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SADC and the Abuja Declaration: Honouring the Pledge

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Recommendations

- Establish a SADC healthcare fund, backed by the African Union, as an additional source of finance when member states experience health budget shortfalls and are unable to meet their annual 15% allocation under the Abuja Declaration.
- Form regional health public–private partnerships to leverage additional funding sources and private-sector expertise in addressing healthcare challenges.
- Strengthen existing domestic resource-generation mechanisms (such as tax compliance) to improve countries' fiscal position.
- Involve civil society organisations in ensuring transparency in governments' health-financing policy formulation and implementation processes.

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Executive summary

In 2001, the African Union (AU) member states signed the Abuja Declaration, thereby pledging to allocate at least 15% of their national budgets each year to improving their healthcare systems. To this day, fulfilling this pledge has been a struggle for the Southern African Development Community member states. Having caused unprecedented damage, the COVID-19 pandemic has been a wakeup call for the region. It also presents a unique opportunity for governments to critically examine their healthcare systems with a view to buttressing them against COVID-19 as it continues to play out and any possible future crisis. Although there has been a groundswell of political and public support in SADC for more funding to go to healthcare, governments need to find new and innovative sources of funds, particularly in the face of a declining regional economy. Proposed options include forming a regional (supplementary) fund, strengthening local finance-generating mechanisms (such as improving tax compliance) and involving civil society organisations in ensuring transparency in governments' use of funds.

Background

The Southern African Development Community (SADC) is one of the largest regional economic communities (RECs) in the AU, with 16 member states.[1] However, insufficient investment in public healthcare and generally poor access to healthcare are key challenges faced by all SADC member states.[2] Given this troubling picture, governments in the SADC region have committed to improving the health and wellbeing of their citizens[3] by committing to global initiatives such as the UN Sustainable Development Goals (SDGs)[4] and the Abuja Declaration of 2001, which falls under the auspices of the AU.

Abuja Declaration and SADC member states

In April 2001, the SADC heads of state and governments, together with other AU member states, met in the Nigerian capital city of Abuja and signed the Abuja Declaration on health in Africa. The Abuja Declaration calls on all signatory countries to prioritise investment in

1 SADC member states are: Angola, Botswana, Comoros, Democratic Republic of Congo (DRC), Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, Tanzania, South Africa, Zambia and Zimbabwe.

2 Ranchod C, D Erasmus, M Abraham, J Bloch, K Chigiji & K Dreyer, 'Effective Health Financing Models in SADC: Three Case Studies' (Report by Insight Actuaries and Consultants, FinMark Trust, April 2016), https://www.mm3admin.co.za/documents/docmanager/f447b607-3c8f-4eb7-8da4-11bca747079f/00104930.pdf.

3 Southern African Development Community (SADC), 'Social and Human Development,' documents and publications, no date, https://www.sadc.int/sadc-secretariat/directorates/office-deputy-executive-secretary-regional-integration/social-human-development-special-programmes/; SADC, 'Health Policy Framework,' documents and publications, no date, https://www.sadc.int/themes/health/#HealthPolicyFramework.

4 The Sustainable Development Goals (SDGs) are a set of universal goals and targets agreed upon in September 2015 by 194 UN member states to guide their development policies.

public health. The agreement was the result of the growing realisation that the continent's human, political and economic development is dependent on the health of its people.[5] One of the key features of the declaration is a binding pledge to allocate at least 15% of a country's annual budget to improving the health sector. It also calls for donor countries to scale up financial support for the health sector.[6]

As signatories to the Abuja Declaration, SADC member states have found that meeting the annual target of allocating 15% of their national budgets to healthcare is a continuing struggle. Indeed, the push towards the more sustainable allocation of resources to healthcare requires that governments in the SADC region, as in the rest of Africa, increase investment in all facets of the healthcare system. However, a review by the World Bank in 2011, just 10 years after the signing of the Abuja Declaration, on progress made in signatory countries' meeting of the 15% target found that only South Africa – out of the 16 SADC member states – had the potential to achieve that target.[7]

