

The investment case for child survival and other health-related MDGs in sub-Saharan Africa

THE strategies outlined in 'A Strategic Framework for Reaching the Millennium Development Goals on Child Survival in Africa' – prepared for the African Union in July 2005 – are expected to create, in a relatively short time frame, the minimal conditions needed to increase effective coverage of primary health care in sub-Saharan Africa.

These will include a minimum package of evidence-based, high-impact, low-cost services that can be delivered through family and community-based care and through population-oriented services and clinical care.

The key interventions are expected to be: antibiotics to combat pneumonia and neonatal infections; antimalarial combination drugs; infant feeding and hygiene promotion; insecticide-treated mosquito nets; oral rehydration therapy; skilled attendance at birth; vitamin A supplementation; prevention and care of paediatric AIDS; and emergency obstetric and neonatal care.

These strategies and interventions are expected to have a substantial impact on improving child nutrition, maternal mortality, women's status and poverty reduction through women's empowerment.

In *Phase one*, it is estimated that this strategy could reduce Africa's under-five mortality rate by more than 30 per cent and provide initial reductions of 15 per cent in maternal mortality at

an incremental estimated annual cost between US\$2 and US\$3 per capita, or around US\$1,000 per life saved.

In *Phase two*, implementation at scale of an expanded package would lead to an estimated reduction in the region's under-five mortality rate in excess of 45 per cent and would diminish maternal mortality by 40 per cent and neonatal mortality by around 30 per cent. The incremental annual economic cost is estimated at around \$5 per capita, or less than \$1,500 per life saved.

In *Phase three*, it is estimated that reaching the effective coverage frontiers with the maximum package of interventions would allow countries to meet or approach key targets for MDGs 1, 4, 5 and 6 by reducing the under-five mortality and maternal mortality rates by more than 60 per cent, cutting the neonatal mortality rate by 50 per cent and halving the incidence of malaria and undernutrition. The incremental annual economic cost to achieve phase three is estimated at \$12–\$15 per capita, or around \$2,500 per life saved.

Assuming an incremental pace of implementation, the additional annual funding required for the proposed phased acceleration will increase between \$2 and \$3 per capita and per year to take the minimum package to scale in *Phase one*; it will increase by more than \$12–\$15 per capita and per year to take the maximum package to scale by 2015 in *Phase three*. It is noteworthy that these additional costs have recently been estimated using different costing tools, each of which has generated similar projections, suggesting that the estimates are robust.

The cost is for commodities, drugs and supplies. Insecticide-treated mosquito nets represent a very sizeable share of this cost, as do drugs. The cost is apportioned to human resources, health facilities and equipment, and for promotion, demand creation, monitoring and evaluation.

In the context of the Strategic Framework, the following co-financing scenario is proposed: In all three phases, almost half of the additional funding to scale up the minimum package would come from national budgets, including budget support, with 15 per cent coming from out-of-pocket expenditures, and one third from the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNICEF, the World Bank, WHO and other donors.

See References, page 52.

