

Public Financing for Health and the Reduction of Child Mortality as a Key Priority of Sustainable Development

The Urgency to Drastically Increase ODA Grants for Health in parallel with Domestic Public Financing Efforts
to Prevent Deaths in the First Years of Life and Achieve SDG 3.2

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Public Health Financing and Child Mortality: Summary

Study Objective

Explore the connection between levels of public health financing and the risk of dying in the first five years of life aiming to estimate resource needs for reaching SDG 3.2 based on real-world conditions

Approach and Results

- Public health financing comprising health-specific domestic government expenditure and grants provided through official development assistance (ODA) is a key factor in child mortality especially in low-income countries
- The comparative analysis of Sub-Saharan countries namely those with the lowest levels of public financing for health in real terms, which takes cooperation to fight epidemics into account as a major factor in funding, provides meaningful and representative insights
- Determined, yet moderate efforts by national governments combined with cooperation by high-income nations to raise additional funding for health, amounting to 1.2 and 0.12 percent of GDP by 2031 respectively, could accelerate the reduction of child deaths to such an extent that SDG 3.2 could be achieved over the course of the coming decade, even in the most disadvantaged countries

Public Health Financing and Child Mortality: An Urgent Priority for Human Development and Social Justice

Research Question

By how much must public funding for healthcare be increased to reduce child mortality in disadvantaged countries to less than 25 per 1,000 live births, as enshrined in SDG 3.2?

Why this is important

- The fact that we are failing to overcome the disproportionately high risks of deaths in the first years of life constitutes an unacceptable violation of human rights
- Despite significant global progress, preventable child deaths continue to be concentrated in lower-income countries with structural vulnerabilities
- Historical trends in financing provide valuable evidence for estimating the investments needed to accelerate progress towards achieving SDG 3.2
- Understanding the past links between public health financing and child survival can be helpful in developing current and future strategies to mobilize adequate resources

Global Distribution of Public Financing for Health

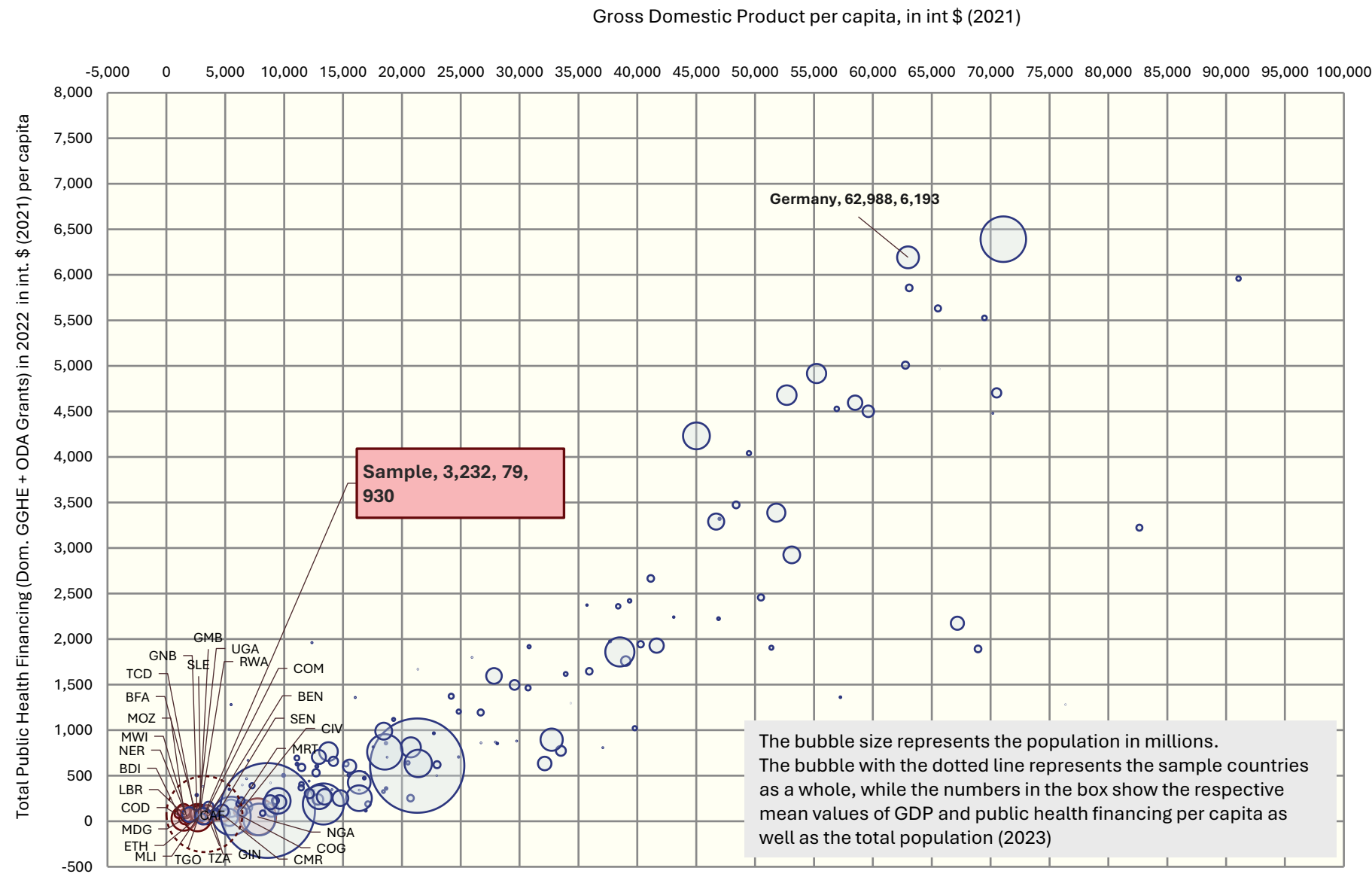
Argument

Countries differ enormously in their capacity to finance health services

Key points

- Economic developments have a significant impact on public health financing
- Disparities regarding levels of public financing for health are far more pronounced than income inequalities between countries
- Even when ODA is considered, low-income countries have too few public funds at their disposal to ensure effective access to essential health services

Figure 1: Public Health Financing incl. Domestic Contributions and ODA Grants per Capita in the Year 2022 in Relation to GDP showing Population Size, in International \$ (2021), 180 Countries with Complete Data



This chart reveals the per capita values of the two principal factors that determine the economic ability to finance health through public means in the most recent year for which all the necessary data is available: Gross Domestic Product (GDP) and Public Financial Resources for Health encompassing Domestic General Government Health Financing as well as Grants for Health provided through Official Development Assistance (ODA). All financial indicators are expressed in constant int. \$ (base year 2021) to ensure comparability across countries and years.

The distribution pattern shows a clear trend of rising percentages of public health financing in relation to GDP with higher per capita income even when countries with lower GDP receive international resources in addition to national financing from taxes and social contributions. In Low-and Middle-Income Countries (LMICs) this percentage on average never reached 3 percent (2.8% in 2020-21 during the COVID-19 crisis) whereas it approaches 8 percent in high-income countries (HICs) and surpassed this value during the pandemic response. Thus, disparity regarding resources for vital health financing is considerably more unequal than income distribution.

The bubble with dotted line represents the sample of 28 Sub-Saharan countries with public health financing of less than 100 int. \$ per capita and year on average over the period 2000-2022.

Selecting Comparable Countries

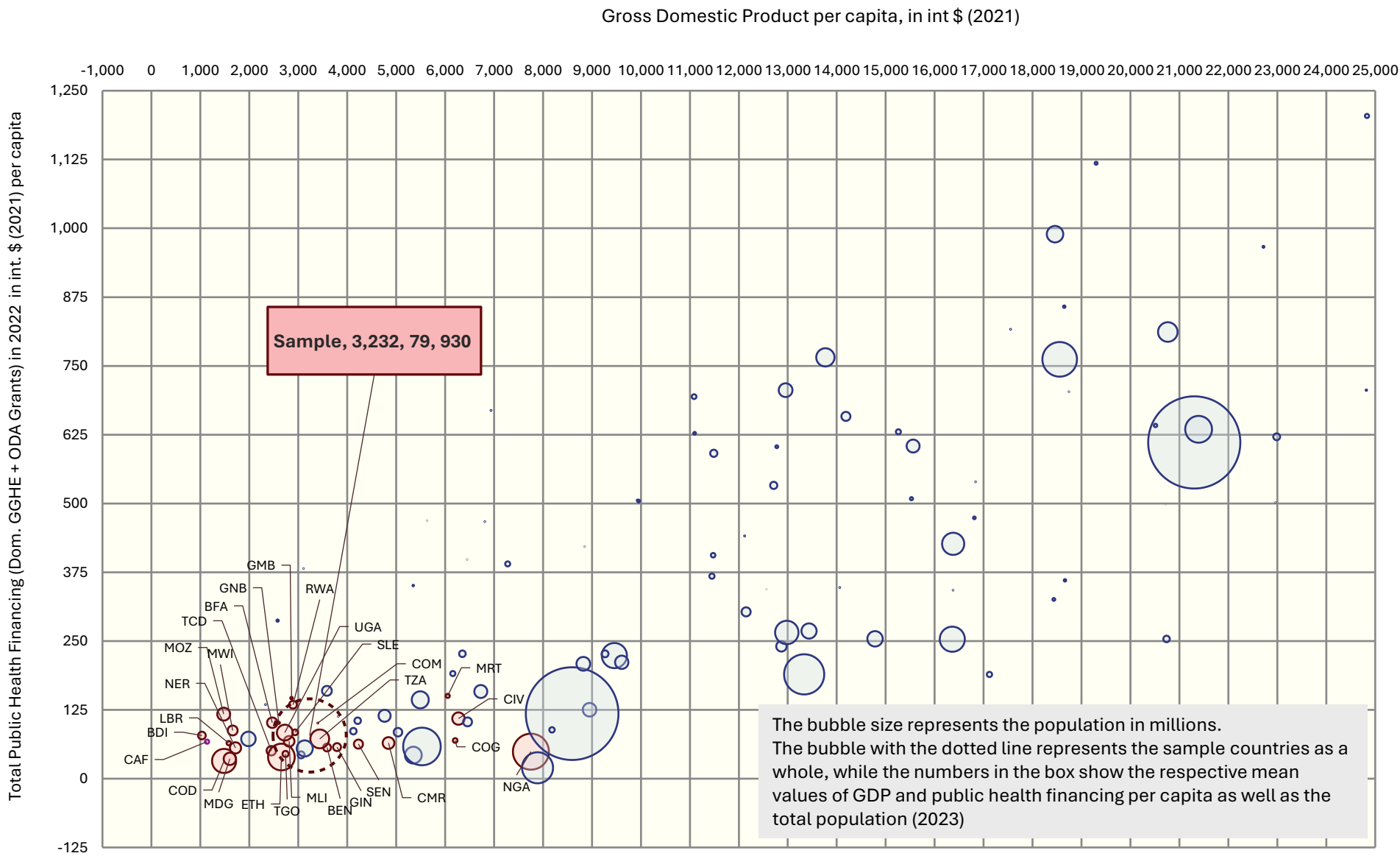
Argument

To estimate the funding needed to achieve health goals, countries with similar epidemiological and structural conditions should be examined

Key messages

- Comparable epidemiological and socioeconomic environments enhance the explanatory power of the quantitative analysis
- Focus on economically disadvantaged countries with the highest needs of international cooperation
- Identification of the 28 sub-Saharan African countries in which public health expenditure was below 100 international dollars (2021) per capita per year during the period 2000–2022
- This group comprises the countries that are furthest behind in achieving SDG 3.2 (including 11 countries accounting for 51 per cent of the sample population, in which the under-five mortality rate exceeded 75 per 1,000 – more than three times the SDG 3.2 target)

Figure 2: Public Health Financing incl. Domestic Contributions and ODA Grants per Capita in the Year 2022 in Relation to GDP and Population, in International \$ (2021), Countries with GDP per Capita below 25,000 int. \$