The latest data from the World Bank's World Development Indicators shows that countries in the SADC region are failing to spend enough on public health. For example, during the period 2011–2015, SADC's total health expenditure as a percentage of gross domestic product (GDP) was around 6.4%.[8] Although the results of recent empirical research suggest that at the end of 2015 most countries in Africa were still struggling to reach the 15% target,[9] there was also evidence that SADC countries had nevertheless made progress in the area of public health investment and had sustained their current health expenditure (CHE) allocation for certain periods between 2001 and 2014. Botswana and Malawi reached this expenditure level in 2003, Mozambique from 2001 to 2006, Eswatini from 2008 to 2011 and Zambia from 2004 to 2011.[10] In 2011, Tanzania even met the Abuja Declaration target of allocating 15% of its total budget to the health sector.[11] However, the most recent data from the World Health Organization's (WHO) Global Health Expenditure Database shows that at the end of 2018, all SADC member states were struggling to meet the 15% annual target (see Figure 1).[12]

5 Olalekan U, CS Wiysonge, M Ota, M Nicol, G Hussey, P Ndumbe & B Mayosi, 'Increasing the Value of Health Research in the WHO African Region Beyond 2015—Reflecting on the Past, Celebrating the Present and Building the future: A Bibliometric Analysis,' *British Medical Journal* open 5, no. 3 (2015); Angus D & R Tortora, 'People in Sub-Saharan Africa Rate their Health and Health Care among the Lowest in the World,' *Health Affairs* 34, no. 3 (2015): 519–527.

6 World Health Organization, 'The Abuja Declaration: Ten Years On' (WHO, Geneva, 2011), https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1.

7 WHO, 'The Abuja Declaration'.

8 WHO, 'Global Health Expenditure Profiles,' database, no date, https://apps.who.int/nha/database/country_profile/Index/en.

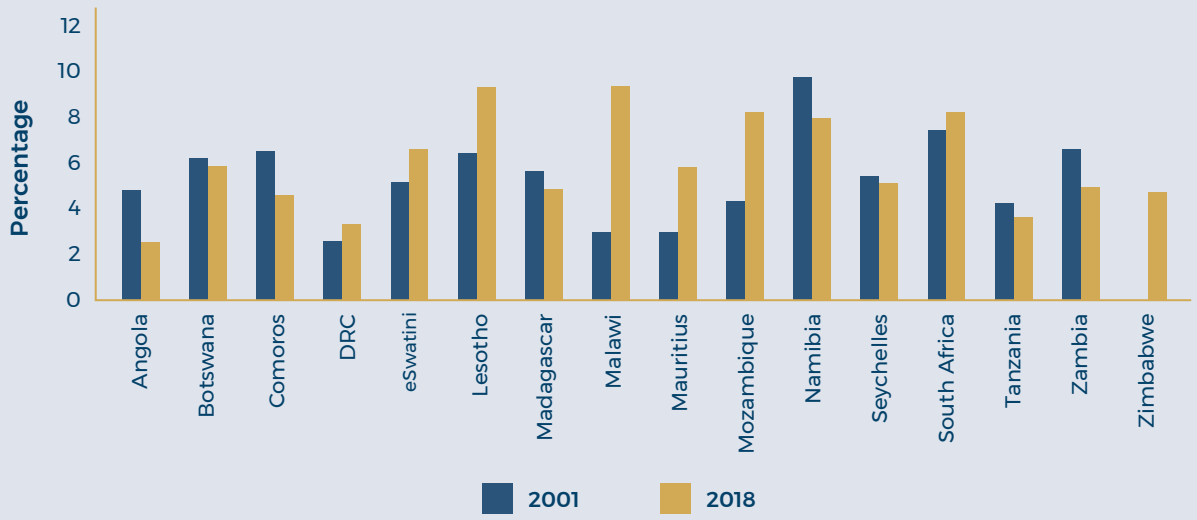
9 McIntyre D, A Obse, E Barasa & J Ataguba, 'Challenges in Financing Universal Health Coverage in Sub-Saharan Africa,' in *Oxford Research Encyclopedia of Economics and Finance* (London: Oxford University Press, 2018).

10 Piatti-Fünfkirchen M, M Lindelow & K Yoo, 'What Are Governments Spending on Health in East and Southern Africa?' *Health Systems & Reform* 4, no. 4 (2018): 284–299.

