actionaid international africa

Four Years after Abuja:

More Action Required on Spending Commitments!

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Acknowledgments to:

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1. What happened in Abuja Four Years Ago?

In April 2001 the African Union held a special summit on AIDS in the Nigerian capital Abuja. The Abuja Summit concluded with the adoption of the Abuja Declaration, a declaration outlining the continent's response to HIV&AIDS, tuberculosis (TB) and other related infectious diseases. In that declaration, among other commitments[1], the leaders of Africa committed to spend 15 per cent of their national budgets to health with emphasis on HIV&AIDS programmes.

2. Why was it important?

The Abuja Declaration was and still is important because, it,

1. Demonstrated the commitment and resolve that citizens expect from their leaders;
2. Created the legitimacy to ask development partners to assist;
3. Could make a significant difference to the fight against HIV&AIDS;
4. Could provide the types of infrastructure and services that external resources could build upon;
5. Recognised the role of health in the fights against HIV&AIDS, and last but not least,
6. Outlined concrete actions towards the progressive realisation of the provisions of the Covenant on Economic, Social and Cultural Rights (CESCR) reaffirmed in the Declaration on the Right to Development.

3. Is it still important?

The Abuja Declaration is still as important today as it was in 2001. Its implementation is now more urgent than before. There are at least ten good reasons why action on the Declaration must be pursued with urgency!

3.1. The obligation stands!

First and foremost, the obligation to facilitate the realisation of the rights of citizens still stands. HIV&AIDS, TB and other related infectious diseases were recognised as impacting negatively on the rights of the peoples of Africa. This has not changed. The diseases still exist and continue to wreck havoc on the lives of men, women, girls and boys in all corners of the continent.

3.2. Funding is still inadequate!

While there has been a substantial increase in funding for HIV&AIDS between 2001 and 2005, the funding still remains inadequate and Africa needs to play its part. UNAIDS[2] estimates global funding for the AIDS epidemic increased from US$1.7 billion in 2002 to US$4.7 billion in 2003. However, UNAIDS also notes that the level of spending achieved is less than half of the 2005 requirements and only 25% of 2007 requirements. It also worthwhile to note that Africa's share of the additional resources has been lower owing to increasing requirements in Asia and Eastern Europe. Three observations by UNAIDS (2004) on HIV&AIDS funding in Sub-Saharan Africa are particularly important :- a) 'spending in Sub-Saharan Africa, while increasing, is so miniscule as to leave millions without care and support'. b) spending per person living with HIV in Africa is 1/1000th of spending in the United States of America and 1/28th of that in Latin America and the Caribbean. Against this background, every single additional dollar counts.

3.3. Infection rates are still high and TB incidence has increased!

Sub-Saharan Africa with just 10% of the world's population is home to 60% of people living with AIDS[3]. At the end of 2004 there were 25.4 million people living with AIDS in sub-Saharan Africa. In the same year, AIDS claimed 2.3 million lives. Prevention programmes remain under-funded and are beginning to be overshadowed by treatment programmes. It is important to realise that prevention failure today represents a greater burden tomorrow. Today's under-financing will translate to a bigger burden tomorrow. While aiming for progressive improvement in financing there is need to ensure that this is translating to progressive reduction of infection rates. TB incidence is increasing while the performance of responses remains disappointing. The joint UNAIDS, AU, ECA and WHO report 'Scoring African Leadership for Better Health' observes

"*The expansion of the DOTS programme for TB treatment falls short of its coverage target of 90% of the population. Several countries fall below 50% because of inadequate domestic financing and poor health-sector inputs for DOTS expansion*".

3.4. Basic infrastructure is still lacking!

[1] Other commitments included specific actions to scale-up the response to the epidemics and strengthen the capacity to act. A comprehensive review of progress against these commitments is published by UNAIDS, ECA, AU and WHO under the title 'Scoring African Leadership for Better Health'.

[2] UNAIDS (2004) 2004 Report on the Global AIDS Epidemic

[3] UNAIDS, AIDS Epidemic Update, 2004.