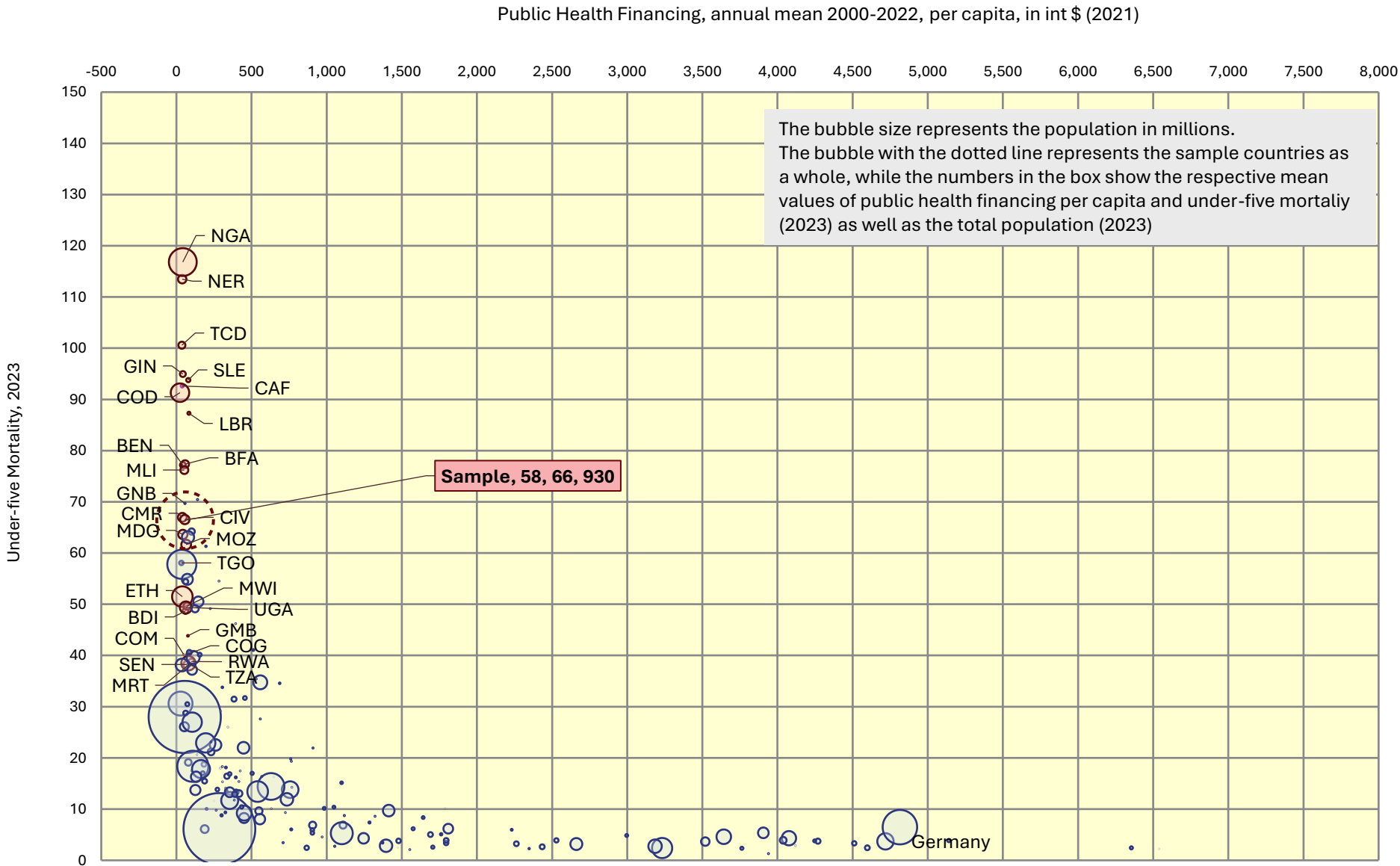


This diagram shows a section of the previous chart, focusing on low- and middle-income countries. This makes it easier to identify the sample of countries included in the subsequent analysis of the relationship between the level of public health expenditure and child mortality as a key indicator of health outcomes.

The sample comprises 28 countries in which public health expenditure averaged less than 100 international dollars per capita between 2000 and 2022. To mitigate the impact of the differing social and economic determinants of health, which lead to significant differences in the demand for financial resources, the analysis focuses on countries in sub-Saharan Africa. With a few exceptions, the poorest countries are included in this sample.

Countries with higher levels of healthcare funding were not included, as their small number would have compromised the representativeness of the data.

Figure 3: The Risk of Premature Death in a Global Context: Child Mortality in 2023 in Relation to Public Health Financing incl. Domestic Contributions and ODA Grants per Capita over the Period 2000-2022 in International \$ (2021)



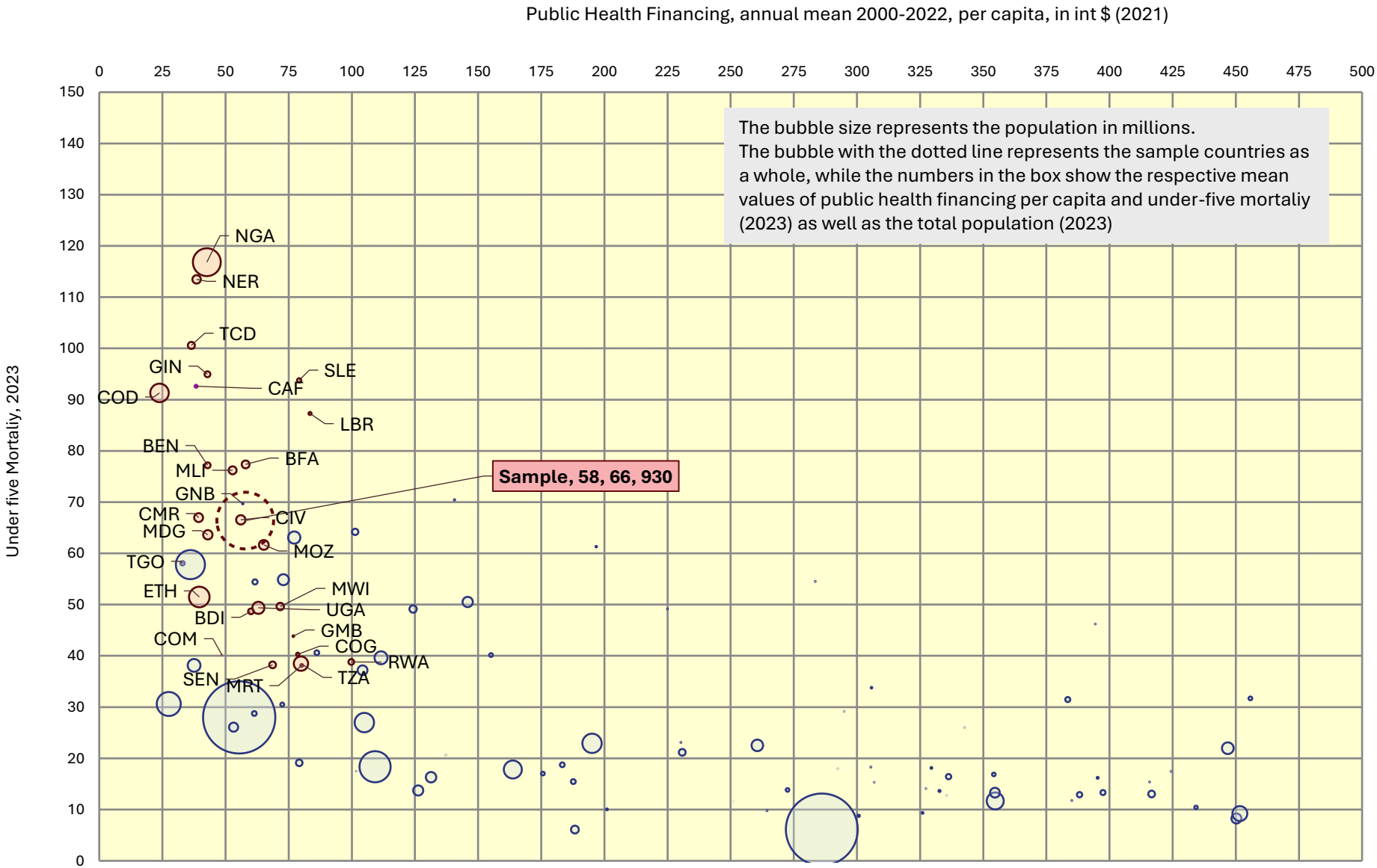
This chart examines the relationship between public funding allocated to healthcare and the under-five mortality rate¹ across all 180 countries. Evidently, public funding is a crucial factor in achieving progress in improving survival rates in the earliest stages of life.

In 2023 there were 27 countries worldwide with child mortality rates that still exceeded 50 per 1,000 live-births that means twice the maximum level set out in SDG 3.2. The majority of these – namely 18 countries – are included in the sample. Furthermore, 4 sub-Saharan nations that fall into higher health financing categories have child mortality rates that exceed this figure. Only five countries facing this critical situation are located outside Sub-Saharan Africa (including Sudan on the African continent).

The connection becomes even clearer when looking on the countries with the most extreme death risks among children under five. All 11 countries still suffering from child mortality figures above 75 per 1,000 are included in the sample. On the other side, even the sample countries with the most favourable child mortality levels around 40 per 1,000 live-births are still far from reaching the target.

¹ In the following, the terms under-five mortality and child mortality will be used interchangeably

Figure 4: Child Mortality in 2023 in Relation to Public Health Financing per Capita over the Period 2000-2022 in int. \$ (2021) with a Focus on the Economically Disadvantaged Countries



This presentation of the previous chart, which focuses on the economically disadvantaged segment, allows for a closer examination of the situation in the selected countries with regard to the key variables and their interrelationships. In addition, the simple averages of per capita public health expenditure and infant mortality, as well as the total population of the sample, are presented.

This clearly demonstrates that the international community – taking into account universal principles such as leaving no one behind and overcoming the most devastating inequalities – should give high priority to these countries and help them to significantly accelerate progress in overcoming the intolerable risks of death, particularly for the youngest members of society.

Child mortality rates highlight the progress that the respective health systems have been able to achieve overall. The failure to ensure the survival of the most vulnerable age group underscores the urgency to enhance the financial efforts. On the other hand, sustainable improvements in child health can only be secured if we succeed in enhancing the essential health services for all population groups.

Public Financing and Child Mortality

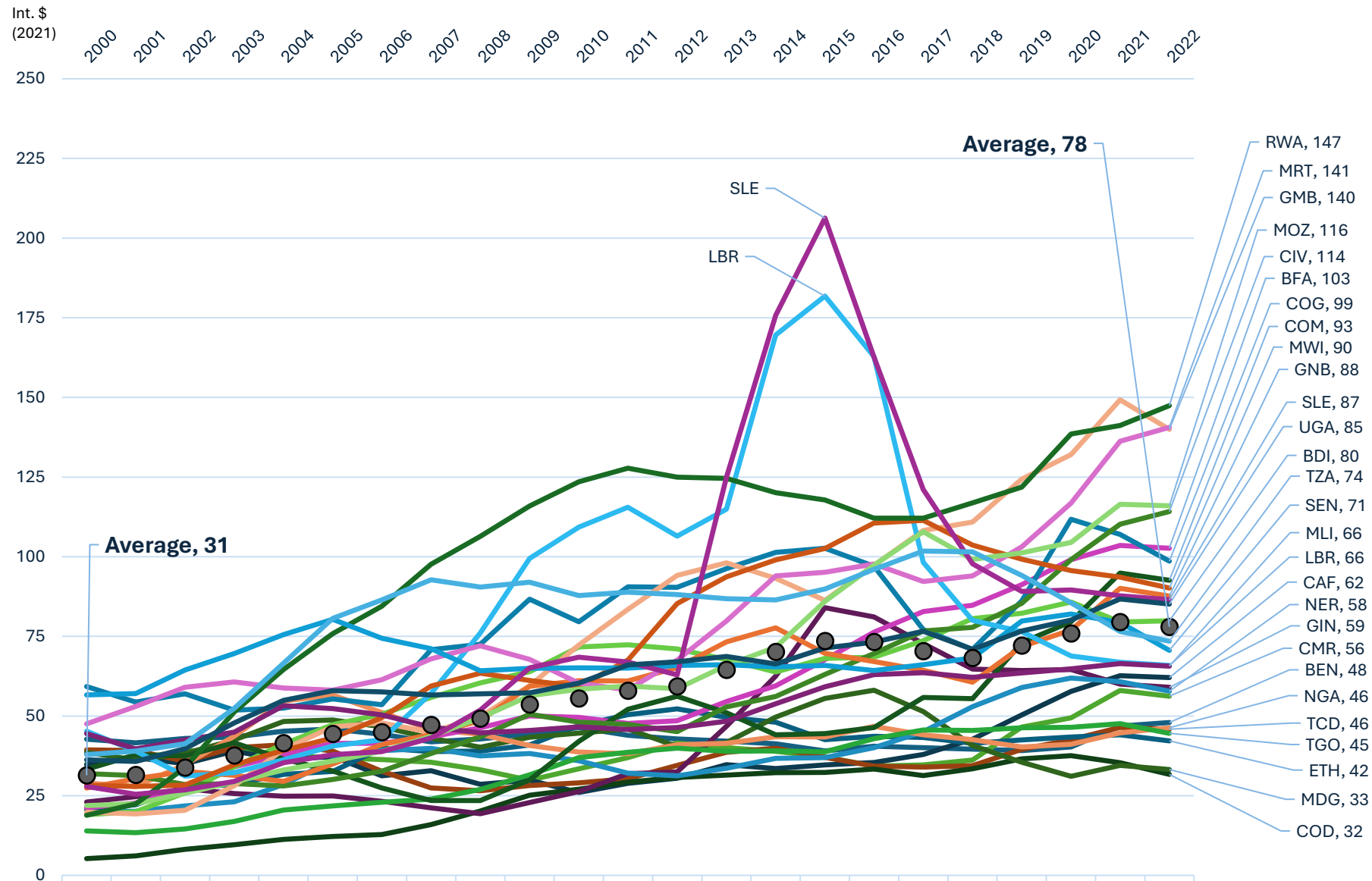
Argument

Higher levels of public health financing are associated with better child survival

