



Africa: Meeting The Abuja Promise Goes Beyond The 15 Percent Target

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opinion

When the African Union (AU) Heads of State committed to allocating at least 15% of annual government budgets to their health sectors in Abuja, Nigeria in 2001, they also called on high income countries to fulfil their own commitment to devote at least 0.7% of their GNP as ODA to developing countries and to cancel Africa's external debt in favour of increased investment in the social sector.

The Abuja target, thus, consists of three components; African countries should:

- mobilise domestic resources for health (15% now);
- unencumbered by debt servicing (Debt cancellation now); and
- be supported by ODA (0.7% GNP to ODA now).

After the significant fall in public sector funding of the health sector funding associated with structural adjustment programmes and market reforms, most African countries clearly need to increase public sector investment in health. Poorer groups have considerably worse health than the better off and economic growth and achievement of the Millennium Development Goals (MDGs) in the region is seriously undermined by the prevalence of HIV and AIDS, TB, Malaria and other diseases. Eleven of the 16 countries in east and southern Africa spend in their public sectors less than the US\$34 needed for the most basic interventions for these conditions, let alone the US\$80 needed for more comprehensive health services. Very few East and Southern African (ESA) countries have health care spending levels anywhere near this amount, and there are thus major unmet health needs. Ten of the sixteen countries in the region, if they met the Abuja target, would, however, increase their public financing to health above the level of US\$34/capita needed for the basic health programmes.

Nobel Peace Prize Winner Archbishop Desmond Tutu stated this year:

"The AU Abuja 15% pledge is one of the most important commitments African leaders have made to health development and financing, and our Heads of State should strive to meet this pledge without further delay. The continued loss of millions of African lives annually which can be prevented is unacceptable and unsustainable. Our leaders know what they have to do. They have already pledged to do it. All they have to do now is actually do it. This is all we ask of them."

This call needs to make clear that countries are expected to spend 15% of their own funds on health, excluding external funding. As the Southern African Development Community (SADC) made clear in its regional conference on poverty this year, a public sector led response is vital to addressing the burden of ill health in the region, and for states to meet their obligations to health in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESR) (1976). With 35% of the

people living with HIV globally, the world's worst TB infection rate, new epidemics of multi-drug resistant tuberculosis (MDR-TB), an estimated 30 million cases of malaria and 400 000 deaths from malaria, and high levels of maternal and child mortality, the demand for health care is high. without adequate domestic funding to the health sector, states will not meet ICESCR commitments for health facilities to be within safe physical reach for all sections of the population and for facilities to be affordable for all with payment based on the principle of equity.

This demand that the 15% pledge be met from national resources has not been made clearly enough. The lack of attention to this basic demand is reflected in the current monitoring of the Abuja commitment, which often combines domestic tax funding and donor funds in the category of 'government expenditure', including in the World Health Organisation National Health Accounts data. Tracking progress toward the Abuja target calls for accurate data on government health care expenditure from domestic funding sources to be made regularly available.

Meeting the 15% pledge is necessary, but also not sufficient:

- Unless government spending is also rising as a share of Gross Domestic product, with meaningful shares of progressive tax revenue, the 15% can be a small, and dwindling share of overall national economic resources;
- Unless governments also reprioritize spending towards district and primary health care services, with at least 50% of health spending directed to these levels, the health services that are used by the majority of poor people could continue to remain starved of resources, even as public spending begins to rise;
- Unless national spending is complemented by sustained predictable forms of global solidarity, even reaching the 15% will not be enough for many health sectors to provide adequate funding for health.

EQUINET research has shown that several countries in east and southern Africa (ESA), such as Malawi, Namibia, Zambia and Uganda, have made considerable progress in increasing domestic funding towards the Abuja target, shortly after the commitment was made. Yet ten out of sixteen ESA countries are trying to deliver health systems with public sector resources of less than \$80 per capita and eight with resources below \$34 per capita. Meeting the Abuja commitment would still not bring health spending above \$34 per capita for six of these countries, and above \$80 per capita for nine.

This is where global fairness and accountability becomes as important for health as the accountability of African states.

One reason for inadequate funding for health is that government efforts to increase domestic funding of health services has been jeopardised by unviable debt burdens. Over the past three decades, ESA countries paid an average US\$14 per capita annually in debt servicing, which in many countries is more than their average per capita spending on health. Cancelling debt is not simply a moral issue: By 2002 debt repayments from Africa had reached about four times the original 1980 debt, with a net outflow by 2000 of US\$6.2 billion. The 2005 G8 summit setup the Heavily Indebted Poor Countries (HIPC) initiative with a commitment to cancel 100% of outstanding multilateral debts of eligible HIPCs, with some implementation in 26 eligible countries in Africa. However this is not yet debt cancellation, and although Africa's debt stock has fallen, total debt service obligations remained unchanged in 2006 due to rising interest rates and the debt burden continues to seriously constrain social spending. Cancelling all debt servicing obligations still remains an urgent message for those campaigning for the Abuja commitment.

Raising domestic resources for health is also limited by the significant net outflow of resources from Africa. Outflows through areas such as worsening terms of trade, outflows of skilled health workers, private finance outflows, or the depletion of natural resources, have left Africa in a position of net resource outflows. One form of reverse flow to health is through overseas development aid (ODA). Yet OECD countries have been slow to meet the commitment they made to contribute 0.7% of their GNP as ODA. A recent analysis of aid suggests that excluding debt relief for Nigeria, real levels of aid to sub-Saharan Africa rose by only 2% in 2006. Average contributions of 0.3% of GNP to ODA from OECD countries remained well below the 0.7% pledge, with only Sweden, Luxembourg, Norway, the Netherlands and Denmark meeting this in 2006. It is not only some African governments that are failing to meet their commitments. High income countries are, with some exceptions, also not meeting their agreed aid targets.

Meeting the Abuja promise is thus not just a call within Africa to meet the 15% target, but a call globally to cancel debt and meet the 0.7% target for ODA. Activism on the Abuja deceleration should thus be clear on all three fronts:

- African countries to mobilise domestic resources for health (15% now);
- unencumbered by debt servicing (Debt cancellation now); and
- supported by ODA (0.7% GNP to ODA now)!

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