Basic infrastructure and services that should underpin the fights against HIV&AIDS is still lacking. The vast majority of people living with HIV&AIDS and the general populations in Africa have no access to lifesaving drugs, testing facilities or even basic preventative health care.

A comprehensive review of strategies addressing structural deficiencies commissioned by The World Health Organization's Commission for Macroeconomics and Health (CMH)in 2002 revealed that the infrastructure necessary to stem the spread of AIDS do not require the extensive facilities of modern hospitals but can be effectively administered through small clinics and dispensaries. Such basis facilities are simply not as yet available.

3.5. *Access to treatment and support services still low!*

Access to treatment and support services remains low. Although there has been an increase in the number of Africans on treatment, there are many more that need such treatment who have failed to access it and their lives have ended much quicker than would be the case if we acted with greater urgency to prolong them. UNAIDS estimates that in 2004, only 3% of people needing treatment in sub-Saharan Africa obtained it.

3.6. *Women and girls have become unpaid and untrained nurses operating with minimal support*

Africa's girls and women are increasingly taking on the role of nurses and doing so without support. This role comes at great expense to the personal ambitions and life potential of the women. While we take comfort in communities taking responsibility and action, we are not doing enough to facilitate the performance of such roles without permanently harming the life aspirations, opportunities and potential of girls and women. Failure to balance the burden on girls and women with their life aspirations and choices is not consistent with stated commitments to the realisation of women's rights.

3.7. *Lack of funding is taxing the poor further and condemning them to a life of poverty!*

Africa has more than 270 million people living on less than US$1 per day. It is a continent where poverty continues to grow. Inadequate funding of the HIV&AIDS response places the cost burden on the poor pushing them deeper into poverty. Evidence from a few countries suggests that in excess of 40% of AIDS expenditures can be out-of-pocket expenditures by affected households. In 2002, the level of out-of-pocket expenditure was found to range from 41% in Kenya to 98% in Rwanda (1998).

3.8. *Achievement of the MDGs depends on success against HIV&AIDS!*

If the tide is not turned against HIV&AIDS, the likelihood of achieving the Millennium Development goals is significantly diminished. Poverty, hunger, under-5 mortality, and maternal mortality rates, and gender disparities in education will increase while school enrolment rates will fall.

3.9. *We need to maintain the commitment to inspire others!*

Africa bears the worst HIV&AIDS burden, and needs to show a high level of commitment to address the HIV&AIDS burden. Africa must do as much as is possible within its resource constraints. That is, the countries must act to in line with the principle of 'maximum extent of available resources' not only to comply with human rights treaties but also to inspire greater commitment from development partners.

3.10. *Last but not least, it is a credibility issue!*

When Africa's leaders made the commitments, the peoples of Africa viewed the commitment as deliverable targets that were based on much deliberation and reflection and to be attainable.

Delivery on these commitments has a bearing on the collective credibility of the leaders, the commitments they make in future and on the soundness of the basis for their decision-making.

4. What has been done to date?

A 2005 study commissioned by ActionAid[4] to examine compliance with the funding commitments in 9 countries (Cameroon, Ethiopia, Gambia, Ghana, Kenya, Malawi, Sierra Leone, South Africa and Swaziland) found that none of the countries currently meet the 15% target. The trends in country expenditures are mixed with some countries showing a decline in the health sector's share of total expenditure (Figures 1 and 2).

[4] Tracking Progress Towards The Abuja Target: Are African states allocating 15% of their annual budgets for health?

Figure 1: Gambia, Kenya and Cameroon - Total health expenditure as share of total annual budget, including and excluding debt payments (recurrent and development expenditure; includes health expenditure outside Ministry of Health)

