

Reproductive, maternal, newborn and child health expenditures in the WHO African Region



World Health
Organization

African Region

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Designed in Kamapala, Uganda

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Foreword

Reproductive, maternal, newborn, and child health (RMNCH) remains a cornerstone of health and well-being across the African Region, representing both a critical challenge and a significant opportunity for development. As the world continues its efforts toward achieving the Sustainable Development Goals (SDGs), particularly SDG 3—ensuring healthy lives and promoting well-being for all at all ages—understanding the financial landscape of health investments is vital. This report on RMNCH expenditures in the WHO African Region is timely and informative, providing essential insights into the flow of financial resources dedicated to improving the health and well-being of women and children.



Health financing plays a pivotal role in ensuring equitable access to quality healthcare. Adequate funding helps strengthen healthcare systems, improve service delivery, and ultimately save lives. This report brings to light the diverse trends and financial commitments made by countries in the African Region to address reproductive, maternal, newborn, and child health issues. The findings reveal substantial variations in spending, reflecting each country's unique context, priorities, and challenges.

The report shows that from 2016 to 2019, reproductive, maternal, and newborn health (RMNH) expenditures totalled approximately US\$ 28.8 billion, while child health expenditures amounted to US\$ 18.4 billion. However, spending trends varied significantly, with some countries substantially increasing RMNH and child health allocations, while others experienced notable declines. Average per capita spending on RMNCH peaked at US\$ 8 in 2018, whereas per capita child health spending remained stable at around US\$ 6.

It is crucial to highlight that while financial commitments are increasing in many parts of the region, more efforts are needed to address the underlying disparities, particularly in terms of out-of-pocket expenditures and reliance on external funding. These factors continue to impede progress towards universal health coverage (UHC), leaving vulnerable populations at risk of financial hardship when accessing essential healthcare services. The data presented in this report underscores the need for continued advocacy, strategic investments, and coordinated efforts to support RMNCH interventions that will ultimately reduce maternal and child mortality.

I am confident that the insights presented in this report will serve as a valuable resource for policymakers, health planners, donors, and stakeholders. By understanding the patterns and gaps in RMNCH expenditures, we can better align our collective efforts, mobilize resources effectively, and drive positive change for the health and well-being of women and children across the African Region. Together, we can make meaningful strides towards ensuring that no mother or child is left behind.

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Abbreviations

AARR	annual average reduction rate
CHE	current health expenditure
EXT	external health expenditure
GBD	global burden of disease
GGHE-D	domestic general government health expenditure
GHED	Global Health Expenditure database
MDGs	Millennium Development Goals
mCPR	modern contraceptive prevalence rate
N.E.C.	not elsewhere classified
NHA	national health accounts
NTDs	neglected tropical diseases
PVT-D	domestic private health expenditure
RMNH	reproductive, maternal and newborn health
SDGs	Sustainable Development Goals
SHA	system of health accounts
SSA	sub-Saharan Africa
STDs	sexually transmitted diseases
TB	tuberculosis
UHC	universal health coverage
WHO	World Health Organization

Executive summary

This report provides an analysis of reproductive maternal, newborn, and child health (RMNCH) expenditures across countries in the WHO African Region for the period 2016-2019. It highlights trends in expenditure on maternal, newborn, and child health, and provides insights into the sources of financing for these expenditures.

Key findings indicate that RMNH expenditures totaled approximately US\$ 28.8 billion from 2016 to 2019, and child health expenditures approximately US\$ 18.4 billion during the same period. The highest levels of spending occurred in 2018 for RMNH and child health. Despite these investments, child and maternal mortality rates remain high, indicating that increased financial resources alone are insufficient to ensure improved health outcomes.

The analysis shows that RMNH expenditures, on average, accounted for around 15% of current health expenditures (CHE) in the region, with notable variations across countries. Comoros and Burundi demonstrated a high commitment to RMNH, spending on average 37.2% and 27.5% of CHE respectively, while Mauritius allocated only 4.7%. Child health expenditures showed significant variation, averaging around 24% of CHE over the four-year period. While countries like Niger allocated as much as 55% of their CHE to child health, South Africa allocated only 6.8%. However, in absolute terms, South Africa's expenditures were nearly seven times higher than those of Niger. These results indicate a need for increased resource allocation towards these critical areas of health, particularly in countries where the levels are below the regional average.

RMNCH expenditures were predominantly financed by domestic private and public sources, representing on average 39% and 41.4% of RMNH funding respectively, and 39% and 38.7% for child health. External funding played a smaller role but was significant in some countries such as Malawi, Mali, Uganda, and Senegal where external contributions ranged from 50.2% to 60.4% of RMNH funding. The reliance on out-of-pocket (OOP) expenditure remains a major barrier to achieving financial protection, particularly for vulnerable populations. Notably, OOP funding accounted for an average of 30.6% of total RMNH expenditures, with seven countries (Central African Republic, Comoros, Congo, Democratic Republic of the Congo, Nigeria, Liberia, and Togo) with OOP proportions ranging from 75.1% to 52.3%.

Child health expenditures were also largely financed by domestic private and public sources, which accounted for an average of 39% and 38.7% of funding, respectively. In 2019, domestic government sources accounted for more than 50% of child health spending in four countries (Cabo Verde, Gabon, Seychelles, and South Africa). Out-of-pocket (OOP) expenditures formed a significant portion of child health financing, averaging 33% of total expenditures, and accounting for more than 50% of child health expenditures in Comoros, CAR, Guinea and Togo in 2019. External funding contributed a smaller share overall (22.3%) but remained a crucial source in certain countries. In 2019, external contributions were the primary funding source for child health in countries like Sao Tome and Principe, Malawi, Uganda, and Mali, with proportions ranging from 42.8% to 50.1%. The reliance on external funding in these countries highlights the variability in domestic capacities to finance child health services across the Region.

Country-specific trends reveal significant differences in expenditure changes. For example, RMNH spending in the Central African Republic surged by 135.8% between 2016 and 2019, whereas Côte d'Ivoire experienced a decline of 54.4% during the period. Similar variations were observed in child health expenditures, with the Central African Republic increasing its allocation by 104%, while Gabon saw a 14% decrease during the same period.

While RMNH and child health expenditures increased in most countries, data gaps and variations in reporting limit the ability to fully understand trends and draw comprehensive conclusions. The report recommends enhancing data collection efforts, standardizing reporting practices, and coordinating resource tracking initiatives to provide a more accurate picture of RMNCH funding and to support advocacy for increased investment.

1. Introduction

Despite the global decline in the maternal mortality ratio (MMR) between 2000 and 2020, MMR is still high in the African Region, with 531 deaths per 100 000 live births in 2020 (World Health Organization, 2023b). There has been a significant reduction in the under-five mortality rate (U5MR) in Sub-Saharan Africa over the last three decades - from 176 per 1000 live births in 1990, to 74 deaths per 1000 live births (59% reduction) in 2021. However, the rate at which mortality is declining has stagnated. The annual average reduction rate (AARR) over 2000-2015 was 3.8%, and declined to 2.8% over 2016-2021. To meet SDG targets, an AARR of 11.7% is needed from 2021-2030 to reach the target of 25 per 1000 live births (UN Inter-agency Group for Child Mortality Estimation, 2023).