Key messages

- Countries with very low public financing exhibit the highest mortality rates among children under five
- Conversely, higher financing is consistently associated with lower under-five mortality
- This correlation is particularly pronounced in the categories with the lowest level of resources allocated to the health sector.
- The impact of specific levels of healthcare funding on child mortality is a key factor in estimating the resources required to deliver adequate health services for all sections of the population

Figure 5: 3-Year Moving Average of Public Financing for Health per Capita in int. \$ (2021) including Domestic Government Resources and ODA Grants, Countries in Africa South of Sahara with Expenditure per capita < 100 \$

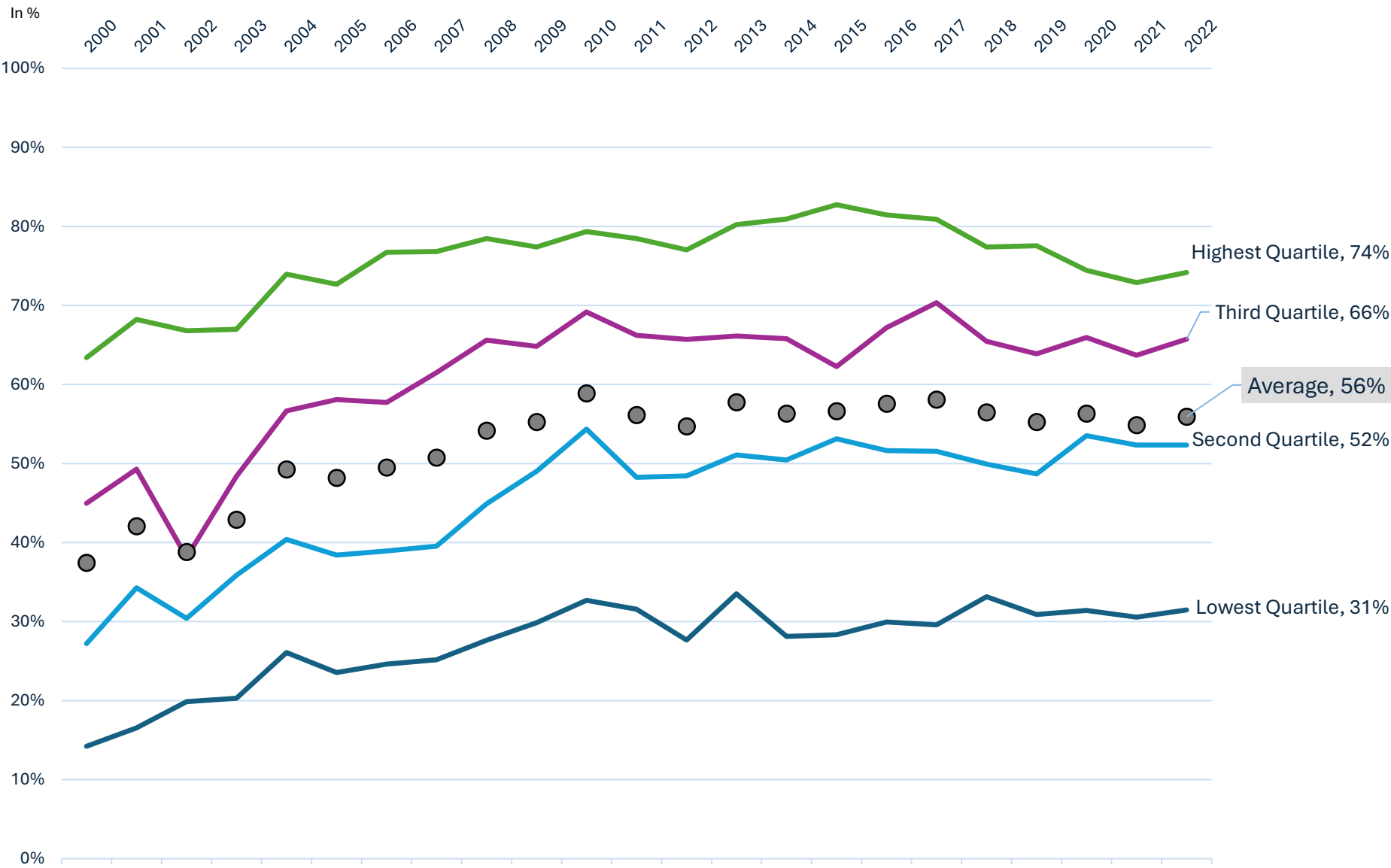


This chart permits to observe the evolution of the public financial resources made available by internal and international sources in each of the sample countries showing in addition the trend of simple mean values for the sample as a whole.

On average, the amounts per capita more than doubled over the period under review, with the bulk of the increase, roughly two-thirds, occurring in the first decade. Whilst the range of healthcare expenditure per capita widened up to the start of the second decade, it subsequently narrowed slightly until the outbreak of the COVID-19 pandemic.

The short-lived peaks in the years 2014 and 2015 were related to the response to the Ebola outbreak in Sierra Leone and Liberia mainly driven by ODA contributions, the share of which reached and even exceeded 90 per cent.

Figure 6: ODA Grants for Health as a Percentage of Total Public Health Financing, Mean and by Quartiles of ODA Share by Year



The share of ODA grants in public health funding rose significantly across all quartiles until 2010. On average, it stood at between 55 and 60 percent, having previously accounted for less than 40 per cent of the total. Since 2009, ODA grants have accounted for more than half of total public health expenditure in at least 17 of the 28 countries studied.

On the other side, the percentage figures of the quartiles reveal the significant differences between countries. In the lower quartiles, a clear upward trend can be observed over the first decade, which underlines the importance of ODA contributions for public health financing in the most disadvantaged countries.

The Contribution of ODA

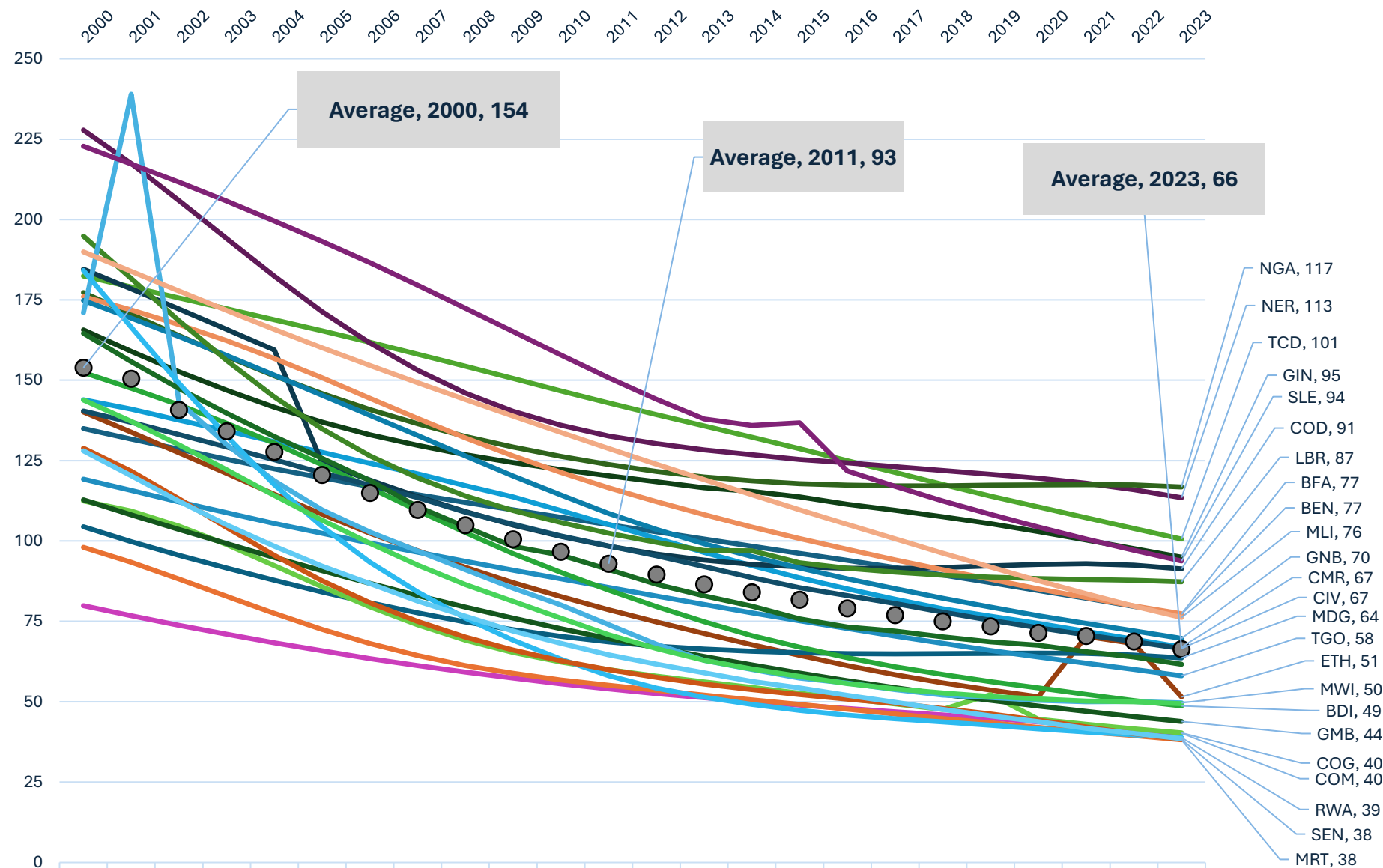
Argument

Both domestic financing as well as ODA grants constitute essential components of public health funding in economically disadvantaged countries

Key messages

- ODA is particularly important for countries with very limited capacity to raise domestic resources
- In the 2000s, ODA represented the main source of additional health financing in countries in need, whereas thereafter government expenditure from internal taxes and contributions gained in importance

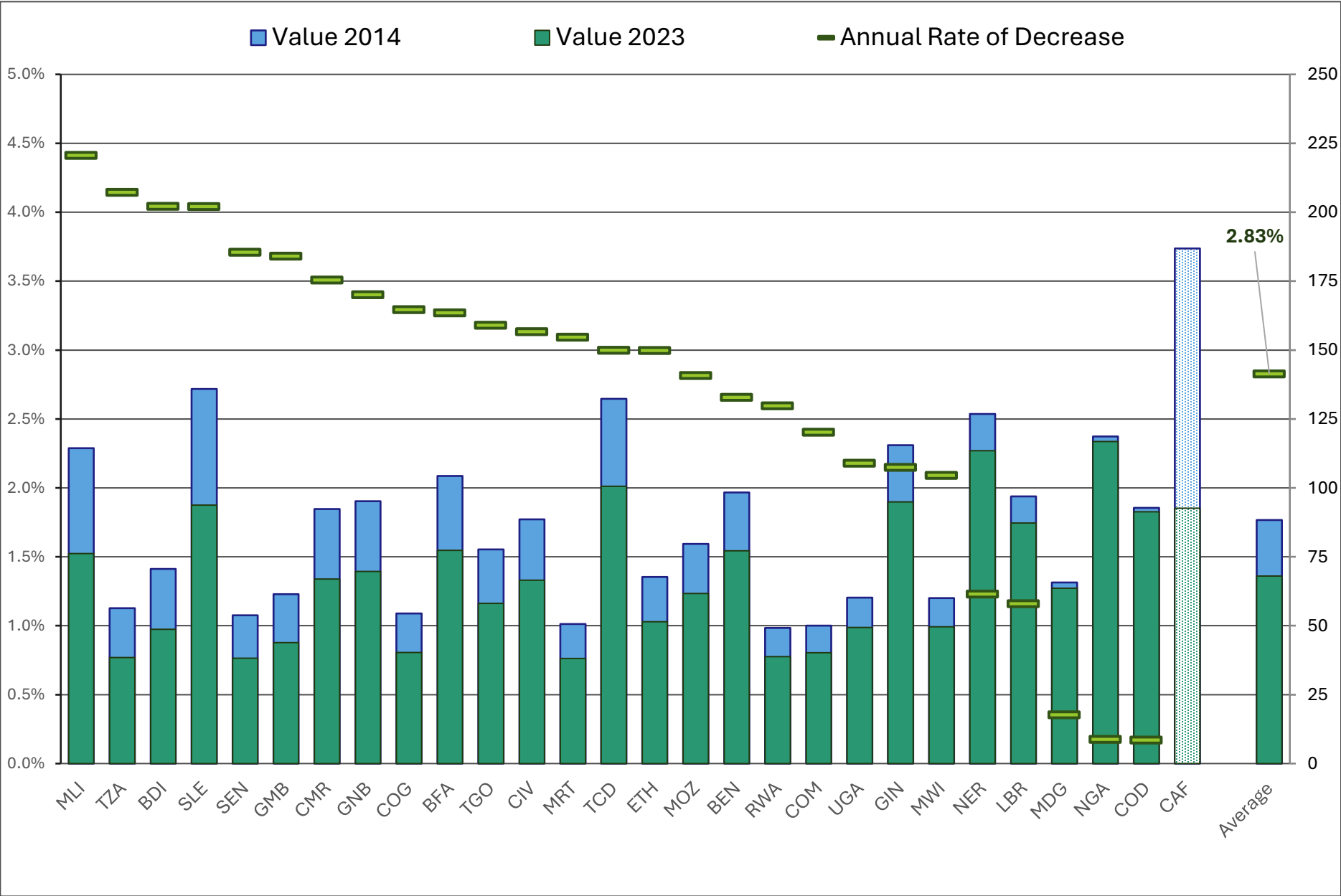
Figure 7: Child Mortality, Both Sexes, Sub-Saharan Countries in the Period 2000-2023



This graph shows the trend in mortality among children under five from 2000 to 2023 for the 28 countries in the sample. On average, the annual rate of decline in the first phase, up to 2010, was 4.5 per cent, whilst it slowed to 2.9 per cent in the second phase, from 2011 to 2019. This is consistent with trends in public health funding, where per capita expenditure almost doubled in the first phase, whilst in the second phase it increased by barely a fifth.

