzati nella regione Sub-Sahariana, ho cercato, attraverso la mia ricerca, di trovare una possibile (in)diretta correlazione tra le deboli istituzioni di questi stati ed lo stato di salute delle loro popolazioni.

Dai bilanci annuali che riportano i progressi fatti da ogni paese africano lungo l'impegnativo percorso verso il raggiungimento degli Obiettivi del Millennio, si è riscontrato che l'Africa sarà l'unico continente che non riuscirà a raggiungere alcuno dei tre obiettivi della salute.

Nonostante i timidi progressi registrati nella riduzione della mortalità infantile e nell'incidenza di malattie trasmissibili come la tubercolosi, la

malaria o la più recente infezione da HIV/AIDS, grazie a nuovi progetti di prevenzione e trattamento, i paesi del continente africano subiscono ancora delle enormi perdite di popolazione a causa delle pessime condizioni di salute.

Tuttavia, in Africa la mortalità materna resta la maggiore preoccupazione e l'ostacolo più significativo per il raggiungimento degli Obiettivi di Sviluppo del Millennio, poiché, come evidenziato da dati empirici, generalmente questo indicatore è sintomatico della debolezza del sistema sanitario di un paese. Troppo spesso infatti, i governi non possono o addirittura non vogliono fornire alla propria popolazione neppure i servizi e le strutture di base, fondamentali per affrontare qualsiasi emergenza durante e dopo il parto, così come raccomandato dall'Organizzazione Mondiale della Sanità.

Questo altissimo tasso di mortalità materna è dovuto inoltre, dall'incapacità dei governi africani di superare le grosse disuguaglianze tra aree rurali e aree urbane, dove le donne hanno quasi il doppio delle possibilità di partorire assistite da uno staff competente, rispetto alle donne che vivono nelle aree rurali più povere.

Analizzando la natura multisetoriale dei fattori determinanti della salute, ho ritenuto appropriato adottare un approccio più politico-economico per capire le cause che stanno alla base delle precarie condizioni di salute dell'Africa.

Riportando i risultati ottenuti da precedenti dati empirici, si è riscontrato che il tasso di mortalità infantile, impiegato come indicatore sensibile della disponibilità, dell'utilizzo e dell'efficacia dell'assistenza sanitaria, rivela come i deficit finanziari possano influenzare negativamente le condizioni di salute del continente.

In Africa i deficit finanziari sembrano essere dovuti da uso inappropriato delle risorse finanziarie, non solo di cui dispongono direttamente gli stessi governi, ma anche di quelle risorse generosamente fornite da aiuti esterni. La debolezza delle istituzioni di tali stati si traduce di fatto anche in questa consistente mancanza di "disciplina finanziaria" che porta gli stessi governi ad impiegare gran parte delle risorse disponibili in attività o progetti ben

lontani dall'interesse sociale, come l'acquisto di armi o il riciclo dei cosiddetti "petrodollari", che originariamente e teoricamente avrebbero dovuto essere destinati al miglioramento del sistema sanitario e dell'istruzione.

Normalmente, l'analisi della piaga della corruzione in Africa si limita alla più evidente e clamorosa corruzione presente negli alti ranghi politici, tuttavia però, vi è un'altra forma più pericolosa di corruzione seppur silente e quasi invisibile, che colpisce direttamente la popolazione africana e che comporta maggiori conseguenze di lunga durata.

In Africa, la cosiddetta "corruzione silenziosa" è una forma di corruzione che si insinua direttamente nei sistemi sanitari dei paesi africani. Per definizione, quello sanitario è uno dei settori più corrotti sia per la sua complessità, che per l'asimmetria di informazioni e per il grande numero di attori coinvolti; ma, come già anticipato, esso stesso riflette anche l'integrità dei governi. Pertanto quei paesi il cui sistema sanitario è fortemente corrotto sono solitamente paesi con problemi più generali di debole governance e mancanza di trasparenza nell'amministrazione delle questioni pubbliche.

La corruzione silenziosa sembra quindi spiegare perché la distribuzione delle risorse al settore sanitario non si traduce necessariamente in migliori condizioni di salute in Africa.

L'uso inappropriato di risorse è la causa principale della mancanza di una sufficiente ed efficace immunizzazione contro i parassiti, la malaria e l'HIV. Le allarmanti percentuali di mortalità materna invece, sono spesso dovute all'impossibilità delle vittime di sostenere i pagamenti informali richiesti dallo staff medico per garantire migliore assistenza durante il parto; mentre i bambini sono le vittime dirette dell'esteso assenteismo che dilaga tra lo staff sanitario. I lavoratori assenteisti però, troppo spesso rimangono impuniti e perciò liberi di adottare nuovamente questo atteggiamento, per esprimere la loro insoddisfazione nei confronti dei propri governi che hanno essi stessi portato l'intero continente Africano a vivere in un ambiente quotidianamente corrotto.