11 WHO, 'The Abuja Declaration'.

12 WHO, 'Global Health Expenditure'.

Figure 1 Current health expenditure in SADC member states (% GDP), 2001 and 2018



Source: Author's compilation based on data from the WHO Global Health Expenditure Database (2011), http://apps.who.int/nha/database

As suggested in recent empirical studies and a 2019 WHO report on global spending on health, one of the main reasons for signatory countries' (including those in the SADC region) failure to meet the Abuja Declaration target is their reliance on external aid to cover their expenditure requirements in several sectors, including health.[13]

Furthermore, in countries like Zambia, reliance on external aid is accompanied by various austerity measures that have been introduced to reduce the national debt burden. This makes meeting the 15% target all the more challenging. At present the average annual allocation in the region is 5.3%. Ultimately, this pattern of aid dependency has had unintended consequences for the ability of governments in the SADC region to intensify their efforts, using sustainable funding models, to allocate more public funds to health.

Looking ahead, despite the SADC member states' economic constraints, the COVID-19 crisis presents countries in the region with a unique opportunity to look at their healthcare systems in a critical light and find ways to allocate more resources to sustainably expand and strengthen these systems. This will not only ensure that SADC member states honour their pledges under the Abuja Declaration, but will also help to reinforce their healthcare systems against any future crisis, while at the same time mitigating the overall, lasting impact of the COVID-19 pandemic on their health sectors and economies.

13 J Dieleman, M Schneider, A Haakenstad, L Singh, N Sadat, M Birger, A Reynolds et al., 'Development Assistance for Health: Past Trends, Associations, and the Future of International Financial Flows for Health,' *The Lancet* 387, no. 10037 (2016): 2536–2544.

COVID-19 and SADC countries' new drive to invest in healthcare

The COVID-19 pandemic has brought into sharp relief the historical gaps in SADC member states' health services and the urgency with which they need to be overhauled in order to meet the health needs of their populations. The persistent challenges confronting the SADC region's healthcare systems include: high morbidity and mortality rates, insufficient supplies of drugs and medicines, a legacy of underinvestment in healthcare infrastructure, poor retention of indigenous medical professionals and the widespread incidence of HIV/AIDS.[14] These deficiencies in SADC countries' health services, together with longstanding and severe shortages of healthcare professionals, are compounded by the fact that additional effort currently needs to go into mitigating the impact of COVID-19.

Somewhat ironically, the immense challenges that the COVID-19 crisis presents to the SADC region's overstretched and underfunded healthcare systems, on top of declining economic conditions, may provide the impetus for countries to begin addressing these challenges – using the crisis to inform strategic investments in health services which could go some way towards meeting investment targets and honouring the financing pledge in the Abuja Declaration.

Despite problems in SADC countries' healthcare systems, the COVID-19 case count in the SADC region has been low compared to other world regions, such as the European Union (EU)[15] (see Table 1). Had COVID-19 taken hold more fiercely in the SADC region, the consequences may have been disproportionately catastrophic, given the state of the countries' healthcare systems and their relative inability to cope with patients with severe or complex needs. There has, however, been the growing realisation that healthcare systems across the region cannot meet the unprecedented demands placed on them by the COVID-19 crisis;[16] nor will they be able to adequately cope with possible future epidemics and pandemics. Thus, investing more heavily in national healthcare systems has become a priority. Table 1 shows the situation with respect to COVID-19 cases in individual SADC member states as at 17 December 2020.

14 See, eg, P Gona, C Gona, S Ballout, S Rao, R Kimokoti, C Mapoma & A Mokdad, 'Burden and Changes in HIV/AIDS Morbidity and Mortality in Southern Africa Development Community Countries, 1990–2017,' *BioMed Central (BMC) Public Health* 20, no. 1 (2020): 1–14.

15 Note: South Africa has been hit the hardest in terms of numbers of COVID-19 cases in the SADC region.

16 'Africa Coronavirus Round-up: Healthcare Systems in Crisis,' *The Economist Intelligence Unit*, May 13, 2020, http://country.eiu.com/article.aspx?articleid=719548655&Country=Equatorial%20Guinea&topic=Economy_4.