The fact that a rapid increase in financial resources goes hand in hand with a faster decline in child mortality is also evident in many individual countries. With an average annual decline in mortality of 10.1% (from 184 to 63 per 1,000), Rwanda made by far the greatest progress in improving the survival rates of young children between 2000 and 2010. During this period, public per capita expenditure for health increased seven and a half-fold, from 17 to 127 int. \$. In the years that followed, right up until the outbreak of the coronavirus crisis, healthcare spending stagnated, and infant mortality fell by just 3.8 per cent each year. A similar trend, albeit on a much lower level, can be observed in the Democratic Republic of the Congo (a reduction in child mortality of 5.8 per cent and 0.8 per cent). In this case, the comparatively slower progress in child health was very likely linked to the lack of further increase of health expenditure, but less favourable conditions in terms of poverty, regional inequality, reduced access to education and armed conflict are also likely to have played a part.

Figure 8: Child Mortality in the most Disadvantaged Countries South of Sahara in the Period 2014-2023



This graph shows the trend of under-five mortality in the selected Sub-Saharan countries over the ten-year period from 2014 to 2023. The columns represent the start and end points, while the bar-shaped markings indicate the average decline rates per year. The calculations rely on the data published by the UN Inter-agency Group for Child Mortality Estimation (UN IGME) in March 2026.

The fact that the average child mortality rate is currently more than two and a half times higher than the target set in SDG 3.2 underscores the need for a dramatic intensification of efforts to achieve this critical goal as soon as possible. In 11 of the countries considered, the infant mortality rate in 2023 stood at more than 75 per 1,000 live births, i.e. it was more than three times as high as the target. It is therefore imperative that both national governments and economically advantaged countries mobilise additional resources to close this disastrous funding gap.

Due to the uncertainty of the data, the Central African Republic is shown with dotted bars.

Main Trends of Child Mortality

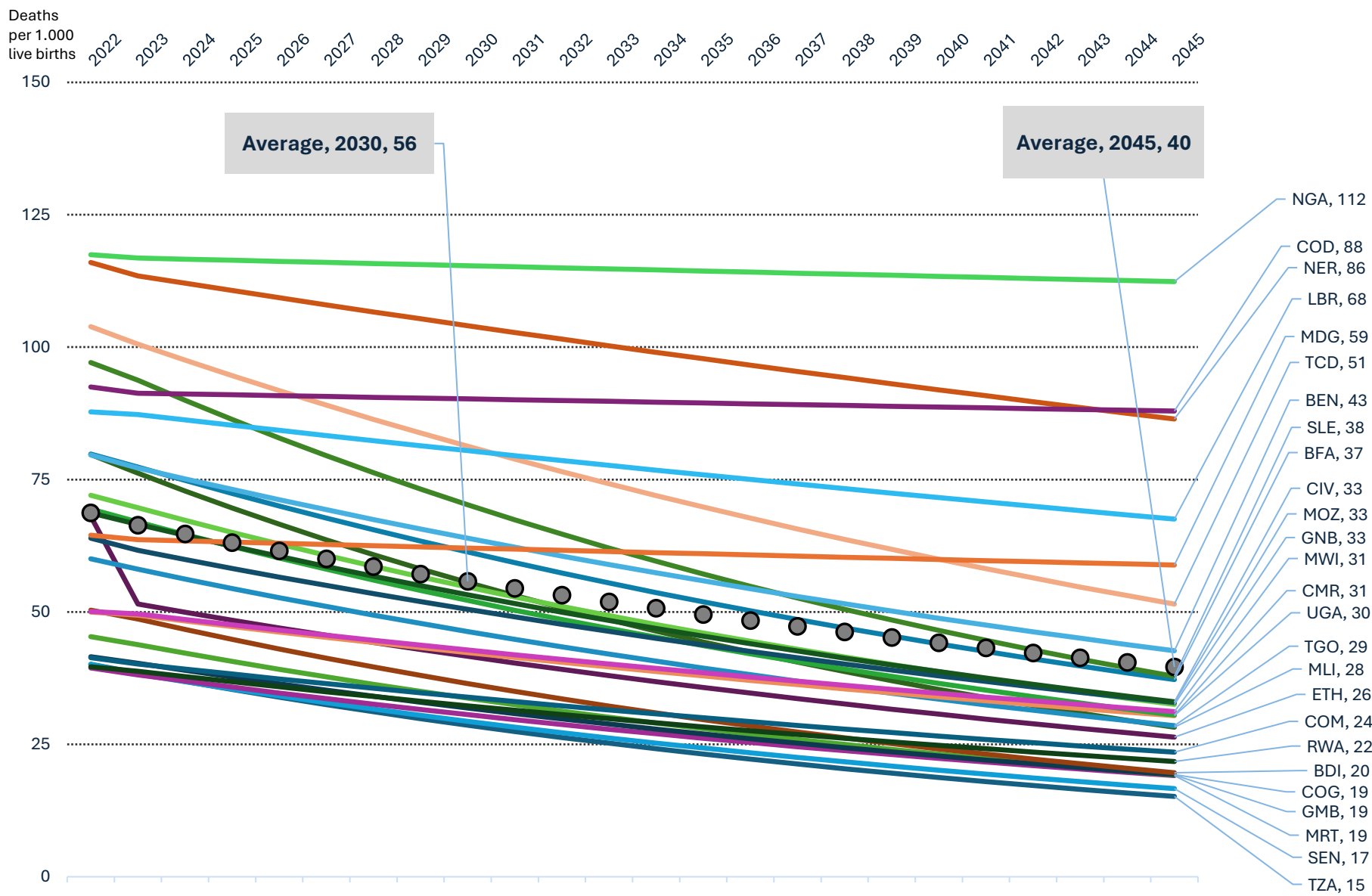
Argument

Child mortality fell more rapidly when public funding for healthcare was significantly increased

Key messages

- In general, countries that experienced a sustained increase in public funding achieved a sharper decline in mortality rates
- The greatest progress was made during the initial phase up to 2010, when public funding was increased the most
- Improvements in children's chances of survival may also have been aided by investments in relevant areas outside the health sector, as well as by political stabilisation
- Long-term investment appears essential

Figure 9: Projection of Child Mortality for the Period 2024-2045, Based on the 10-Year Trend 2014-2023



This chart confirms the conclusion drawn in the previous section, namely that virtually none of the countries examined will achieve SDG 3.2 on time unless significant efforts are made to improve children's chances of survival. If current trends continue, by 2040 – that is a decade after the end of the SDG timeframe – only seven of the 28 countries could achieve the target. The average under-five mortality rate in the countries studied is projected to be just under 50 per 1,000 by the middle of the next decade – which is twice as high as the maximum level set out in the 2030 Agenda. This would be a terrible failure on the part of the international community and this, of all things, in the context of one of the most devastating and irreversible consequences of injustice.

Nevertheless, we could greatly accelerate progress if we make this issue a top priority and take all necessary measures to achieve this central goal of the 2030 Agenda. This could save the lives of millions of young children and, at the same time, serve as an inspiration for humanity to work towards successfully overcoming other major challenges as well. It is worth bearing in mind that in 2024, in the 28 countries studied alone, over 2.4 million children under the age of five died, accounting for more than 52 percent of global deaths among children under five – a significant increase from 34 per cent in 2000.

Projections of Child Mortality until 2045

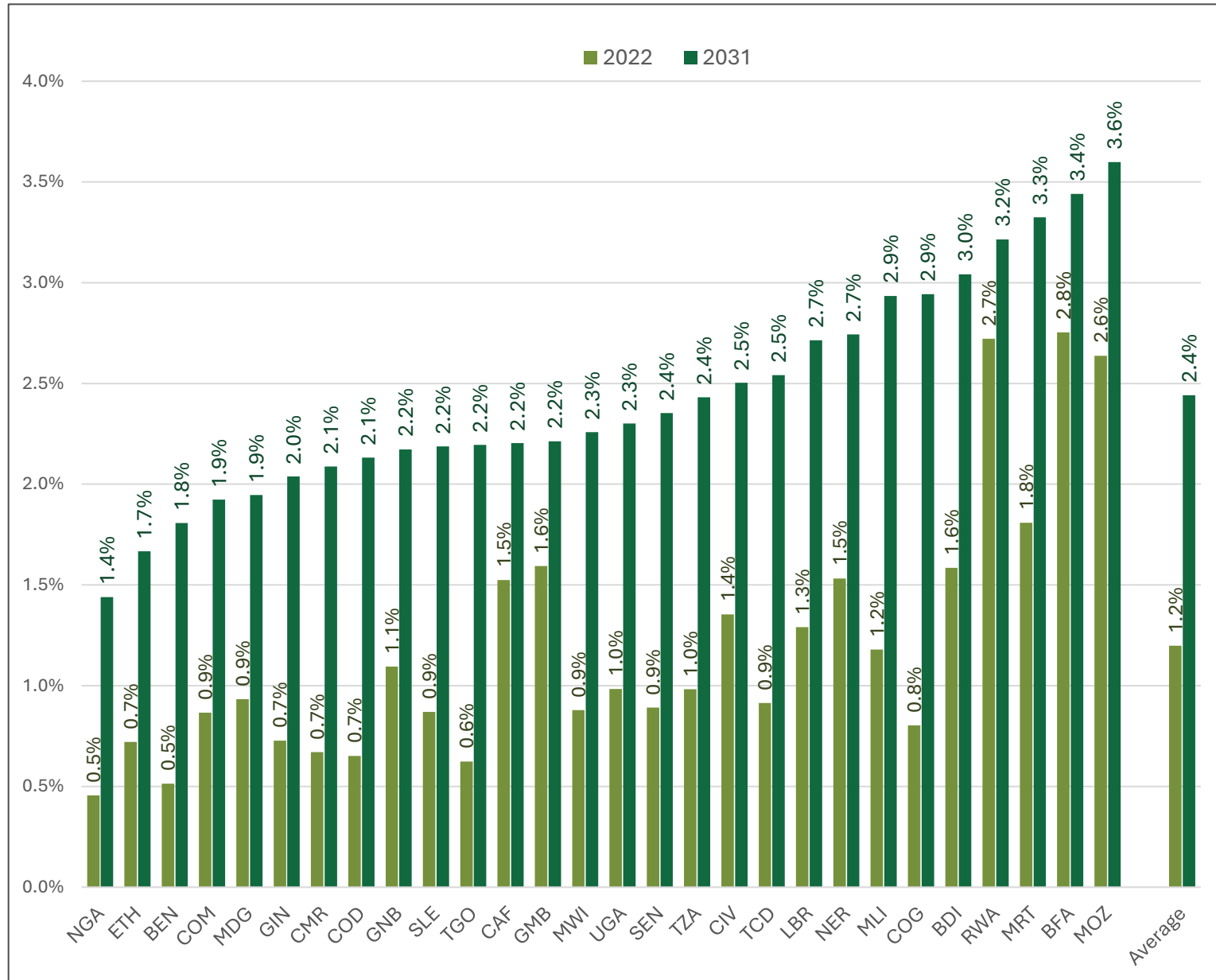
Argument

The progress currently being made is nowhere near enough to achieve SDG target 3.2 in the countries with the lowest levels of public health expenditure in sub-Saharan Africa

Key messages

- By 2045—that is, after another 15-year period—only 8 of the 28 countries will be able to achieve SDG 3.2 if current trends continue
- On average, 40 out of every 1,000 children in these countries would still die before their fifth birthday, and in six countries the figure would be over 50 out of every 1,000
- To make faster progress, significantly greater efforts are needed to improve children's chances of survival, particularly in terms of financial resources

Figure 10: Ambitious Efforts to Increase General Government Health Expenditure as a Percentage of GDP in Sub-Saharan Countries where average per capita public health expenditure was below 100 int. \$ (2021) during the period 2000–2022



Action-oriented research can help to determine what financial contribution can realistically be expected from additional efforts by national governments to mobilise domestic resources. We are therefore examining both means of raising further public funding for the health sector, namely increasing government revenue as a proportion of GDP and giving greater priority to the health sector in government spending. For these parameters, we intend to produce an estimate of both the final values to be achieved and the respective annual growth rates.