Many of the countries with the highest maternal and child mortality rates are also characterised by low utilization of family planning methods. Sub-Saharan Africa (SSA) countries, in particular, exhibit the lowest global rates of modern contraception prevalence (mCPR). Nevertheless, it is noteworthy that this Region has also experienced the most substantial growth in mCPR, moving from 17.1% and 19.8% in 2012 to 23.4% and 28.4% in 2023 for all women and married women, respectively¹.

Ensuring the well-being of mothers and children relies on adequate funding to implement cost-effective interventions that can fulfil the Sustainable Development Goals (SDGs) and achieve universal health coverage (UHC). This depends significantly on the level of investment in health, particularly domestic investment in reproductive, maternal, newborn and child health (RMNCH), to sustain advancements in health outcomes. Hence, understanding the financial flows and gaps in RMNCH spending is critical as countries pursue preserving the lives of women and children and promoting their health and well-being. Moreover, gaining insight into levels of funds is imperative for advocating for adequate funding for RMNCH.

This analysis aims to shed light on expenditure trends for reproductive health, maternal and newborn care, and the health of children under five in the African Region. By providing insight into the financial landscape, this analysis intends to facilitate informed resource mobilization and allocation, ensuring women's and children's health and well-being.

2. Methodology

We utilized data from national health accounts (NHA) sourced from the Global Health Expenditure Database² (GHED) available on the World Health Organization (WHO) website. This database offers comparable health expenditure information for over 190 WHO Member States since 2000. The NHA data constituting this database relies on the System of Health Accounts 2011 (SHA 2011) framework, providing a systematic, comprehensive, and consistent approach to tracking and analysing financial transactions within a

country's health system over a specified period. The SHA encompasses three dimensions: consumption, provision, and financing of health care. In our analysis, we mostly use the consumption and financing dimensions.

The consumption axis delves into the breakdown of health care expenditures based on functions or health care activities and beneficiaries' characteristics such as disease, age, gender, region, etc. In our

1 https://www.track20.org/pages/data_analysis/core_indicators/progress_report.php (downloaded on 21 December 2023)

2 <https://apps.who.int/nha/database/Select/Indicators/en> (data downloaded on 12 November 2023)

analysis, we specifically employed consumption classifications based on diseases or conditions to capture reproductive maternal and newborn health expenditures, and based on age to capture expenditures on child health. The financing axis distinguishes between different sources of financing for health care expenditures in the GHED. Still, for this analysis, those sources are summarized into three broad categories: domestic public, domestic private and external (Annex 3).

In the GHED, expenditures related to reproductive, maternal, and newborn health (RMNH) fall within the comprehensive umbrella of the reproductive health category DIS.2 (Annex 2). This category encompasses spending on maternal conditions, perinatal conditions, contraceptive management and an unspecified reproductive conditions category, which accounts for spending identified as reproductive health but lacks allocation to a specific reproductive health condition. Expenditures attributed to maternal conditions include all spending estimates associated with health conditions occurring throughout pregnancy (from conception to delivery), childbirth, and the puerperium. Allocations to perinatal conditions cover expenditures related to conditions affecting the fetus or newborn originating in the perinatal period. Expenditures in contraceptive management are specifically tied to family planning activities. The total RMNH expenditure estimates are further classified by financing sources in the GHED: domestic public, external, and domestic private.

The age classification disaggregates healthcare consumption for the under-five and over-five population (Annex 2). The under-five category includes all health care goods and services consumed by children under five and will be referred to as child health (CH)

for this analysis. Similar to RMNH expenditures, CH expenditures are also further delineated by types of financing sources in the GHED, such as domestic public funds, external sources, and domestic private spending.

Note that the disease and age classifications are distinct dimensions, preventing their direct summation to avoid double-counting. More details on NHA data and estimation methods can be found in the SHA 2011 Methodological Guide (World Health Organization et al., 2022).

Lastly, the available GHED data starts from 2013 for disease classification and 2016 for age classification. Since then, data availability has progressively increased, covering up to 39 countries for disease classification and up to 29 countries for age classification in 2019. For our analysis, we have up to 39 countries with RMNH data and up to 29 countries with CH data out of the 47 countries in the African Region between 2013 and 2019. However, not all countries have reported data for every year in that period (Annex 1). We will restrict our analysis to the subset of countries with complete data on 2016-2019 (which has the most reported data) to allow comparison and trend estimations. For RMNH, in 2016-2019, we have 27 countries that have reported data for every year, and for CH, we have 18 countries with complete data for every year. The reported data for all countries and all years can be found in Annex 1.

Despite the limited data availability, the findings offer valuable insights into RMNH and CH expenditures for the Region. These insights contribute to a better understanding of the financial landscape and help inform future research and policy decisions.

3. Limitations

Health accounts serve as valuable input for resource allocation planning. However, important caveats should be considered when measuring expenditures by disease or condition. The estimation of expenditures

by disease heavily relies on reported cases, and variations in reporting practices might exist among countries.

A notable limitation in this analysis is the inability to offer a detailed breakdown of RMNH and CH expenditures which could enhance decision-making. The available data in the GHED lacks granularity, limiting insights into specific functions or activities, such as type of maternal care (for example, prenatal versus delivery versus postnatal care) or type of child care (for example, immunization versus sick child care). Additionally, the analysis is constrained by the limited number of countries regularly reporting RMNH and CH expenditures.

Lastly, it is important to note that this assessment could benefit from existing initiatives related to resource tracking for RMNCH expenditures, such as those part of the World Bank Global Financing Facility (GFF) grants, to provide a more comprehensive picture of RMNCH expenditure. Therefore, efforts to align and harmonize resource tracking initiatives should be recommended.

4. Results

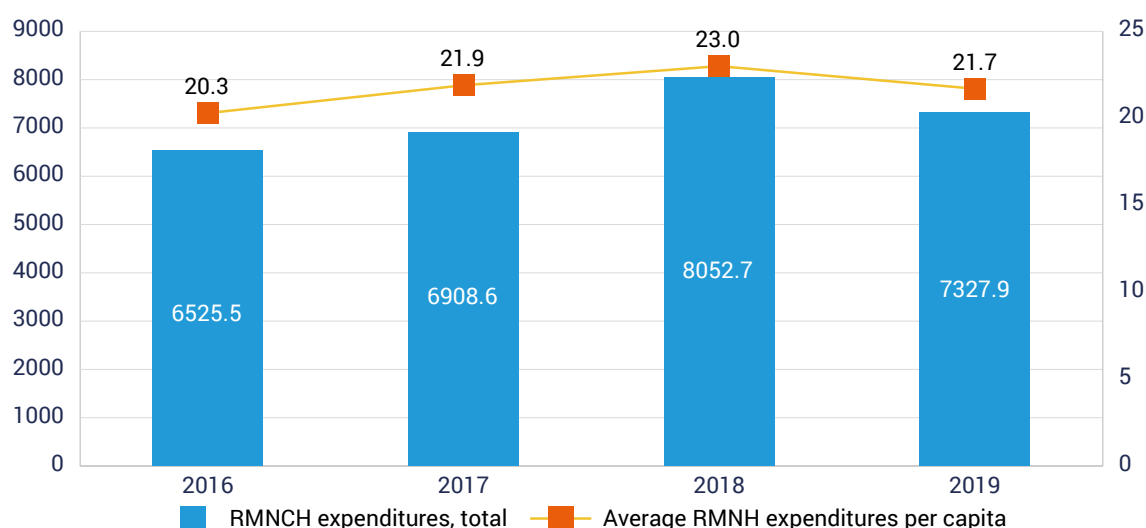
4.1. Trends in reproductive, maternal and newborn health (RMNH) and child health (CH)