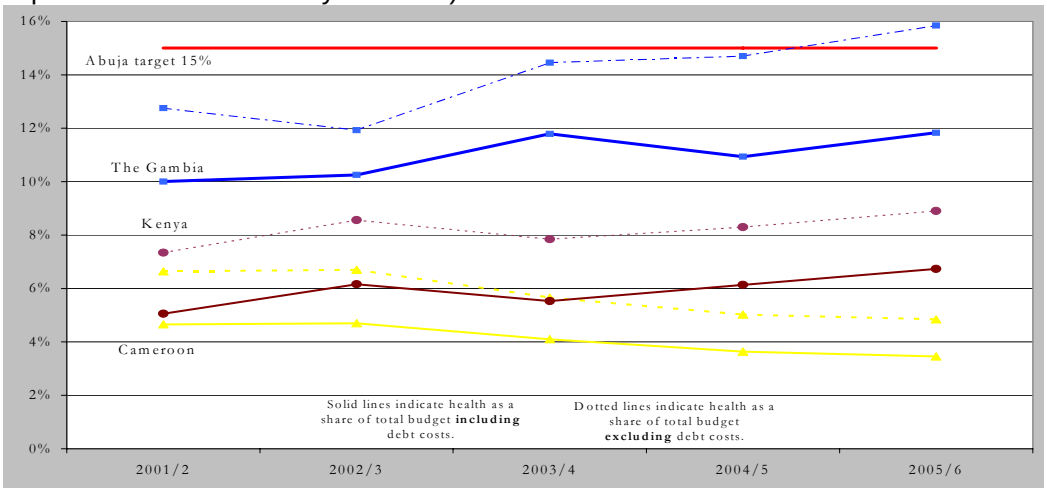
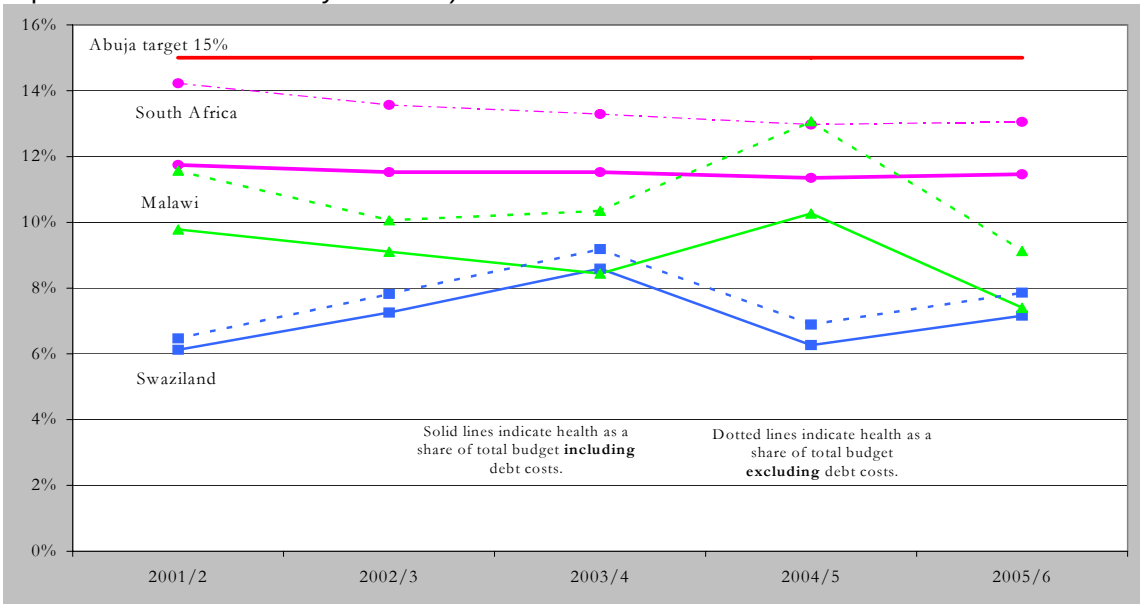