The interval 2012–2019 serves as the baseline period for estimating the government revenue that may be generated in the coming years, to avoid any potential distortions caused by severe crisis conditions. In terms of the expected share of public expenditure allocated to health, the response to the COVID-19 pandemic provides an extremely relevant precedent for examining the potential fiscal scope for mobilising additional funds for the health sector. We assume that all countries will, for both parameters, at least match the pace and target figures of the 25 per cent (7 out of 28) of countries with the best results. In the case of the budget share allocated to health, only the seven pioneering countries are considered, where the percentage was not affected by a decline in government revenue

This chart shows the base figures and interim results for 2031, the final year for which the IMF's World Economic Outlook (April 2026) provides GDP projections. On average, government revenue would rise from 15.3 per cent to 17.9 per cent of GDP, reaching 21 per cent when the countries achieve their respective final targets. At the same time, the share of public expenditure allocated to healthcare would rise from 8.5 per cent to 13.9 per cent, heading towards a threshold of 14.7 (average 15.1) per cent. Taken together, these two efforts would lead to a doubling of the share of national health care spending in GDP to an average of 2.4 percent by 2031, with a further increase to 3.3 per cent once the projected targets are achieved. This would mean that all countries would be making an unprecedented financial effort for health. This would mean that 25 countries would reach a higher level as early as 2031 than at any time since the global financial crisis

To observe both underlying parameters separately go to Complementary figures 1 and 2 (on pages 31 and 32).

The Potential for Mobilising Domestic Resources

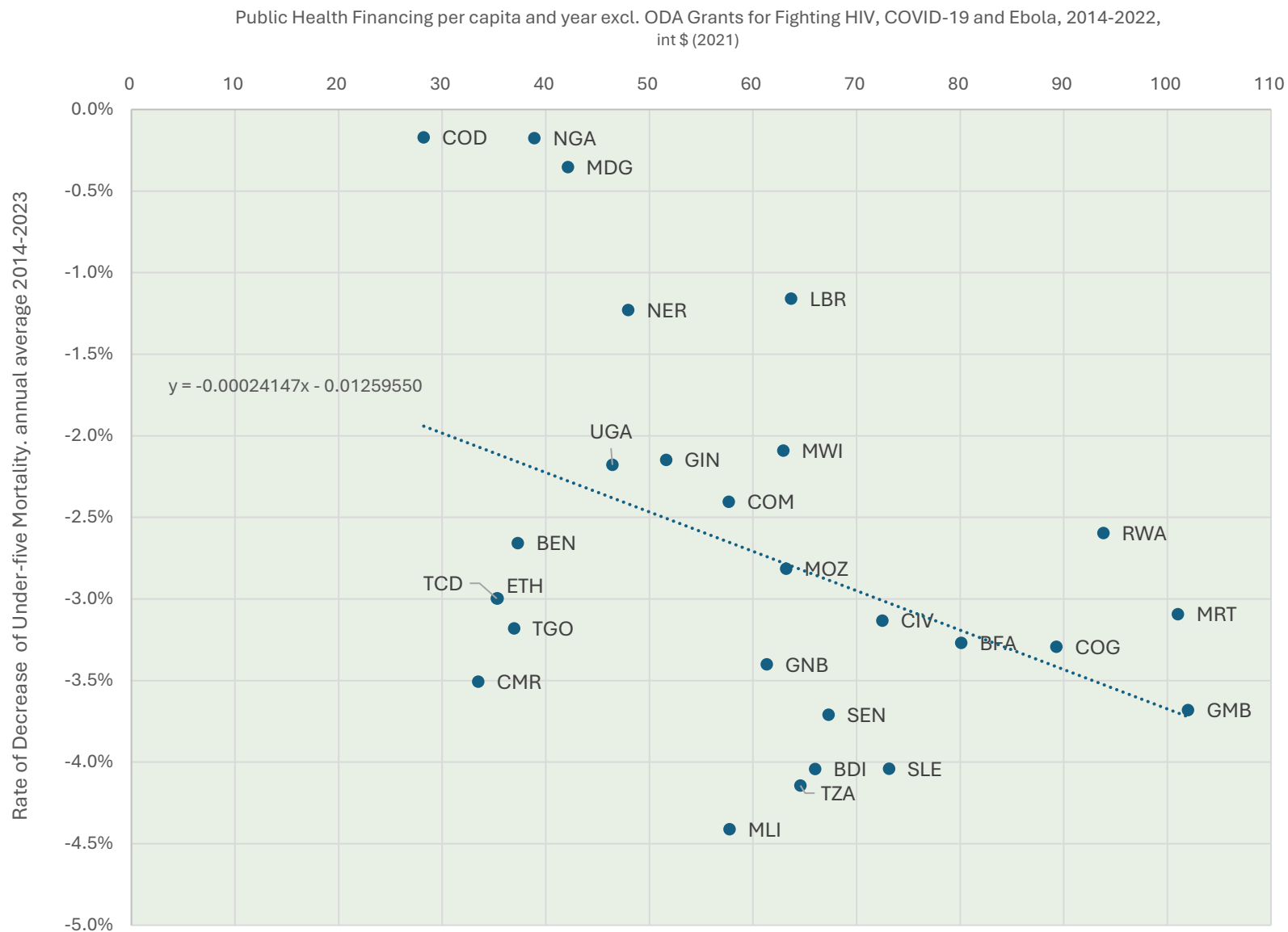
Argument

If we take the 25 per cent of countries that have achieved the best results in the recent past as a benchmark, domestic funding for health could be significantly increased by generating higher government revenue and giving greater priority to health expenditure in national budgets

Key messages

- Domestic resource mobilization is determined by government revenue in relation to GDP and the health share of public expenditure
- Countries that have achieved particularly good results in the past in mobilising and distributing revenue provide valuable guidance for future funding targets
- Nearly all sample countries could achieve their highest level of public health financing ever under this scenario

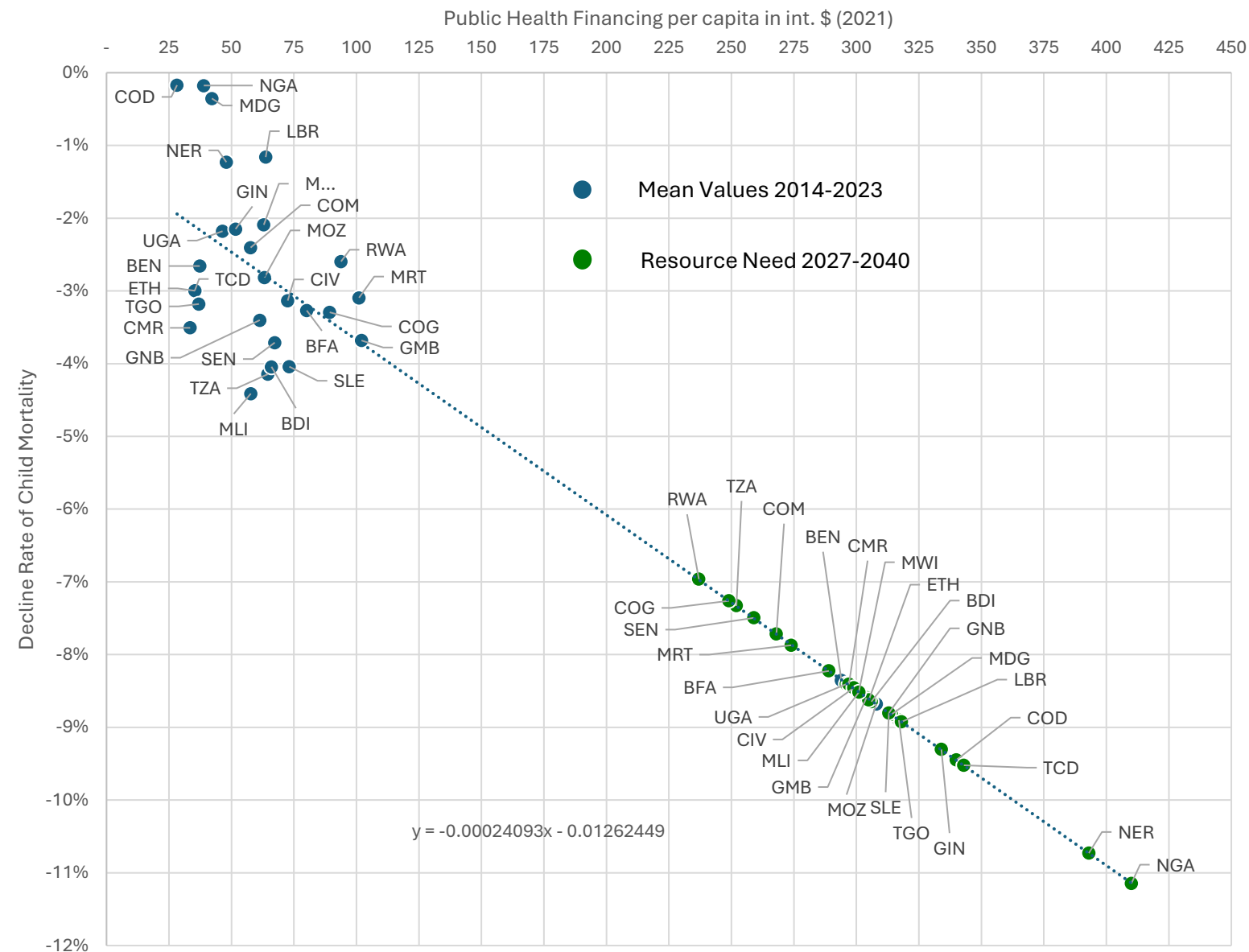
Figure 11: Statistical Correlation between Public Health Financing (excluding ODA grants for Epidemics) and the Annual Rates of Decline in Child Mortality



To develop a more reliable analysis of the relationship between public health financing and child mortality we opted for excluding ODA grants specifically directed to fight certain epidemics, namely HIV/AIDS, Ebola and COVID-19. These affect individual countries in very different ways and have prompted widely varying responses. The Ebola outbreak in Sierra Leone, Liberia, and Guinea, as well as the varying course of the HIV epidemic—which has hit countries in southern and eastern Africa the hardest—have prompted the international community to adjust the mobilization and allocation of official development assistance accordingly. Consequently, the ODA grants for combating these epidemic diseases accounted for roughly 40% of total public health financing in Liberia, Malawi, Mozambique and Sierra Leone compared to hardly 5% in Madagascar, Niger and Senegal over the period 2014-2022 (average: 19%). These funds helped to stabilise the health systems in the respective countries and, as a result, also to reduce child mortality. The enhancement of HIV treatment programmes significantly reduced AIDS-related child deaths especially in high prevalence countries. However, the focus on a limited number of countries, together with the relatively high level of resources allocated, suggests that considering comparability priority should be given to the other financial flows, which are more closely linked to preventing deaths from common childhood illnesses and more general health risks. For more details see complementary figures 3 and 4 (on pages 33 and 34)

Notwithstanding differences in health conditions, the graph shows a clear correlation between adjusted per capita health expenditure and the average rates of decline in mortality among children under five. According to the linear trend, every additional amount of 10 int. \$ is associated with an annual decline in child mortality by about 0.24 percent.