(a) RMNH expenditures, total and per capita

From the 27 countries with available data, RMNH expenditures amounted to around US\$ 28.8 billion in 2016 - 2019. The peak occurred in 2018, reaching

US\$ 8 billion, a 23% increase from the 2016 figure (Fig. 1). The average RMNH per capita expenditures trend over the same period follows the same pattern observed in total expenditures.

Fig. 1. Total reported RMNH expenditures in million current US\$ and average RMNCH expenditures per capita in current US\$, 2016-2019



A closer look at RMNH expenditures indicates that almost two-thirds of the expenditure is directed toward maternal conditions, followed by contraceptive

management, unspecified RMNH conditions, and perinatal conditions (Fig. 2).

Fig. 2. Reported RMNH expenditures by sub-categories, 2016-2019.

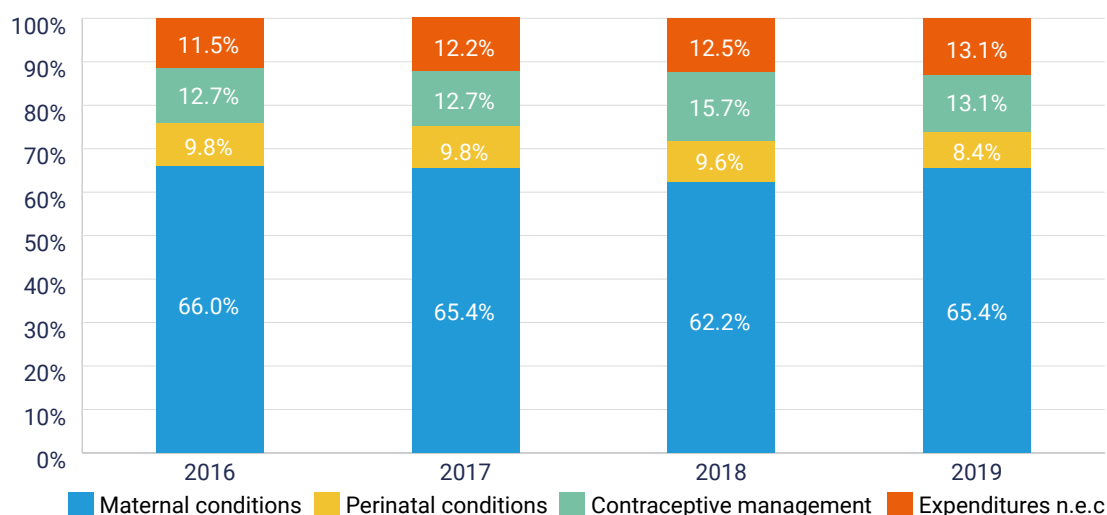


Table 1 presents the data by year over 2016-2019, and we can see that RMNH expenditures exhibited some variability among most countries. Congo, Cote d'Ivoire, Liberia and Uganda witnessed substantial declines in RMNH expenditures of 45.2%, 54.4%, 47.2%, and

35.5%, respectively, between 2016 and 2019. In contrast, the Central African Republic, Mali, and Mauritania and Senegal, experienced notable increases of 135.8%, 56.6%, 43.2%, and 78.7% respectively during the same period (Table 1).

Table 1. Reported RMNH expenditures in millions of current US\$ by country and year, 2016-2019.

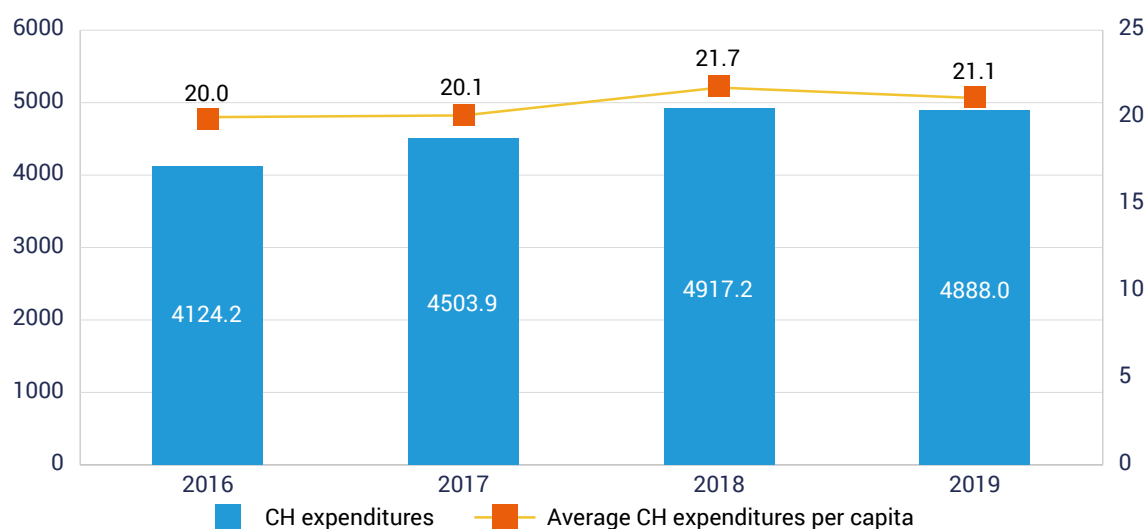
Countries	2016	2017	2018	2019	Percent change 2016-2019
Botswana	78.0	101.8	90.5	102.5	31.3%
Burkina Faso	91.3	137.5	122.7	124.8	36.7%
Burundi	45.0	60.4	71.0	60.8	35.0%
Cabo Verde, Republic of	19.5	22.5	24.7	24.6	26.6%
Central African Republic	14.5	21.8	48.6	34.2	135.5%
Comoros	17.8	21.0	21.6	22.6	27.0%
Congo	35.6	30.5	27.6	19.5	-45.4%
Côte d'Ivoire	438.0	533.6	517.8	199.9	-54.4%
Democratic Republic of the Congo	197.9	243.2	234.6	246.5	24.5%
Gabon	71.2	82.6	86.4	86.4	21.2%
Guinea	42.3	23.2	28.3	47.7	12.8%
Liberia	84.9	77.1	65.1	44.8	-47.2%
Malawi	66.2	71.6	112.0	85.3	28.9%
Mali	53.8	10.8	78.9	84.3	56.6%
Mauritania	16.3	19.2	22.0	23.3	43.2%
Mauritius	32.3	35.7	38.5	41.5	28.6%
Namibia	214.0	242.1	251.5	232.3	8.5%
Niger	71.4	58.4	81.7	51.7	-27.6%
Nigeria	1,383.9	1,131.8	1,845.5	1,519.2	9.8%
Sao Tome and Principe	5.3	5.9	6.1	5.5	4.5%
Senegal	110.8	168.6	165.4	197.9	78.7%
Seychelles	11.8	11.7	12.8	12.8	8.3%
South Africa	2,874.7	3,362.7	3,609.0	3,532.0	22.9%
Togo	43.4	38.3	43.4	34.9	-19.6%
Uganda	228.3	81.3	96.4	147.2	-35.5%
United Republic of Tanzania	176.6	191.7	207.2	211.7	19.9%
Zambia	100.6	123.6	143.1	134.0	33.3%