TABLE 1 COVID-19 SITUATION IN SADC MEMBER STATES AS AT 17 DECEMBER 2020							
SADC member states	**Confirmed cases**	**New cases**	**New deaths**	**Total deaths**	**Recovered**	**Active**	**Cases per million**
Angola	16 188	27	5	371	8 898	6919	486
Botswana	12 501	0	0	37	9 940	954	5 270
Comoros	928	0	0	7	606	15	715
DRC	14 461	0	0	346	12 465	1 644	159
Eswatini	6 768	54	0	127	6 379	262	5 807
Lesotho	2 250	0	0	44	1 319	887	1047
Madagascar	17 587	0	0	259	16 992	336	628
Malawi	6 066	3	1	187	5 491	388	313
Mauritius	515	0	0	10	478	27	405
Mozambique	16 954	142	0	140	14 818	1 994	536
Namibia	16 536	267	0	133	14 684	1 692	6 456
Seychelles	187	0	0	0	182	5	1896
South Africa	860 964	7999	170	23 376	761 011	76 677	14 435
Tanzania	509	0	0	21	183	305	9
Zambia	18 274	57	1	367	17 388	519	982
Zimbabwe	11 246	27	0	307	9 451	1 488	752

Source: SADC (2020) 'SADC region: COVID-19 status update', https://www.sadc.int/issues/COVID-19/

The COVID-19 pandemic has injected a new dynamism into SADC member states, evidenced in their expressed desire to invest in their healthcare systems to curb the spread of the virus. Whereas previously, countries' alleged commitment under the Abuja Declaration produced inadequate levels of support and weak implementation, the advent of COVID-19 has made SADC member states cognisant of the need to earmark sufficient financial resources from their national budgets to health and to the building of a much more resilient healthcare system.

This new-found, collaborative energy was first observed during an extraordinary meeting of the SADC ministers of health held on 9 March 2020 at the Julius Nyerere International Convention Centre in Dar es Salaam, Tanzania. At that meeting, the ministers agreed that the COVID-19 pandemic was a serious wake-up call for SADC leaders to find ways to increase public funding in order to bolster their healthcare systems.

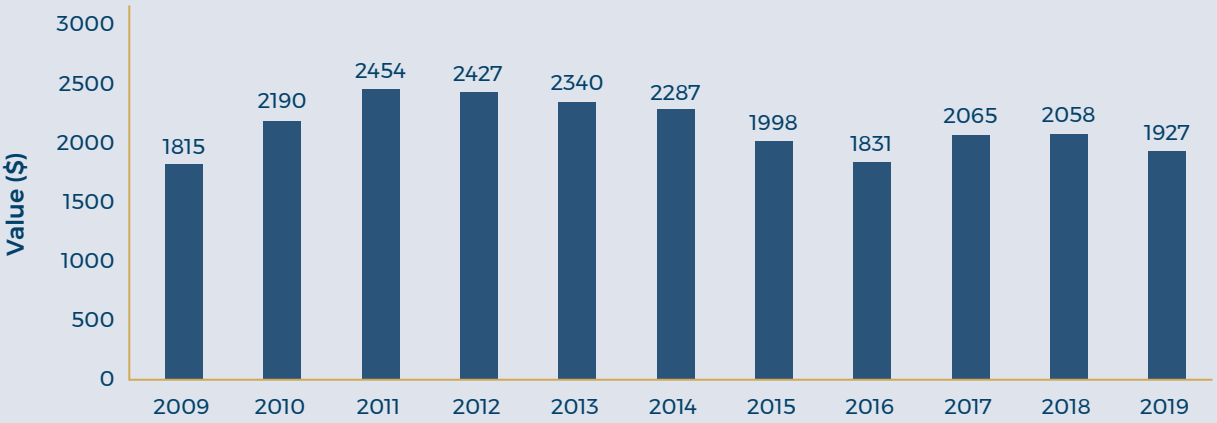
The same type of collaborative response was evident at the 70th meeting of the highest decision-making body on health in the African region – the WHO Africa Regional Committee – which was held from 19 to 23 August 2020 in the Republic of Congo capital city of Brazzaville. Health ministers from 47 countries in the WHO Africa Region, officials from non-governmental organisations from across Africa and representatives from the UN all agreed that the COVID-19 crisis was a poignant reminder to all AU members, including

countries in the SADC region, that sustainable ways to fund public healthcare systems were greatly needed.