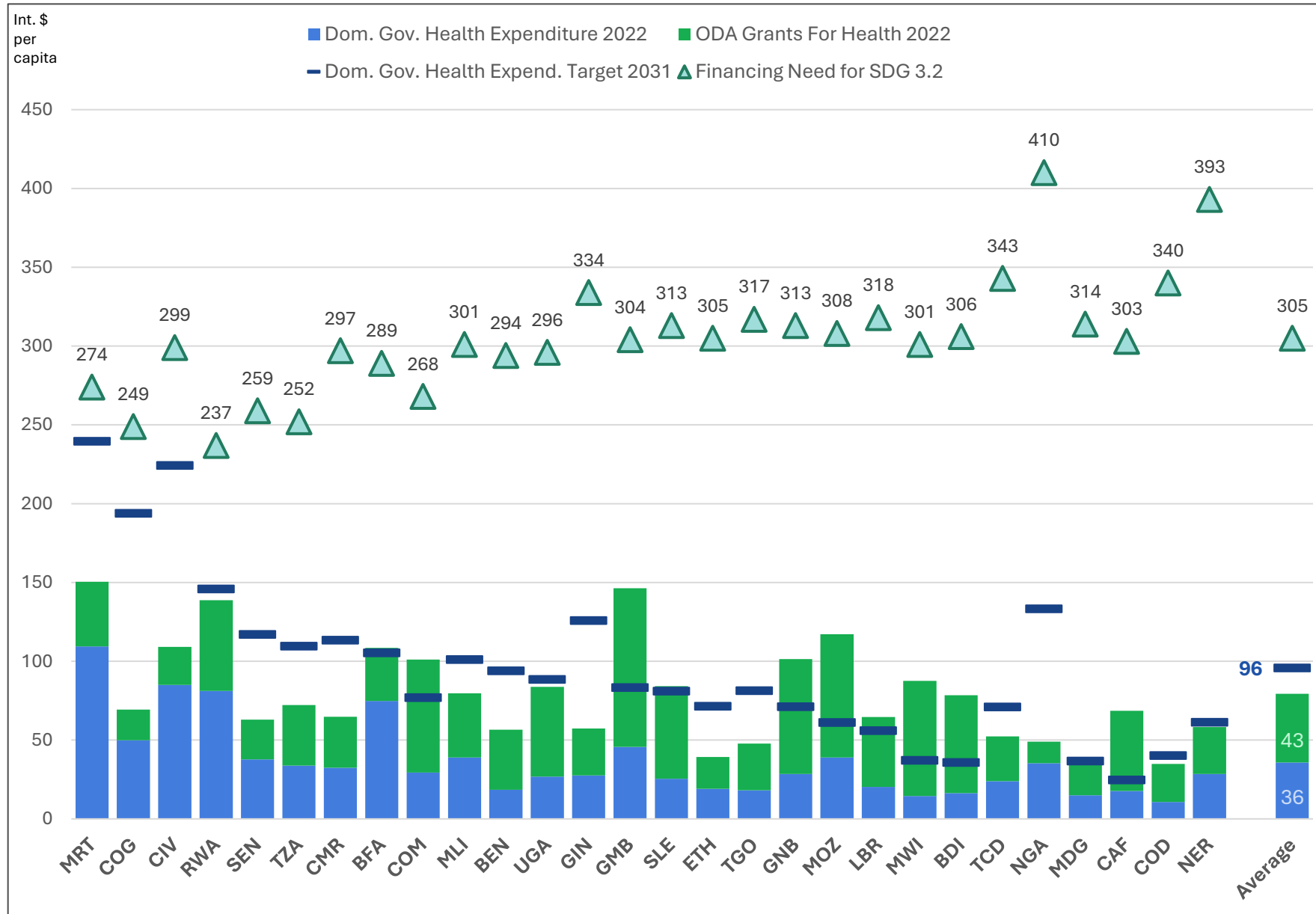
Figure 12: Projection of Annual Decline Rates of Child Mortality Depending on the Required per capita Amounts of Public Health Financing (excl. ODA Grants for Epidemics)



This chart illustrates the statistical relationship between the per capita levels of public health expenditure required to achieve SDG 3.2 and the annual rate of decline in child mortality, as indicated by the linear regression analysis. According to this simplified calculation – which is, however, derived from real-world conditions – public expenditure on health would need to be shifted along the horizontal axis from the blue to the green markers for each country to enable them that mortality among children under the age of five is reduced at the necessary rate shown on the vertical axis. The inaccuracies associated with this estimation method seem minor when we keep the objective in mind and take into account the allocation of resources to other purposes that are far less essential to human development.

Other countries in sub-Saharan Africa with higher per capita public expenditure on health, such as Cape Verde and São Tomé and Príncipe, demonstrate that a rapid reduction in child mortality is, in principle, achievable. These two countries reduced under-five mortality by 6.4 per cent annually, which is almost as fast as the target average of 8.6 per cent set for the selected countries. However, in 2023, the figures stood at 12 and 14 per 1,000 live births respectively, which is significantly lower than the SDG target. This may well explain why expenditure (excluding funding for epidemics control) was 50 and 32 per cent higher than would be expected based on the trend in the 28 far more disadvantaged countries. These examples suggest that, at lower mortality levels, more resources are needed to make further progress.

Figure 13: Public Financing for Health: Baseline Values in 2022 and Projected National Contributions in 2031 in Relation to Resource Needs for Achieving SDG 3.2, sorted by Size of Financing Gap



This chart compares the funding requirements for public health with the ambitious targets for domestic funding which, according to our projections, should be achieved by the national governments of the countries included in the sample by 2031. Furthermore, it shows the public resources for health made available in 2022 from both sources, namely internal government revenue and ODA grants. Countries are sorted by the amount of the remaining financing gap.

The total resources required from domestic sources and development partners combined would range from 410 (Nigeria) to 237 (Ruanda) int. \$ per capita with an average of around 305 int. \$. Even if the ambitious domestic funding targets were to be met by 2031, 10 out of the 28 countries examined would not be able to cover the 2022 level of public expenditure per capita through their own contributions by that time. In the absence of international cooperation, public financing for health would decline by 33 int. \$ across these nations. It is important to note that no country would be able to mobilise the resources required to achieve SDG 3.2 by 2031. The estimated funding gaps range from 34 to 332 int \$ (2021) per capita per year, with the simple average standing at 209 int \$. On average, these countries could raise almost a third of the funds required to implement SDG 3.2 by 2031.

The figures demonstrate that international cooperation is essential for the financing of healthcare systems in disadvantaged countries that are capable of sufficiently accelerating the decline in child mortality and ultimately achieving SDG 3.2 by the end of the next decade at the latest.

Financing the Path to SDG 3.2

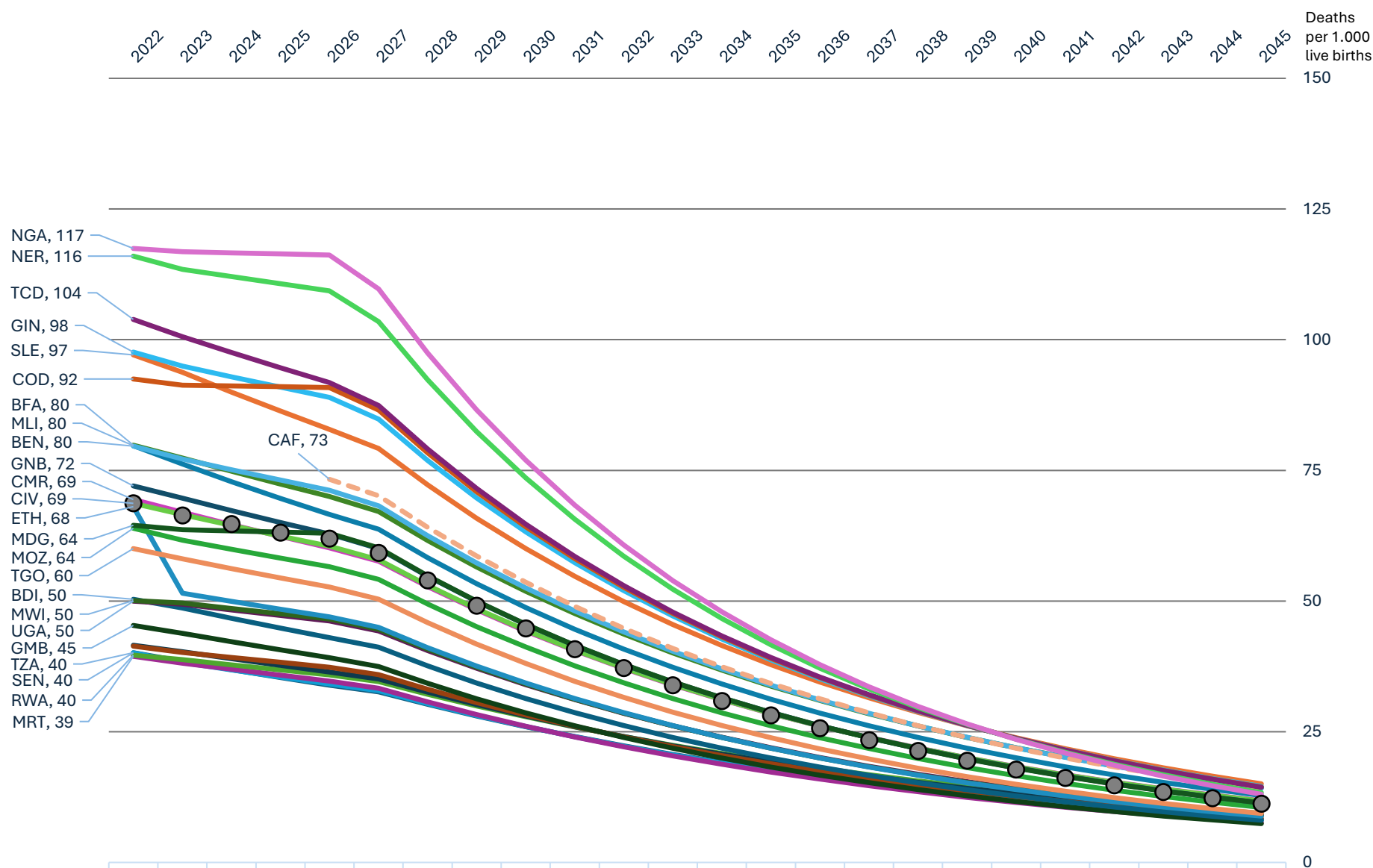
Argument

An increase in public health expenditure to an average of 305 international dollars per capita per year could enable most countries in sub-Saharan Africa to achieve SDG target 3.2 within the next decade

Key messages

- The country-specific funding requirements are based on a comparative analysis of progress to date in reducing child mortality
- According to the projections, even the most disadvantaged countries will achieve SDG 3.2 under the proposed funding scenario
- Sustained funding is crucial to accelerating improvements in the survival rates of young children

Figure 14: Projection of Child Mortality for the Period 2022-2045, Africa South of Sahara, Based on the 10-Year Trend for 2014-2023 and an Increase of Public Health Financing per Capita to an Average of nearly 275 int. \$ 2027-2045



There is no doubt that achieving SDG 3.2 in the most disadvantaged countries will require additional financial efforts. The comparative analysis of the countries studied provides important insights for estimating the total funding required to bring about the necessary acceleration.

On average, a \$10 per capita increase in public funding for essential health services between 2014 and 2022 was associated with a 0.24 per cent acceleration in the annual rate of decline in child mortality, which would correspond to a 2.4 per cent improvement for every additional investment of \$100.

This chart illustrates the expected trend in child mortality if funding were increased to the respective target levels derived from the analysis results set out above and the planned achievement of SDG 3.2 over the course of the coming decade. In this model, the additional investment in the first year (2027) would initially bring about only 50 per cent of the calculated acceleration.

Whilst seven countries with relatively low mortality rates would achieve the SDG target as early as the beginning of the decade (2031/32), the ten most disadvantaged countries would not do so until the end of the decade (2038/39). In the remaining ten countries, child mortality would fall below this threshold in the intervening years.