(b) Child health expenditures, total and per capita

A total expenditure of approximately US\$ 18.4 billion was expended on child health from 2016-2019. Total

child health expenditure and average child health expenditure per capita remained consistent over the four years (Fig. 3).

Fig. 3. Reported child health expenditures in million current US\$ and average CH expenditure in current US\$, 2016-2019



During the period 2016 – 2019, CH expenditures increased in most countries; the Central African Republic and Niger witnessed a notable increase, moving respectively from 35.8 and 253.6 million in 2016, to 73, and 414.4 million in 2019. South Africa

emerged as the top spender on child health, allocating an average of US\$ 2 billion per year. In the same period, we observed a decrease in Gabon's and Uganda's total child health expenditures, -14 % and -3 %, respectively.

Table 2. Reported child health expenditures in million current US\$, by country and by year, 2016-2019

Countries	2016	2017	2018	2019	Percent change 2016-2019
Burkina Faso	187.5	240.3	209.8	201.8	8%
Cabo Verde, Republic of	20.1	23.3	25.5	25.3	26%
Central African Republic	35.8	55.8	104.9	73.0	104%
Comoros	9.9	12.5	12.7	14.1	43%
Congo	55.4	58.4	53.0	70.6	27%
Côte d'Ivoire	379.4	422.0	433.2	388.8	2%
Gabon	95.5	76.2	82.5	82.3	-14%
Guinea	142.4	119.9	134.8	155.7	9%
Malawi	89.4	117.3	118.3	95.1	6%
Mali	157.2	56.4	145.9	152.8	-3%
Mauritania	42.9	48.9	55.0	58.3	36%
Niger	253.6	343.1	368.6	414.4	63%
Sao Tome and Principe	4.2	4.6	4.6	4.2	-1%
Seychelles	8.9	8.3	9.0	9.0	1%
South Africa	1,771.0	2,074.5	2,226.8	2,194.4	24%
Togo	121.4	128.0	137.5	133.0	10%
Uganda	363.4	294.5	340.7	352.5	-3%
United Republic of Tanzania	386.0	420.0	454.5	462.8	20%

4.2. RMNH and CH expenditures as a share of current health expenditures (CHE)

(a) RMNH expenditures as a share of current health expenditures (CHE)

In the GHED, current health expenditures represent the total health care goods and services consumed during a year in a country. This indicator does not include capital health expenditures such as buildings, machinery, equipment and stocks of vaccines for emergencies or outbreaks.

Reported data show that, on average, RMNH expenditures represented around 15% of CHE for 2016-2019. Countries such as Comoros and Burundi demonstrated a high commitment to RMNH, spending 37.2% and 27.5%, respectively, as a percentage of their current health expenditures from 2016 to 2019 (Table 3). In contrast, RMNCH accounted for only 4.7% and 7.5% of current health expenditures in Mauritius and Guinea, respectively.

During the same period, Burundi and Comoros experienced reductions in maternal mortality rates (MMR), with decreases of 4% and 17%, respectively, while Mauritius saw an increase. In Burundi, the MMR fell from 514 deaths per 100 000 live births in 2015 to 494 deaths per 100 000 live births in 2020. In Comoros, it decreased from 261 to 217 deaths per 100 000 live births. Conversely, in Mauritius, the MMR increased from 57 to 84 deaths per 100 000 live births between 2015 and 2020.

However, it is important to recognize that increases in investment do not always result in better outcomes. Despite spending an average of only 7.5% on RMNH, Guinea experienced a 15% decrease in maternal deaths during the same period.

Table 3. Reported RMNH expenditures as a percentage of current health expenditure (CHE) by country and by year, 2016-2019

Countries	2016	2017	2018	2019	Average
Botswana	9.0	9.5	8.8	10.0	9.3
Burkina Faso	12.0	16.1	15.4	14.5	14.5
Burundi	21.2	26.2	31.6	30.9	27.5
Cabo Verde	24.1	24.1	24.2	24.5	24.3
Central African Republic	14.6	15.8	19.4	19.2	17.2
Comoros	37.7	37.0	37.4	36.7	37.2
Congo	12.6	10.9	10.7	5.9	10.0
Côte d'Ivoire	27.2	31.3	28.6	10.4	24.4
Democratic Republic of the Congo	12.2	15.4	15.1	13.8	14.1
Gabon	16.3	19.9	18.7	18.5	18.3
Guinea	9.1	5.7	6.4	8.7	7.5
Liberia	26.5	23.3	20.3	17.3	21.8
Malawi	11.1	10.6	16.5	15.1	13.3
Mali	10.2	1.9	12.4	12.6	9.3
Mauritania	8.2	8.5	8.7	8.8	8.6
Mauritius	4.6	4.6	4.6	4.8	4.7
Namibia	21.4	21.5	22.1	22.0	21.8
Niger	15.2	9.4	12.0	7.1	10.9
Nigeria	9.4	8.0	14.2	10.7	10.6
Sao Tome and Principe	23.7	24.2	25.0	24.5	24.3
Senegal	13.7	19.3	16.1	18.8	17.0
Seychelles	16.0	15.6	15.7	15.6	15.7
South Africa	11.0	11.1	11.1	11.0	11.0
Togo	10.9	9.3	10.2	8.6	9.7
Uganda	15.1	6.4	7.0	10.3	9.7
United Republic of Tanzania	9.0	8.8	8.7	8.9	8.9
Zambia	10.7	10.9	10.8	10.8	10.8

(b) CH expenditure as a share of current health expenditure (CHE)

The share of CH expenditure to current health expenditure remained relatively stable over the four years, with an average of 24%. However, there were substantial variations across countries. In South Africa, CH expenditures represented, on average, 6.8% of CHE over the period 2016-2019, while the Central African Republic and Niger emerged as the countries with the highest average share of CH

expenditures in CHE, with respectively 39.8% and 55% over the period. Despite large differences in investment in CH, the Central African Republic, Niger and South Africa experienced similar decreases in child mortality rates, with decreases of 15.4%, 16.7% and 17.15 respectively over 2015-2020. This underscores the fact that the significance lies not only in the amount a country invests, but the strategic approach to investing in child health.