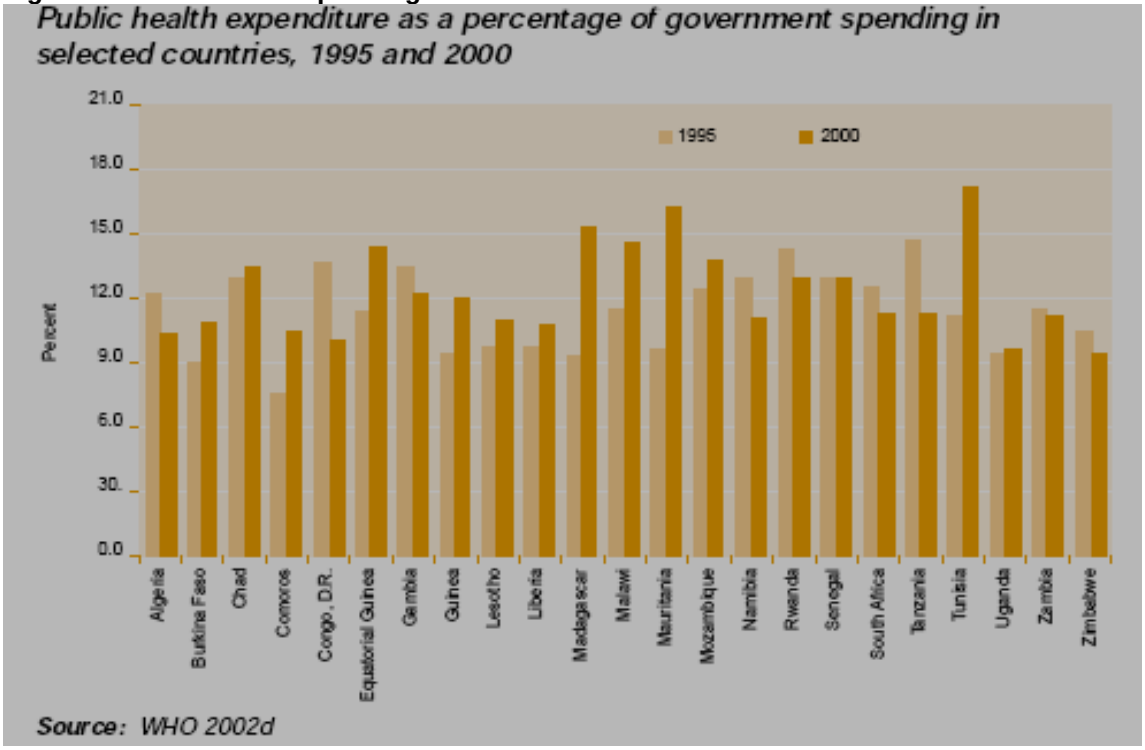
Figure 2: South Africa, Malawi and Swaziland - Total health expenditure as share of total annual budget, including and excluding debt payments (recurrent and development expenditure; includes health expenditure outside Ministry of Health)



A 2002 WHO study found that the trend before 2001 had been mixed (Figure 3). Some countries (Algeria, Democratic Republic of Congo, Gambia, Namibia, Rwanda, South Africa, Tanzania, Zambia and Zimbabwe) experienced a decline in health sector expenditure share between 1995 and 2000. Others recorded substantial increases with three countries (Madagascar, Mauritania and Tunisia) reaching and exceeding the 15% mark. A common characteristic across all countries has been the fluctuation in the expenditure share of the health sector. Countries such as Tanzania and Zimbabwe were in 1998 spending more than 15% on health but this was not maintained. Others that have at some point also attained the target are Chad, and Mozambique[5].

[5] The target was attained with donor funding included as part of the regular budget for health. When the donor contribution is excluded the health share falls to under 9%.

Figure 3: Public Health Spending in Selected African Countries



The ActionAid commissioned study found that because African governments spend a considerable amount of resources on debt servicing, the expenditure shares of health were about 1.8% higher if interest on debt was excluded from the calculation. This finding while affirming the diversion of resources into debt servicing highlights the extent of actual commitment by countries. Even after removing the effect of debt servicing, the health share of national expenditures was below the target of 15%.

Historically, country expenditures on health have tended to vary extensively between countries (Table 1). South Africa as the best spender in absolute terms, spent 57.5 times the per capita expenditure of Ethiopia the lowest spender. The countries with the least expenditure would still fall far short of required basic health care expenditure of at least US$34 per capita even if they meet the 15% target. The need to improve expenditure levels is much more apparent in the countries with the least per capita expenditures.