Achieving SDG 3.2 in the Most Disadvantaged Countries over the Next Decade

Argument

These additional funding efforts could accelerate the decline in child mortality and significantly mitigate one of the most dramatic consequences of socio-economic inequality

Key messages

- Funding targets must be set in line with country-specific development trends that reflect structural and epidemiological circumstances
- Adequate public funding for health can help to reduce child mortality, thereby enabling the target set by the international community to be achieved, albeit up to a decade later
- Improving the living conditions and educational opportunities of disadvantaged groups, as well as protecting them from violence, can also help to save children's lives

International Cooperation Remains Essential

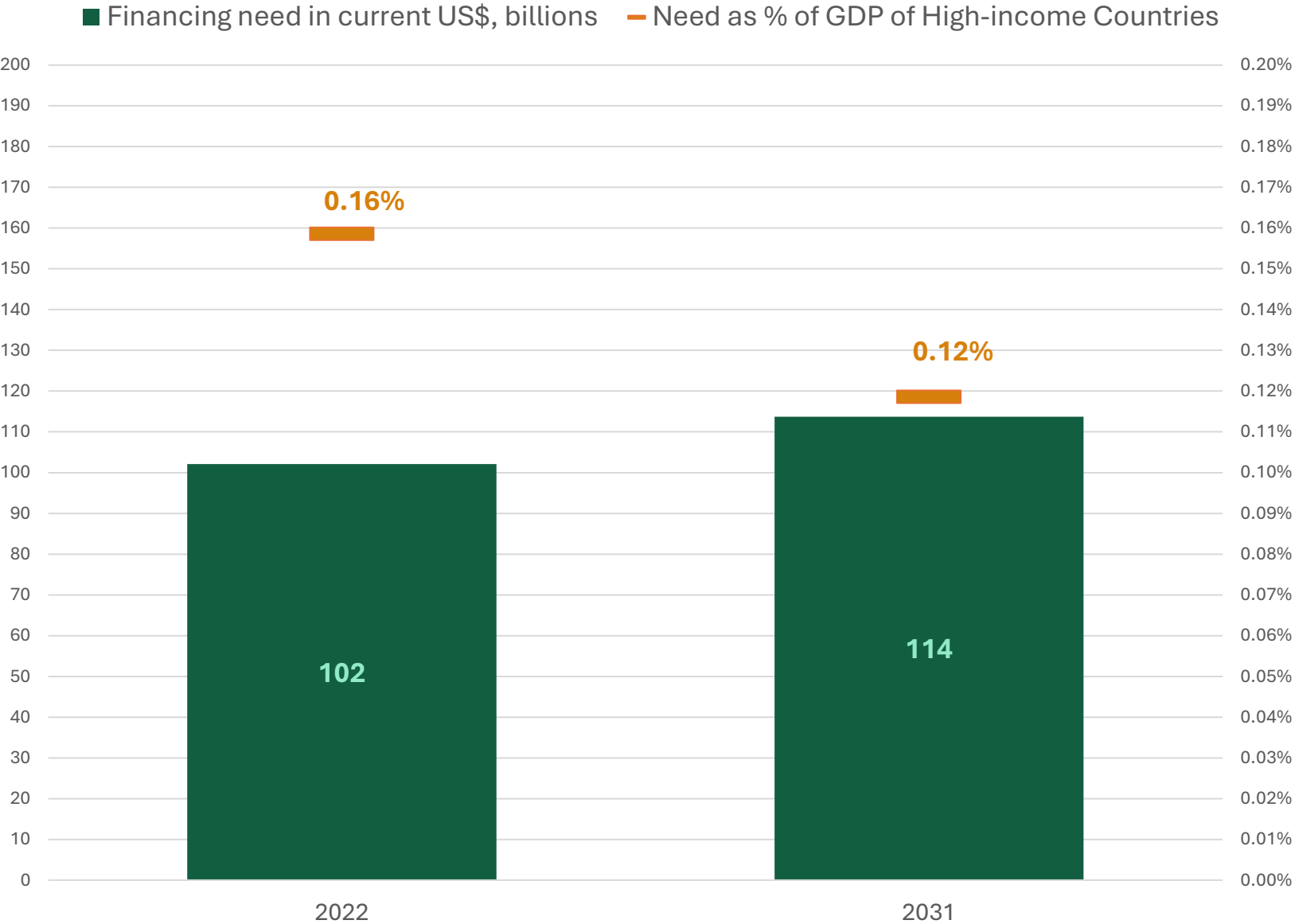
Argument

Mobilising domestic resources alone is not enough to achieve SDG 3.2, which is why sustainable international financing is indispensable

Key messages

- The projected domestic funding falls far short of what is needed to achieve SDG 3.2
- Even under the ambitious scenario, many countries would be unable to maintain even the current, inadequate level of health funding solely from their own resources
- The largest financing gaps remain in countries with the lowest levels of public health financing and the highest death risks among children
- Long-term international support is essential to complement increasing domestic investments

Figure 15: Required International Cooperation to Achieve SDG 3.2 in Countries in Need in Sub-Saharan Africa
(Estimates based on our own calculations as well as relevant economic parameters and forecasts from the IMF)



This chart shows the ODA grants that high-income countries must provide to achieve SDG 3.2. It shows both the amounts converted into current US dollars and the percentage share of the total GDP of the more economically advantaged countries. Whilst the figures for the base year 2022 are hypothetical, the figures for 2031 represent the interim target to be achieved. This calculation is based on IMF data and forecasts regarding country-specific GDP figures, inflation indices and exchange rates, also considering the domestic financing efforts described above.

Whilst the countries most disadvantaged in terms of health financing would mobilise an additional 1.2 per cent of GDP by 2031 (and 2.0 per cent if the expected financial efforts were fully implemented in subsequent years), the economically privileged nations would contribute between 0.16 and 0.12 per cent of their economic output, presumably on a declining trend as the mobilisation of domestic resources progresses. Measured against their respective economic capacities, the former countries' financial contributions towards the common target would, on average, be many times higher than those of the latter.

The specific scope of cooperation required to achieve SDG 3.2 will depend on the support provided by development partners for the mobilisation of additional domestic financial resources and on the efficiency improvements associated with investment in the individual components of the health system. Measures in these areas would have the greatest impact on cooperation needs if they were targeted at the countries that account for the largest share of the total financing gap, such as the Democratic Republic of the Congo and Nigeria.

It is important to note that the funding required to combat AIDS and other epidemics must be considered separately as well as the additional need for general health funding in other disadvantaged countries.

Sharing the Financial Responsibility

Argument

Achieving SDG 3.2 will require sustained international cooperation combined with ambitious increases in domestic health financing

Key messages

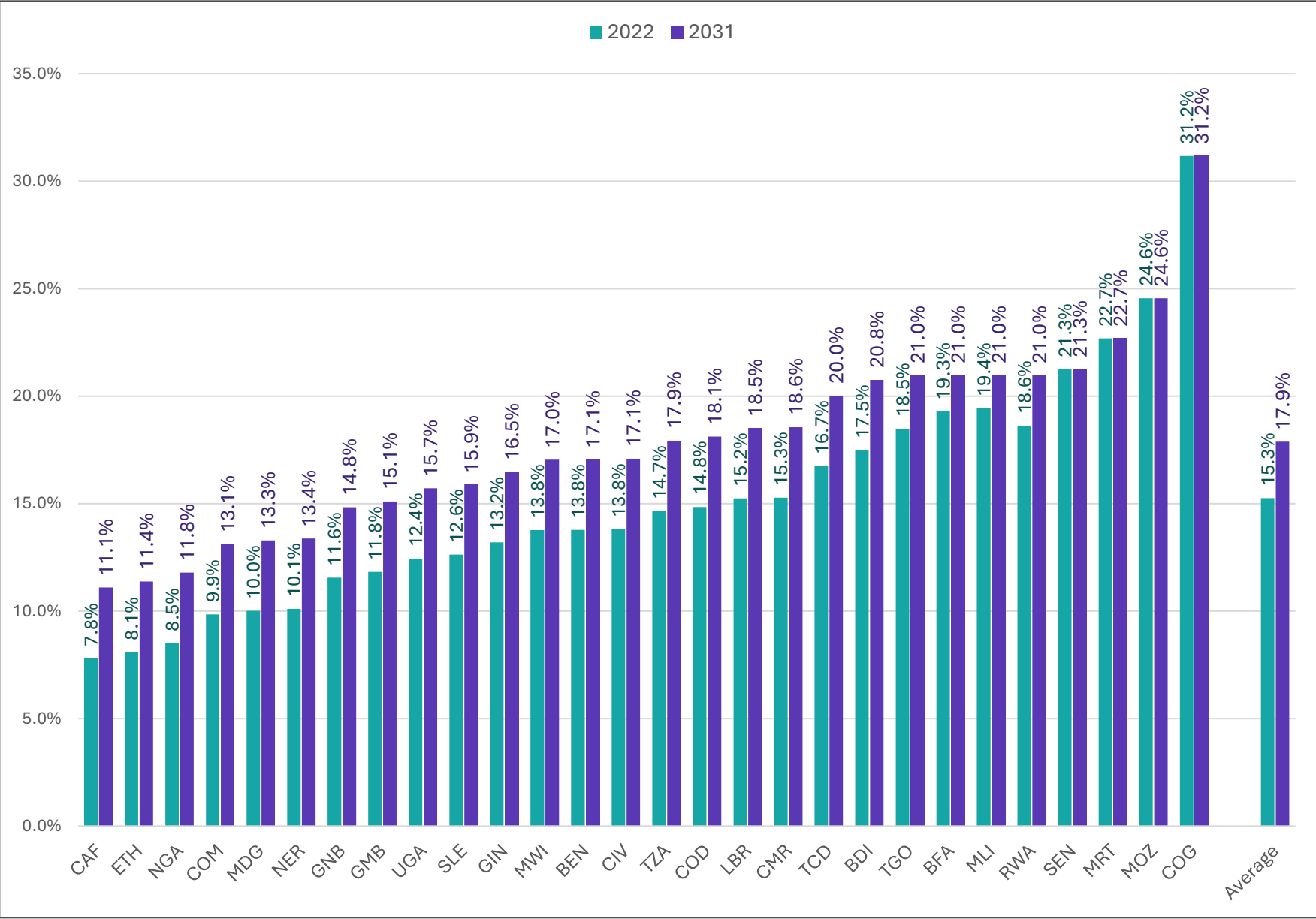
- Mobilising domestic resources alone is not enough to meet the funding requirements for achieving SDG 3.2
- International cooperation for health should complement domestic financing efforts to bridge the funding gap
- According to the projections, lower-income countries would make a significantly greater financial contribution relative to their economic capacity than high-income countries
- Priority should be given to countries with the largest funding gaps in order to maximise the impact of development assistance

Key Takeaways

Main conclusions

- Public health financing from both domestic sources and development assistance is strongly associated with child survival
- Historical trajectories provide valuable evidence for estimating financing requirements
- Domestic financing and ODA should be viewed as complementary
- Increasing public health financing remains essential for achieving SDG 3.2
- By taking decisive action, the international community could achieve this crucial goal and thereby set an inspiring example of human solidarity
- Solidarity-based support for health systems in disadvantaged countries must also encompass the fight against and tackling of AIDS and other epidemics, for which this approach cannot provide estimates

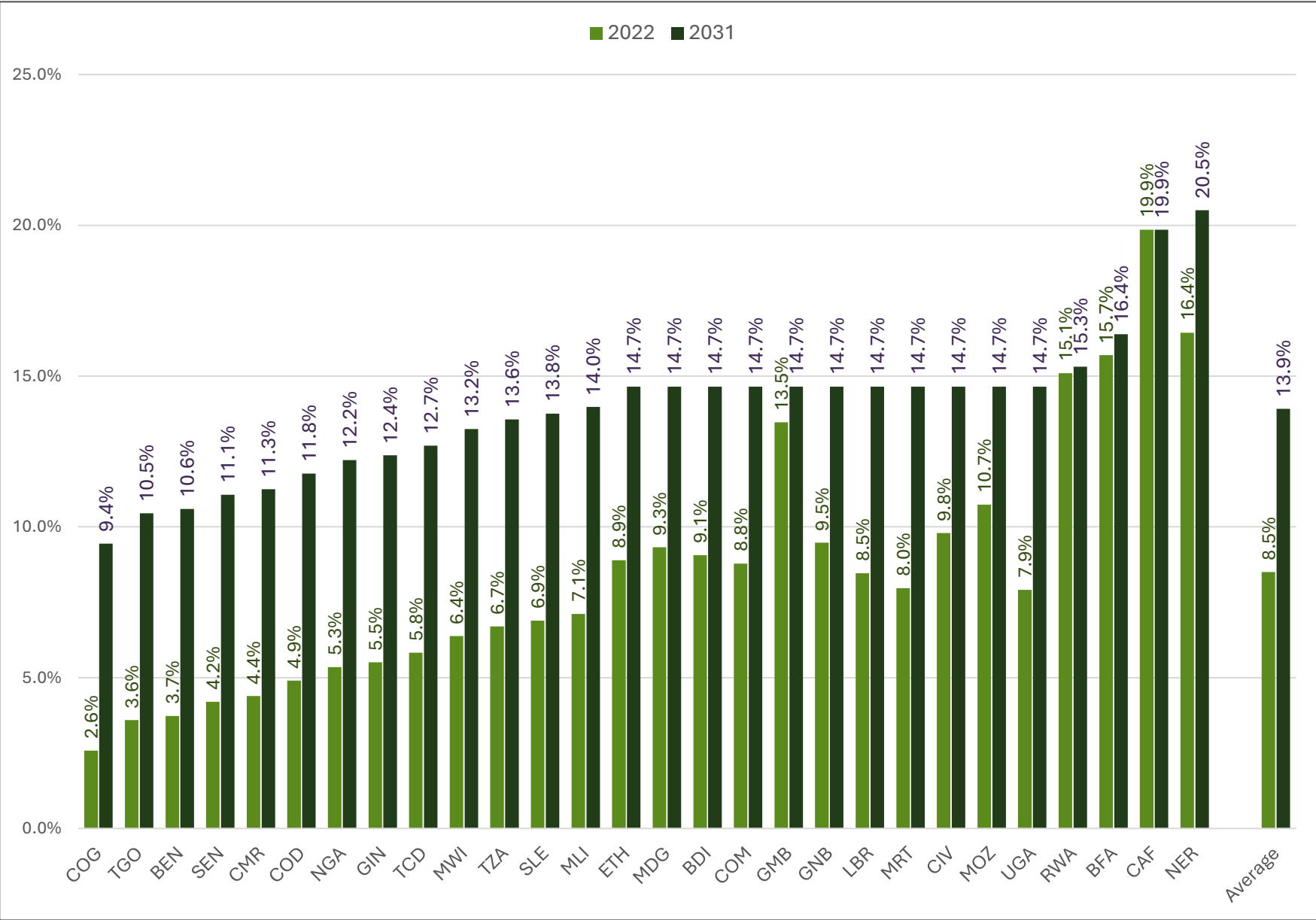
Complementary Figure 1: General Government Revenue as % of GDP in the Sample Countries in Sub-Saharan Africa



This chart shows government revenue as a share of GDP that the most vulnerable countries should achieve by 2031 – the final year of the financing scenario due to data availability – and also illustrates the increase compared with the base year of 2022. The methodology – which is based on the performance of the top 25 per cent of the selected countries over the period 2012–2019 – sets out ambitious yet realistic targets for the mobilisation of domestic resources, using two key indicators: the level to be achieved by the end of the period and the expected annual rate of increase. Consequently, the overall timeframe extends beyond 2031, and in 19 of the 28 countries the target level would not be reached until subsequent years. If all countries were to achieve the final target, the average level of government revenue as a proportion of GDP would stand at 21.6 per cent.