Table 4. Reported CH expenditures as a share of current health expenditure (CHE) by country and by year, 2016-2019

Countries	2016	2017	2018	2019	Average
Burkina Faso	24.5	28.1	26.4	23.5	25.6
Cabo Verde, Republic of	25.0	24.9	25.0	25.2	25.0
Central African Republic	36.0	40.4	41.9	40.9	39.8
Comoros	21.0	22.0	21.9	22.9	22.0
Congo	19.6	20.9	20.4	21.5	20.6
Côte d'Ivoire	23.6	24.8	23.9	20.2	23.1
Gabon	21.9	18.3	17.8	17.6	18.9
Guinea	30.7	29.7	30.4	28.3	29.8
Malawi	15.0	17.3	17.4	16.8	16.6
Mali	29.7	10.0	22.9	22.8	21.3
Mauritania	21.7	21.7	21.8	22.1	21.8
Niger	54.0	55.0	54.3	56.6	55.0
Sao Tome and Principe	19.0	19.1	18.8	18.7	18.9
Seychelles	12.0	11.0	11.0	10.9	11.2
South Africa	6.8	6.8	6.8	6.9	6.8
Togo	30.5	31.2	32.2	32.6	31.6
Uganda	24.0	23.3	24.9	24.6	24.2
United Republic of Tanzania	19.6	19.3	19.2	19.5	19.4

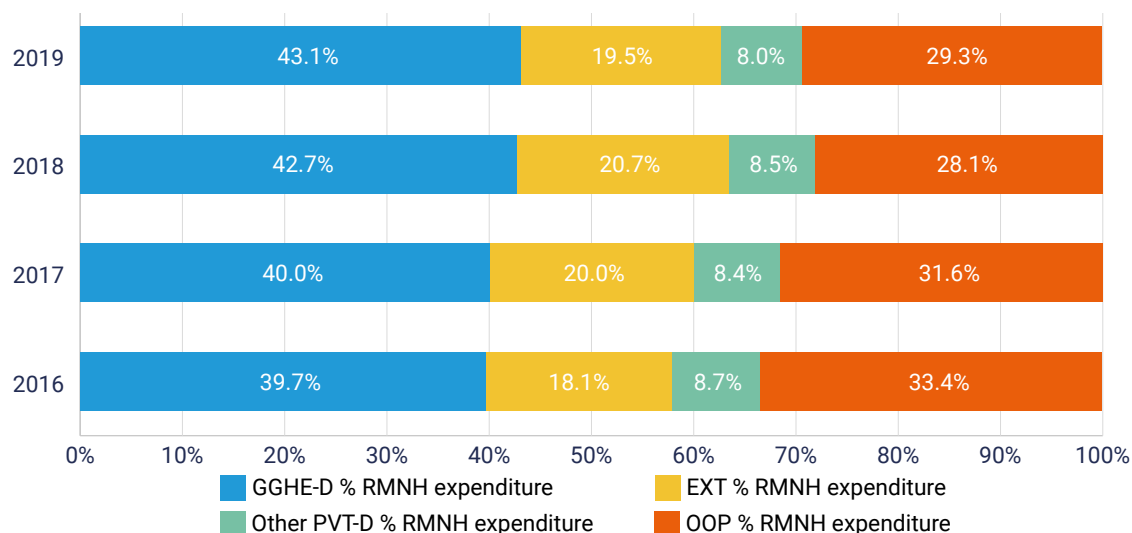
4.3. Financing sources of RMNH and CH expenditures

(a) RMNH sources of financing

RMNH is predominantly funded by domestic private sources and domestic public sources (general government spending). Throughout the four years, there was a minimal fluctuation in the distribution of funding sources, with domestic private sources and government contributions consistently accounting for an average of 39% and 41.4%, respectively

(Fig. 4), representing on average more than 4/5 of total contribution to RMNH. Since the GHED does not further disaggregate private domestic expenditure in RMNH, we estimated RMNH out-of-pocket (OOP) expenditure by applying the share of OOP expenditures to total private domestic expenditures. From 2016 to 2019, RMNH OOP expenditure accounted for an average of 30.6% of total RMNH expenditures.

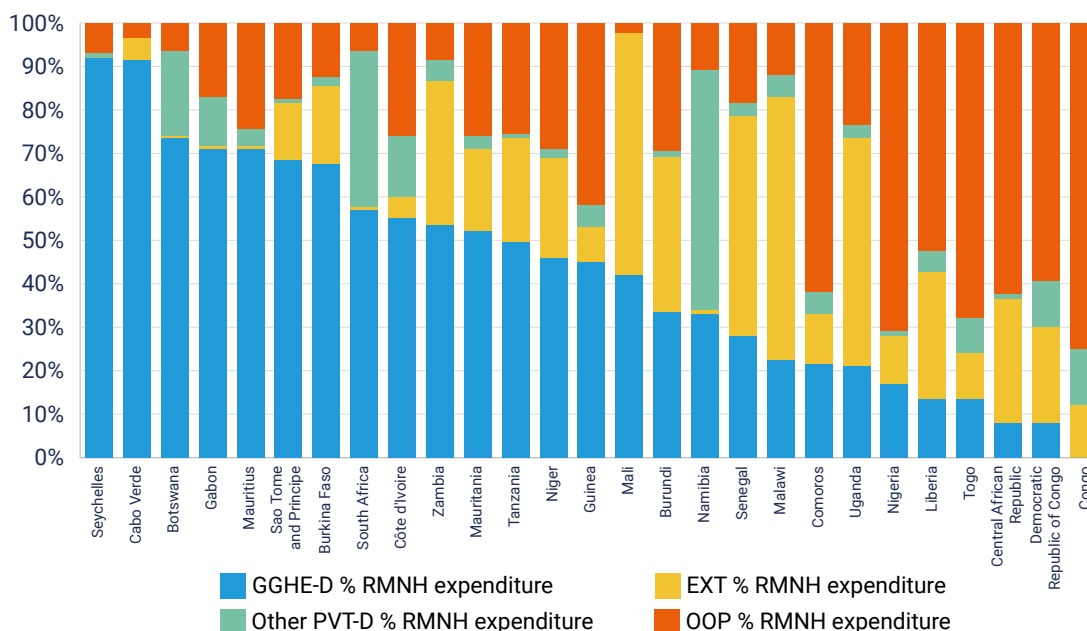
Fig. 4. Financing sources of reported total RMNH expenditures, 2016-2019



A closer look at the most recent year (2019) reveals that domestic general government sources contributed to over 50% of funding in 12 countries, while domestic private funding emerged as the primary source of funding in seven countries (Congo, Nigeria, Togo, CAR, Comoros, DR Congo, and Liberia) with proportions

ranging from 75.1% to 52.3%. Additionally, external funding played a significant role in financing RMNH expenditure in four countries (Malawi, Mali, Uganda and Senegal), accounting for proportions ranging from 60.4% to 50.2% of the total spending (Fig. 5).