Table 1: Per Capita Health Spending in Africa

Country	Spending Per Capita (Ppp) In $Us 1998	Country	Spending Per Capita (Ppp) In $Us 1998
South Africa	**230**	Uganda	**18**
Namibia	**142**	Gambia, The	**13**
Botswana	**127**	Benin	**12**
Gabon	**122**	Malawi	**11**
Tunisia	**108**	Mali	**11**
Swaziland	**46**	Rwanda	**10**
DRC	**40**	Central African Republic	**9**
Zimbabwe	**36**	Burkina Faso	**9**
Kenya	**31**	Togo	**9**
Nigeria	**30**	Sierra Leone	**8**
Cote d'Ivoire	**28**	Mozambique	**8**
Zambia	**23**	Chad	**7**
Senegal	**23**	Niger	**5**
Guinea	**19**	Madagascar	**5**
Ghana	**19**	Burundi	**5**
Mauritania	**19**	Ethiopia	**4**

Source: World Bank. 2002. World Development Indicators 2002. CD-ROM. Washington, DC

5. What are the constraints?

There are three major factors that explain inadequate action on the commitments.

5.1. Lack of accountability

Lack of accountability is perhaps the biggest constraint. When populations are being decimated by disease, health systems are woefully inadequate, what is an acceptable justification for not changing those aspects contributing to the decimation of societies that are within the control of the elected leadership of the continent? If African countries were attacked militarily would the leaders standby and not avail the resources to defend their countries? Why does decimation wrought by disease not attract the same level of resource commitment as a military threat?

5.2. Debt burden

Debt servicing is costly and reduces the available resources for discretionary allocation. UNAIDS (2004) observed that:

'More than one-third of the world's HIV infected people—or 14 million—live in countries classified by the World Bank as heavily burdened by debt. In 2002, the 42 poorest and most indebted countries—34 in sub-Saharan Africa—together owed US$ 213 billion (Hardstaff, 2003). Many of these countries regularly pay out more to rich world creditors to service their debts than they receive in foreign aid. In fact, debt repayments take a larger slice of their budgets than public health (Boyce, 2002; Oxfam, 2002)'.

A question of priorities: the cost of servicing debt

- Zambia has almost one million HIV-positive people, and spends 30% more on servicing its debt than on health. In 2000, the proportion of government revenue absorbed by debt was 20%; this was expected to rise to 32% in 2004 (Oxfam, 2002; World Bank/IMF/IDA, 2003).
- Cameroon spends 3.5 times as much on debt repayment as on health, and Mali spends 1.6 times as much (Oxfam, 2002).
- Kenya spends US$ 0.76 per capita on AIDS, and US$ 12.92 per capita on debt repayments (Kimalu, 2002).
- The cost of implementing Malawi's national strategic plan for AIDS is around US$ 2.40 per capita per year. In 2002 the country transferred US$ 5 per capita to foreign creditors (Oxfam, 2002).
- The first 14 countries identified as key recipients of the United States President's Emergency Plan for AIDS Relief together spent US$ 9.1 billion in servicing their debt in 2001 (Ogden and Esim, 2003).

Addressing the debt burden is one way of improving resources for health spending. However, in the meantime, Africa's leaders have commitments that were made within the context of a heavy debt burden. Knowing their existing debt commitments the leaders made a commitment to spend 15% on health. Having examined possible distorting effect that debt servicing would have on calculations of health expenditures, it is obvious that the share of health in discretionary expenditure is still well below 15% in most countries. Of the 9 countries in the ActionAid commissioned study, the largest improvement was it case of the Gambia where health spending is 10.96% with debt and 13.94% without debt.

5.3. Poor tracking systems

Poor tracking systems for expenditures have meant that many governments are not too sure of how they are doing on the target. Often, there is an attempt to rope in expenditures from other sectors because they make a health contribution. The commitment made in Abuja was cast within a context. A context that has specific programmatic actions that were spelt out. Thus, the accounting boundaries are very clear. They are set by the specific interventions outlined.