The SADC economy and COVID-19 in 2020

The resolve to step up efforts to invest in long-term preparedness and to re-commit to the Abuja Declaration will have to be implemented carefully, given the weak economic conditions in the SADC region. The generally positive economic growth rates observed in the region until 2018 eventually came to an end, with 2019 showing a weaker growth figure. Figure 2 shows trends in nominal GDP per capita in the SADC region for the period 2009–2019.

Figure 2 GDP per capita ($) for the SADC region, 2009–2019



Source: Adapted from a report, '*SADC Selected Economic and Social Indicators 2019*', based on GDP, trade, demography and sectoral indicators for the period 2009 to 2019, https://www.sadc.int/files/2916/0102/7136/Selected_Indicators_2020_September_11v2.pdf

According to the World Bank, the sub-Saharan African (SSA) region would, for the first time in 25 years, enter an economic recession in 2020, driven in part by falling economic growth due to the impact of COVID–19 crisis. More specifically, the economic growth rate across SSA is projected to decline from 2.4% in 2019 to –2.1 to –5.1% in 2020.[17] In the SADC region, the COVID-19 pandemic has compounded this negative trend, with the region currently experiencing an external debt burden of more than 99% of GDP.[18]

17 The World Bank Group, Africa Pulse, Assessing *the Economic Impact of COVID-19 and Policy Responses In Sub-Saharan Africa* (Washington DC: Africa Pulse, 2020) Vol. 21, https://olc.worldbank.org/content/africas-pulse-assessing-economic-impact-covid-19-and-policy-responses-sub-saharan-africa.

18 Mduduzi B, 'General Government Debt and Growth in SADC Countries,' *EuroEconomica* 38, no. 2 (2019).

Logically, a decline in economic growth affects a country's ability to apportion enough resources to health. For example, the devastating impact of COVID-19 on the Zambian economy has contributed to that country's inability to service its foreign debt and meet debt repayment guarantees, leaving the economy teetering on the brink of collapse.[19] However, economic recovery efforts in the SADC region must include health improvements. Importantly, too, regional collaborative efforts should do more to help member states deal with the impact of the virus on their economies; otherwise, SADC's ongoing economic problems and individual countries' budgetary shortfalls in the area of healthcare will never be overcome.

The road ahead: Dealing with shortfalls in healthcare funding

The Abuja Declaration was implemented to buttress Africa's declining healthcare quality and resources. Certainly, finding ways to overcome the serious hurdles that SADC member states face in meeting their annual funding commitment under the declaration would be beneficial for the region as a whole, as well as to each individual country.

Moving forward, COVID-19 will continue to pose risks not only to people's health but also to the economic status of SADC. Therefore, the region will require dedicated funding and innovative approaches to meet the Abuja Declaration pledge threshold. Some of these approaches may include the formation of SADC health public–private partnerships (PPP) to help bridge member states' financing gaps.[20] In southern Africa, health PPPs have been found to be effective in leveraging resources and expertise from the private sector to help governments optimise funding for healthcare.[21] SADC member states could benefit greatly from such partnerships which could act as a major step towards mitigating the ravages of a declining regional economy.

Furthermore, the region as a whole could lobby the AU for help in the establishment of a dedicated SADC regional healthcare fund. The fund would be aimed at helping member states that have insufficient financial resources to allocate to their healthcare sectors, to borrow from the fund in order to make up the shortfall. Creating such a regional fund, consisting of contributions from member states and policed at the SADC Secretariat level, could help member states ensure continuity in their annual allocation of 15% of their national budget to the health sector, thereby honouring the Abuja Declaration pledge, and in the long term strengthen investment in regional healthcare systems. This would bring

19 M Zamokuhle, 'The Impact of Public Economics to Public Debt: A Case of Southern African Development Community Countries (SADC),' *Transylvanian Review* 27, no. 50 (2020): 15408–15416.

20 ED Penfold & P Fourie, 'Regional Health Governance: A suggested Agenda for Southern African Health Diplomacy,' *Global social policy* 15, no. 3 (2015): 278–295.