Fig. 5. Reported RMNH expenditures by financing sources and country, 2019

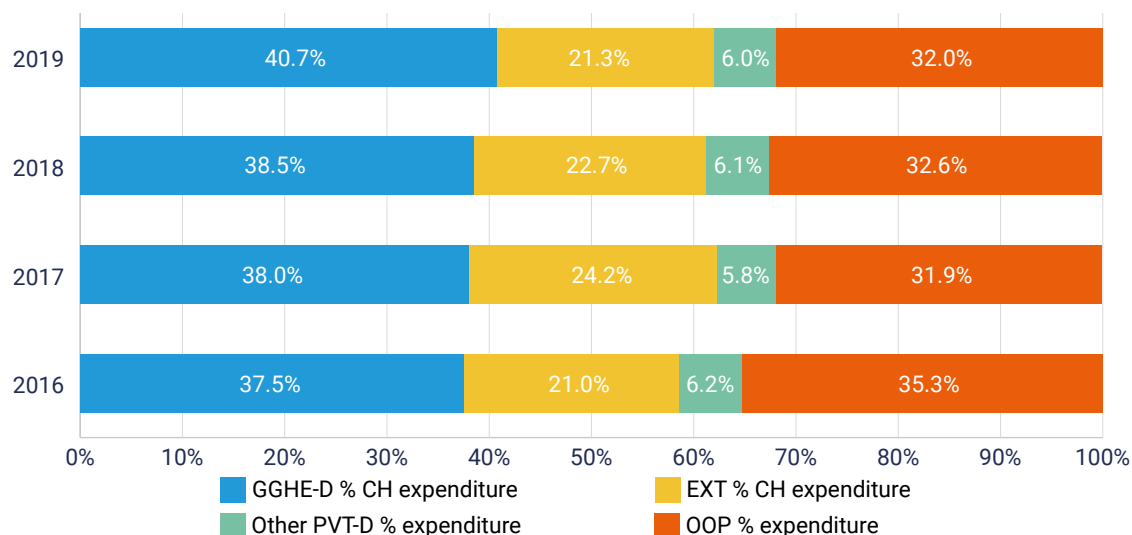


(b) Child Health funding sources

Like RMNH, child health is predominantly funded by domestic private and general government sources, accounting for an average of 39% each (Fig. 6). We went further and estimated CH OOP expenditure

by applying the share of OOP expenditures to total private domestic expenditures. From 2016 to 2019, CH OOP expenditure accounted for an average of 33% of total CH expenditures. The significant reliance on OOP expenditure raises concerns about financial protection for CH.

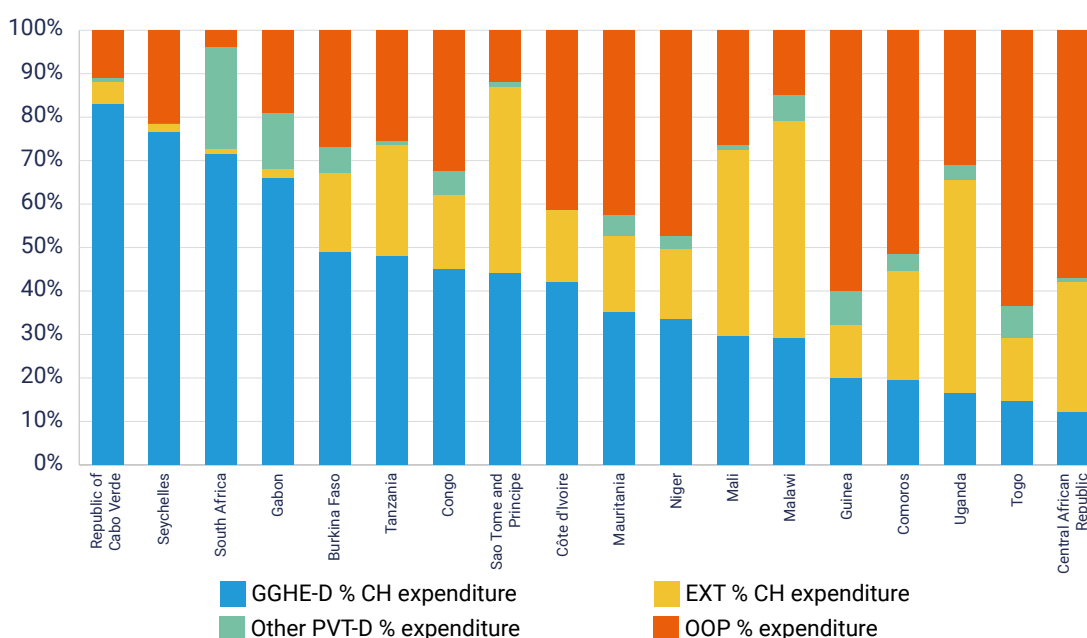
Fig. 6. Financing sources of reported total CH expenditures, 2016-2019



A snapshot of 2019 reveals that domestic private sources represented the primary funding source for child health in six countries, with the share of private sources ranging from 47.6% in Mauritania to 71.2% in Togo. Specifically, OOP was the primary source of CH expenditure in Comoros, CAR, Guinea, and Togo.

On the other hand, domestic government sources accounted for more than 50% of child health spending in four countries (from 66.3% in Gabon to 82.8% in Cabo Verde). External resources were the major funding source in four countries (Sao Tome and Principe, Malawi, Uganda, and Mali), with proportions ranging from 50.1% to 42.8% of child health expenditures (Fig. 7)

Fig. 7. Reported CH expenditures by financing sources and country, 2019



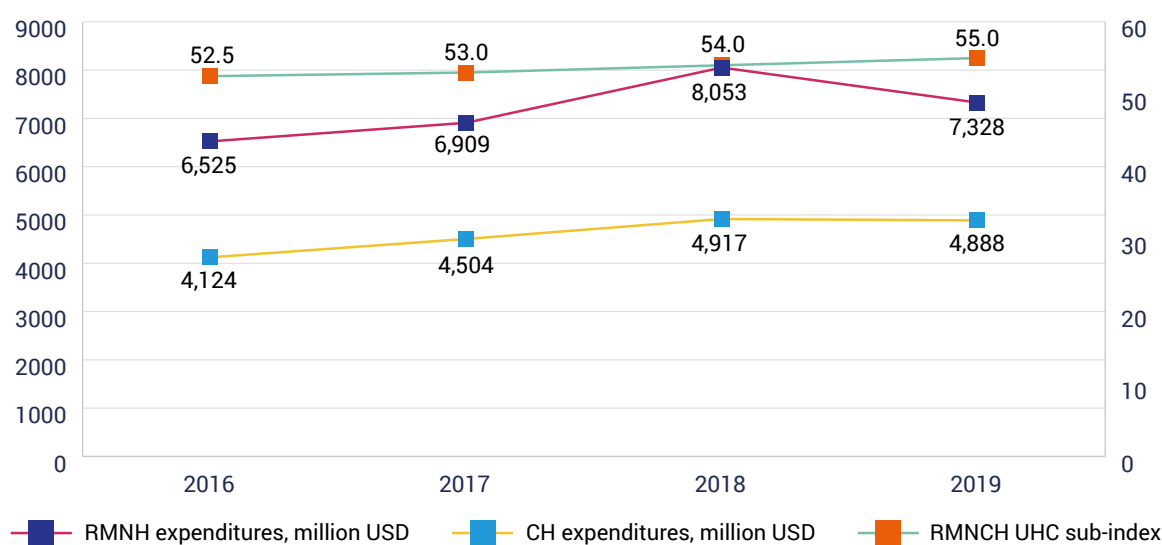
4.4. Analysis of RMNH and CH expenditures vs UHC - Service coverage sub-index on reproductive, maternal, newborn and child health