The fact that 12 of 28 countries showed a negative trend in the reference period underlines the ambitious nature of the scenario.

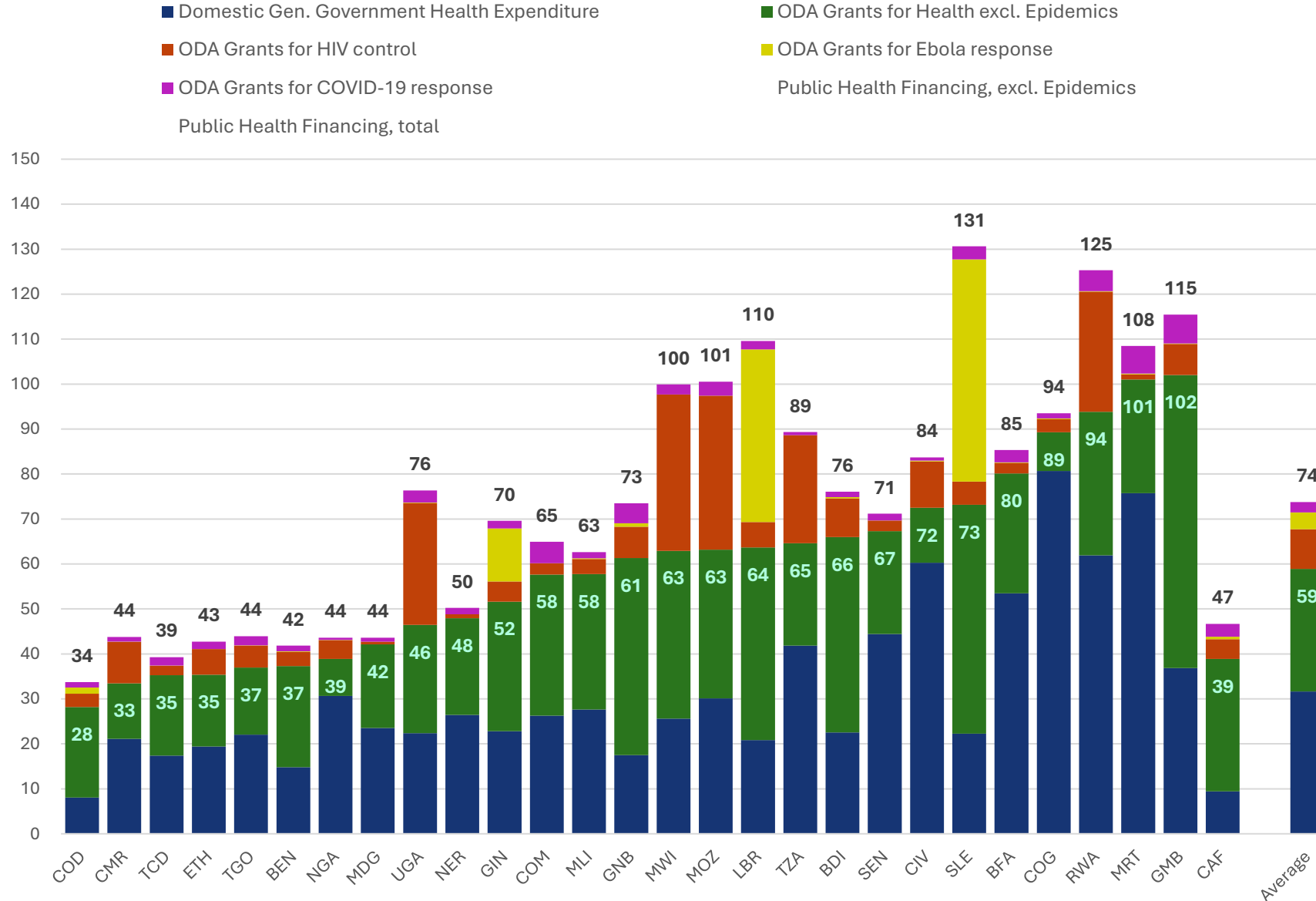
Complementary Figure 2: General Government Health Expenditure from Domestic Sources as % of Government Revenue in the Sample of Sub-Saharan Countries



This chart shows the current and future share of healthcare expenditure in total government revenue from domestic sources such as taxes, social security contributions and other revenue.

The crisis response to the COVID-19 pandemic serves as a benchmark for setting the target ratios and the annual growth rates to be achieved. Here, too, the individual funding targets correspond to the average of the 7 (25 per cent) countries with the best results. This actual progress made in mobilising public resources defines the minimum target for future efforts. However, this calculation only takes into account increases in health shares that were not favoured by a simultaneous reduction in government revenue. Furthermore, for all countries that achieved higher shares in any other two-year period between 2018 and 2022, this figure has been set as the target. The increase derived from the response to the COVID-19 pandemic is expected to be realised within two years, after which annual growth rates of 50 per cent of this value are anticipated.

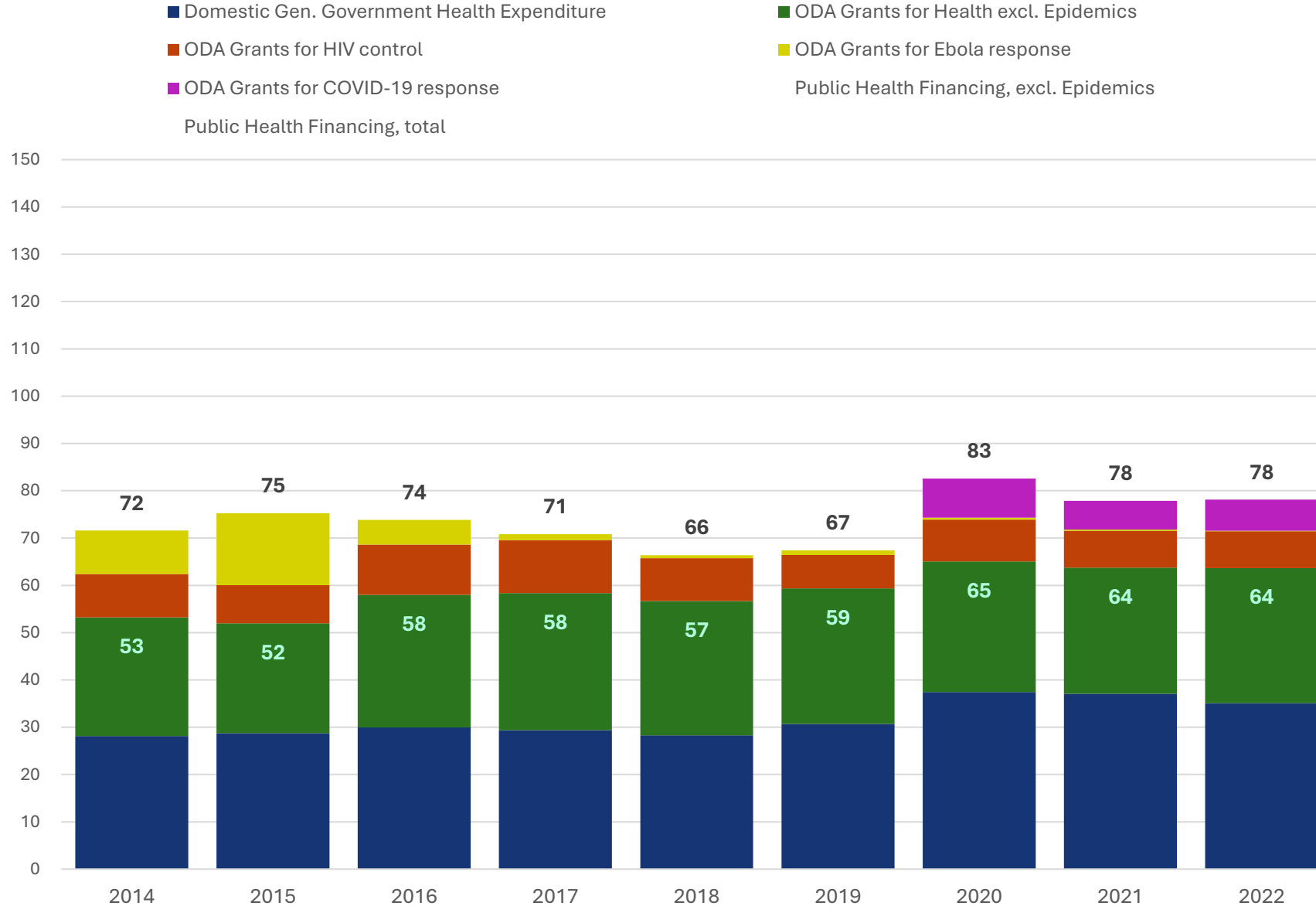
Complementary Figure 3: Public health funding from domestic sources and development cooperation, with a focus on ODA grants for epidemic control in the sub-Saharan African countries under review; annual average per capita amounts for the period 2014–2022 in international dollars



This chart shows average figures for public health expenditure per capita per year in the selected countries. A distinction is first made between resources raised from domestic taxes and social security contributions, and grants provided as part of development cooperation. In addition, ODA grants for combating epidemics, namely HIV/AIDS, Ebola and COVID-19, are shown separately. As explained in the notes to Figure 11, the latter are excluded from the analysis in order to enable a rigorous assessment of the relationship between public health funding, on the one hand, and progress in reducing child mortality, on the other. The figures shown represent the amounts both with and without the inclusion of these epidemic-specific ODA contributions. This makes it clear that, in several countries, ODA grants for tackling HIV or Ebola account for a large proportion of public health funding. Whereas these countries tend to be among the top performers in the sample in terms of total amounts, they tend to be in the middle of the field when these special contributions are excluded.

The Central African Republic is shown at the end of the list because, due to the lack of reliable data on child mortality, this country was not included in the regression analysis.

Complementary Figure 4: Public health funding from domestic sources and development cooperation, with a focus on ODA grants for epidemic control on average across the selected countries, simple mean values for the years 2014 to 2022



This chart depicts the same components of public health financing as in the supplementary Figure 1, but shows the trend in the simple averages for the 28 countries in the sample over time. This reveals that the specific ODA grants allocated to combat the Ebola outbreak in West Africa had a significant impact on public health financing in the early years of the period in question, even though the funds allocated for this purpose were concentrated in just three countries. During the COVID-19 pandemic, the special funds allocated to contain the outbreak played a key role, although there were significant variations in the per capita amounts. Contributions towards tackling the HIV pandemic fell considerably after 2017, primarily due to a reduction in countries particularly affected by the pandemic, such as Mozambique, Malawi, Uganda and Tanzania. The remaining ODA grants, which did not provide specific support for the control of the three epidemics, also showed a stable trend up to 2019 and increased between 2020 and 2022. A similar trend can also be observed in the health financing from domestic sources.

Data Sources Used

- [IMF: World Economic Outlook Database. April 2026 Edition](#)
- [IMF: World Revenue Longitudinal Database \(WoRLD\)](#)
- [OECD data explorer: CRS: Creditor Reporting System \(flows\)](#)
- [OECD data explorer: DAC1: Flows by provider \(ODA+OOF+Private\)](#)
- [OECD data explorer: DAC2A: Aid \(ODA\) disbursements to countries and regions](#)
- [UNAIDS 2025 estimates, HIV estimates with uncertainty bounds 1990-2025](#)
- [UN IGME](#)
- [United Nations: Department of Economic and Social Affairs, Population Division \(2024\). World Population Prospects 2024](#)
- [UNU-WIDER Government Revenue Dataset, 2023](#)
- [World Bank Group: International Comparison Program, World Bank | World Development Indicators database, World Bank | Eurostat-OECD PPP Programme: GDP, PPP \(constant 2021 international \\$\)](#)
- [World Health Organization: WHO Global Health Expenditure Database \(GHED\)](#)
- Own database of all health-specific aid activities for the years 2014 to 2022 registered in the DAC/OECD creditor reporting system classified by health subsectors and programme areas after project-level review

Imprint

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