21 J Mugwagwa & G Banda, 'Role of public private partnerships in health systems: experiences from Southern Africa' (Policy Brief 13, The Scinnovent Center, Nairobi, 2020), https://idl-bnc-idrc.dspacedirect.org/bitstream/handle/10625/59552/59734.pdf?sequence=1.

stability to SADC countries' financial allocations, irrespective of any economic fluctuations that they may experience. The EU, for example, uses the hierarchical Nomenclature of Territorial Units for Statistics (NUTS) system to divide up the EU's economic territory.[22] The system allows for the diagnosis of different areas of need and allocates funds for the purpose of implementing regional or sub-regional policies. For example, those countries with a gross national income (GNI) per capita of less than 90% of the EU average are at NUTS Level 2 and could be eligible for assistance under the Cohesion Fund. The Cohesion Fund aims to reduce economic and social disparities and promote sustainable development, which includes health-related investment within the EU.[23]

Recent empirical studies have found that citizens of the SADC region are willing to see their tax dollars being used to finance public healthcare.[24] It is therefore crucial that SADC member states tap into this expressed willingness among the citizenry and the obvious public support for healthcare to be properly financed. They could, for example, strengthen existing domestic resource-generation mechanisms and subsequently step up healthcare spending in a way that is visible and serves a wide segment of the population.

SADC member states could also encourage the involvement of civil society organisations (CSOs) in member states' health financing policy and health priority-setting processes. As key stakeholders on the ground, local and international CSOs such as Amref Health Africa and EQUINET-Africa[25] signal the involvement of society as a whole and thus the inclusion of different parties' views on optimal health policies and financing mechanisms. In fact, tapping into these networks should be a fundamental part of SADC member states' health-funding processes. Initially, local CSOs could help governments to achieve greater operational transparency, which could in turn inspire greater trust in government decision-making processes and better adherence to health-financing measures – whether this involves tax compliance or supporting various health initiatives such as the National Health Insurance Scheme.

Conclusion

Allocating 15% of the national budget to healthcare is a worthwhile target for SADC member states, especially as the COVID-19 pandemic is still very prevalent. It is important that all SADC member states meet their allocation every year as it will benefit the whole region in the long term. To do this, though, countries need to become innovative

22 The European Union Commission, Eurostats, 'NUTS – Nomenclature of Territorial Units for Statistics,' background, no date, https://ec.europa.eu/eurostat/web/nuts/background.

23 The European Union Commission, European Union Regional and Urban Development Regional Policy, 'Health,' no date, https://ec.europa.eu/regional_policy/en/policy/themes/health/.

24 JC Bwalya, 'Are People in the SADC Region Willing to Pay More Tax to Fund Public Healthcare?' *Development Southern Africa* 37, no. 4 (2020): 601–616.

25 amref health Africa, *Slowing the spread of COVID-19 across sub-Saharan Africa: responding to COVID-19 in Ethiopia, Kenya, Malawi and Senegal*, (August 13, 2020), https://www.amrefcanada.org/why-africa/why-africa/slowing-the-spread-of-covid19-across-subsaharan-africa-/; 'About us,' EQUINET-Africa, https://www.equinetafrica.org/content/about-us.

navigating the challenges of a deteriorating regional economy, while also identifying additional sources of finance to bridge national healthcare budget deficits.

The centrepiece of this process should be a drive to strengthen existing government revenue-generation mechanisms, which should substantially improve the scale of healthcare financing in the region. Strategic approaches like this should be supplemented with the establishment of a regional healthcare fund and public–private partnerships whose role would be to supplement governments' healthcare funding. To ensure that all stakeholders involved are accountable, both to themselves and to others, governments should encourage CSOs to partner with them in ensuring that the health-financing policy formulation and implementation processes are transparent and that performance outcomes can be measured and acted upon.

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Cover image

Tablets for the treatment are seen 23 January 2008 in a cordoned off wing of the extreme drug resistant tuberculosis (XDR-TB), a near untreatable strain of the disease, at the Brooklyn Infectious Disease Hospital in Cape Town (Pieter Bauermeister/AFP via Getty Images)

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