RMNH spending increased from US\$6.525 million in 2016 to US\$7.328 million in 2019. Similarly, CH expenditure rose from US\$4.124 million in 2016 to US\$4.888 million in 2019. Despite these growing

investments, the UHC sub-index on reproductive, maternal, newborn, and child health for the African Region showed a modest increase, rising from 52.5 in 2016 to 53 in 2017 and 55 in 2019³. Additionally, there was an approximate 8% decrease in maternal and under-five mortality rates between 2015 and 2019 (UN Inter-agency Group for Child Mortality Estimation, 2015, 2020; World Health Organization, 2023a).

This suggests that while financial investments in RMNH and CH are crucial, they alone are insufficient to improve health outcomes rapidly. Other factors, such as existing health infrastructure, the efficiency of resource allocation, and quality of care, likely play significant roles in determining the pace of improvement in health service coverage.

Fig. 8. RMNH and CH expenditures vs RMNCH UHC sub index



5. Discussion

During the period 2016-2019, RMNH expenditures peaked in 2018 before declining in 2019, while CH expenditures remained consistent across the years. As more data becomes available in the coming years, it will be important to confirm these trends, especially considering the potential impact of the COVID-19 crisis on health expenditures globally.

A closer look at the data by country shows important differences in RMNH and CH expenditure trends across countries. A more in-depth analysis of the context in each country, which is outside of the scope of this analysis, could explain such fluctuations. Still, we note that these differences could also partly be due to data reporting and analysis challenges at the country level as part of their NHA estimations.

The reported data show that, on average, RMNH expenditures represented around 15% of CHE, and CH expenditures represented around 24% of CHE for 2016-2019. Here too, with important differences across countries: from RMNH expenditures representing 37.2% of CHE in Comoros, to CH expenditures representing 55% of CHE in Niger. There is no established benchmark for the share of these expenditures in total health expenditures. However, relatively low levels—such as 4.7% for RMNH in Mauritius and 6.8% for CH in South Africa—should prompt further analysis and advocacy to allocate more resources to these critical areas of care.

There is no established benchmark for the share of these expenditures in total health expenditures.

³ <https://apps.who.int/gho/data/view.main.INDEXOFESSENTIALSERVICECOVERAGEREGV> (accessed on 11 June 2024)

However, relatively low levels—such as 4.7% for RMNH in Mauritius and 6.8% for CH in South Africa—should prompt further analysis and advocacy to allocate more resources to these critical areas of care.

Both RMNH and CH expenditures are predominantly funded from domestic private and domestic public sources (general government spending), with external funding playing a smaller role overall. On average, domestic private and public sources represented 39% and 41.4% for RMNH and 39% and 38.7% for CH. Note that domestic private sources are mainly made of households' out-of-pocket payments for health. Hence, the reliance on this source of funding for RMNH and CH can constitute a financial burden and deter people from seeking care, aggravating the lack of financial protection and impeding the progress towards UHC. The situation is particularly dire in countries such as Nigeria, Togo, and Congo, where private sources fund more than 70% of RMNH expenditures, and Guinea and Togo, where more than 60% of CH expenditures come from private sources.

Despite the limited number of countries with RMNH and CH expenditures data in the GHED, the results of this analysis reveal trends that can be instrumental in advocating for increased resource allocation to RMNCH. This is crucial for achieving sustainable development health goals and UHC in these countries. To obtain a comprehensive view of the African Region, we need more consistent and complete expenditure data from all 47 countries. To address these data gaps, we propose the following recommendations:

1. Engage more countries in producing disaggregated health expenditure data to enhance the accuracy and depth of policy analysis. In this regard, improving data on financial resources and providing funding for countries to prioritize primary data collection of RMNH and CH disaggregated data as part of their NHA exercises, as opposed to broad estimations, is essential to allow for more accurate information, detailed tracking and analysis that can guide decision-making and further resource allocation.
2. Enhance standardization of reporting practice by (i) encouraging countries to adopt standardized reporting practices for disease or condition expenditures to improve comparability and (ii) establishing guidelines for consistent reporting methods to minimize variations within and between countries.
3. Develop a quality check framework for detailed disease expenditure breakdown: advocate for the development of a comprehensive data quality check framework that will enhance the reporting of detailed expenditure by disease or condition. This framework would complement existing quality and validation processes for the GHED and enhance accuracy and granularity.
4. Enhance coordination and harmonization of resource-tracking initiatives to ensure improved availability and consistency of expenditure estimates beyond the GHED.

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Annexes

Annex 1. Countries with data throughout the study

WHO African Region (47 Member States)	RMNH data for some or all years (2013-2019)	CH data for some or all years (2016-2019)	No data over the period (2013-2019)
Algeria			X
Angola			X
Benin	X	X	
Botswana	X		
Burkina Faso	X	X	
Burundi	X		
Cabo Verde	X	X	
Cameroon	X	X	
Central African Republic	X	X	
Chad	X	X	
Comoros	X	X	
Congo	X	X	
Côte d'Ivoire	X	X	
Democratic Republic of the Congo	X	X	
Equatorial Guinea			X
Eritrea			X
Eswatini	X	X	
Ethiopia	X	X	
Gabon	X	X	
Gambia	X	X	
Ghana	X		
Guinea	X	X	
Guinea-Bissau			X
Kenya	X	X	
Lesotho			X
Liberia	X		
Madagascar			X
Malawi	X	X	
Mali	X	X	
Mauritania	X	X	
Mauritius	X		
Mozambique	X		
Namibia	X		
Niger	X	X	
Nigeria	X		
Rwanda			X
Sao Tome and Principe	X	X	
Senegal	X	X	
Seychelles	X	X	
Sierra Leone	X	X	
South Africa	X	X	
South Sudan	X	X	
Togo	X	X	
Uganda	X	X	
United Republic of Tanzania	X	X	
Zambia	X		
Zimbabwe	X	X	

Annex 2. Disease/condition and age categories from the SHA

SHA Code	Classification of diseases/conditions
DIS.1	Infectious and parasitic diseases
DIS.2	Reproductive health
DIS.2.1	Maternal conditions
DIS.2.2	Perinatal conditions
DIS.2.3	Contraceptive management (family planning)
DIS.2.nec	Unspecified reproductive health conditions (n.e.c)
DIS.3	Nutritional deficiencies
DIS.4	Noncommunicable diseases (NCDs)
DIS.5	Injuries
DIS.nec	Other and unspecified diseases/conditions (n.e.c)
AGE	Current health expenditure by age
AGE.1	< 5 years old
AGE.2	≥ 5 years old
AGE.nec	Other and unspecified age (n.e.c.)

Annex 3. Glossary⁴

- (a) Domestic private health expenditure as a share of RH or CH expenditure (PVT-D % RH or CH expenditure): revenues from domestic private sources spent on RH or CH as a percentage of total RH or CH expenditure indicates how much is funded domestically by the private sector. Domestic private health expenditure sources include domestic revenues from households, corporations, and non-profit organizations. Such expenditures can be either prepaid (such as compulsory and voluntary prepayments to private insurance) or paid directly out-of-pocket by households to health care providers. This indicator describes the role of private domestic sources in funding health care relative to government or external sources.
- (b) Domestic general government health expenditure as a share of RH or CH expenditure (GGHE-D % RH or CH expenditure): revenues from domestic general government sources spent on RH or CH health as a percentage of total RH or CH expenditure indicate how much is funded domestically by the government. Domestic general government sources include government internal transfers and grants, government transfers and subsidies to voluntary schemes, and social health insurance contributions. This indicator describes the role of the general government's domestic sources in funding health care relative to domestic, private, and external sources.
- (c) External health expenditure as a share of RH or CH expenditure (EXT % RH or CH expenditure): revenues from external sources spent on RH or CH health as a percentage of total RH or CH expenditure indicate how much the health system is dependent on external funding sources. External sources include direct foreign transfers and foreign transfers distributed by the government, encompassing all financial inflows into the national health system from outside the country. This indicator describes the role of external sources in funding health care relative to domestic sources.

⁴ Adapted from The Global Health Observatory available on <https://www.who.int/data/gho/indicator-metadata-registry>

Annex 4. RMNH expenditures in million current US\$, by country and by year, 2013-2019

Countries	2013 (n=19)	2014 (n=23)	2015 (n=26)	2016 (n=30)	2017 (n=36)	2018 (n=39)	2019 (n=36)
Benin	47.0	41.3	35.0	33.8	40.0	40.1	
Botswana	116.2	59.8	48.1	78.0	101.8	90.5	102.5
Burkina Faso	64.0	67.5	61.9	91.3	137.5	122.7	124.8
Burundi				45.0	60.4	71.0	60.8
Cabo Verde	21.4	22.0	16.2	19.5	22.5	24.7	24.6
Cameroon						169.5	140.4
Central African Republic			11.4	14.5	21.8	48.6	34.2
Chad						207.1	202.0
Comoros			16.8	17.8	21.0	21.6	22.6
Congo	141.2	141.7	74.5	35.6	30.5	27.6	19.5
Côte d'Ivoire	518.1	486.4	422.0	438.0	533.6	517.8	199.9
Democratic Republic of the Congo	183.7	193.6	138.6	197.9	243.2	234.6	246.5
Eswatini					10.4	11.7	10.4
Ethiopia					216.7	215.0	236.6
Gabon	102.4	79.3	64.5	71.2	82.6	86.4	86.4
Gambia						3.2	10.3
Ghana		272.1	222.4	192.0	201.9	229.7	
Guinea	40.7	29.8	28.8	42.3	23.2	28.3	47.7
Kenya					522.5	724.5	897.7
Liberia				84.9	77.1	65.1	44.8
Malawi	65.3	62.6	64.6	66.2	71.6	112.0	85.3
Mali	41.3	73.3	60.8	53.8	10.8	78.9	84.3
Mauritania	13.9	12.3	14.0	16.3	19.2	22.0	23.3
Mauritius				32.3	35.7	38.5	41.5
Mozambique			85.9	71.2	86.5	100.7	
Namibia		282.3	263.5	214.0	242.1	251.5	232.3
Niger	99.1	77.7	72.0	71.4	58.4	81.7	51.7
Nigeria	1637.2	1802.4	1623.5	1383.9	1131.8	1845.5	1519.2
Sao Tome and Principe	2.8	3.6	2.0	5.3	5.9	6.1	5.5
Senegal	75.3	148.6	105.7	110.8	168.6	165.4	197.9
Seychelles				11.8	11.7	12.8	12.8
Sierra Leone					60.4	61.4	67.1
South Africa		2926.3	2976.9	2874.7	3362.7	3609.0	3532.0
South Sudan					25.3	24.7	20.2
Togo	32.5	35.4	33.1	43.4	38.3	43.4	34.9
Uganda	272.6	254.6	227.7	228.3	81.3	96.4	147.2
United Republic of Tanzania		311.0	246.9	176.6	191.7	207.2	211.7
Zambia	134.8	134.5	84.2	100.6	123.6	143.1	134.0
Zimbabwe					221.7	324.8	92.8

Annex 5. Child health expenditures in million current US\$, by country and by year, 2016-2019

Countries	2016 (n=19)	2017 (n=27)	2018 (n=30)	2019 (n=29)
Benin	96.9	106.5	119.3	
Burkina Faso	187.5	240.3	209.8	201.8
Cabo Verde	20.1	23.3	25.5	25.3
Cameroon			328.2	353.0
Central African Republic	35.8	55.8	104.9	73.0
Chad			125.7	123.2
Comoros	9.9	12.5	12.7	14.1
Congo	55.4	58.4	53.0	70.6
Côte d'Ivoire	379.4	422.0	433.2	388.8
Democratic Republic of the Congo		595.6	530.3	657.4
Eswatini		100.0	109.3	98.3
Ethiopia		452.6	460.5	532.4
Gabon	95.5	76.2	82.5	82.3
Gambia			12.7	12.9
Guinea	142.4	119.9	134.8	155.7
Kenya		1072.8	1260.4	1477.6
Malawi	89.4	117.3	118.3	95.1
Mali	157.2	56.4	145.9	152.8
Mauritania	42.9	48.9	55.0	58.3
Niger	253.6	343.1	368.6	414.4
Sao Tome and Principe	4.2	4.6	4.6	4.2
Senegal		259.7	317.7	293.6
Seychelles	8.9	8.3	9.0	9.0
Sierra Leone		135.3	96.0	107.1
South Africa	1771.0	2074.5	2226.8	2194.4
South Sudan		105.9	107.6	91.2
Togo	121.4	128.0	137.5	133.0
Uganda	363.4	294.5	340.7	352.5
United Republic of Tanzania	386.0	420.0	454.5	462.8
Zimbabwe		232.4	306.2	100.2

The WHO Regional Office for Africa

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Africa is one of the six regional offices throughout the world, each with its own programme geared to the particular health conditions of the Member States it serves.

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Benin	Gabon	Nigeria
Botswana	Gambia	Rwanda
Burkina Faso	Ghana	Sao Tome and Principe
Burundi	Guinea	Senegal
Cabo Verde	Guinea-Bissau	Seychelles
Cameroon	Kenya	Sierra Leone
Central African Republic	Lesotho	South Africa
Chad	Liberia	South Sudan
Comoros	Madagascar	Togo
Congo	Malawi	Uganda
Côte d'Ivoire	Mali	United Republic of Tanzania
Democratic Republic of the Congo	Mauritania	Zambia
Equatorial Guinea	Mauritius	Zimbabwe
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