6. What difference will additional resources make?

There are many gaps/ areas of weakness in the response to HIV&AIDS, TB and other related diseases. Focusing on HIV&AIDS, there is much to choose from depending on country-specific needs. The list would include the following:

HIV prevention activities

- Mass media campaigns
- Voluntary counselling and testing
- Condom social marketing
- School-based AIDS education
- Peer education for out-of-school youth
- Outreach programmes for sex workers and their clients
- Outreach programmes for men who have sex with men
- Public sector condom promotion and distribution
- Treatment of sexually transmitted infections
- Prevention programmes for people living with HIV
- Workplace prevention programmes
- Prevention of mother-to-child transmission
- Post-exposure prophylaxis
- Blood safety

AIDS treatment and care activities

- Palliative care
- Diagnosis of HIV infection
- Treatment of opportunistic infections
- Prophylaxis for opportunistic infections
- Antiretroviral therapy

- Laboratory services for monitoring treatment

Of course, in addition to these, governments could improve access to health primary health care facilities, ensure availability of medicines, equipment and adequate staff. Africa is losing medical personnel to rich countries at an alarming rate. None of the countries in Africa can claim to have adequate nurses at the lowest level of service provision. Community-based counsellors and community health workers to provide advice to the millions of women who have are forced to take on the role of nursing the ill are sorely needed. None of the governments would reject additional resources to improve delivery of health services. All are calling for more resources. The increased allocation of local resources cannot be any more 'harmful' to economies than additional external resources.

7. What do Africa's Leaders need to do?

7.1. Keep their word!

A target of 15% was set and must be met. The need for the resources is not in question. The levels of allocations are choices that governments make. The target of 15% was set not as a thumb-suck figure. We trust it was a considered decision. If indeed there are operational reasons as to why it is not practicable, the least that Africa's peoples expect is that the leaders will use the same platform to communicate that a mistake was made.

7.2. Stop giving excuses!

There is a funding shortfall. It is undermining the health sector. Even after making provisions for debt repayments, the share of health expenditure in the discretionary budget is still lower than 15%. Excuses will not address the devastation wrought upon societies by HIV&AIDS.

7.3. Stop hiding behind technicalities!

The technical explanations on accounting and inflationary pressures that would arise from increased expenditures are excuses. Are these new developments that were not known in April 2001? A number of countries have at one point or another reached the 15% target. Many need to increase spending on health by about 30%. There is no evidence to suggest that those who reached the 15% target suffered anything untoward for making the investment. Whatever the accounting issues, citizens believe there was a common meaning and governments must account on the basis of the common meaning and understanding of the commitment.

7.4. Take leadership of the Fight against HIV&AIDS and be accountable!

The responsibility to ensure countries comply with the target lies with the heads of states that made the commitment. Internal resource allocation decisions must respond to match commitments made and the leaders need to hold someone to account and then be accountable themselves for commitments they make.

7.5. Remember! The 15% is not an end but simply the means!

As we strive towards the 15% target we ought to also keep in mind that the target is but just a step towards making resources available to strengthen the responses to HIV&AIDS, TB and other related diseases. For those countries that are close to or have attained 15%, the time to celebrate is not now. The celebrations ought to wait for the time when health spending is sufficient to decisively turn the tide against HIV&AIDS. The point is to save and prolong lives.

7.6. Capitalise on growth!

The majority of African economies have recorded encouraging growth rates over the past three years. It is time to capitalise on these. Attaining the target of 15% will substantially increase the resources available to the health sector. Conversely, attaining 15% through a shrinking budget only reflects the relative protection of the health sector but does not translate into badly needed resources.

7.7. Make the available dollars go further!

Available resources for the health sector can be made to go further by addressing some of the additional costs of health provision that are within the control of governments. Such measures could include reducing or removing import taxes and tariffs on health sector imports.

8. What can civil society do?

There are at least four things that civil society can and should do to improve delivery on these and other commitments. The key message in these actions should be 'Gone are the days of blind trust! Show us the evidence!'

8.1. Hold governments to account!

Civil society must hold governments to account. Accountability or lack thereof, must

be understood as primarily being a human rights issue as well as a governance issue. There are many human rights that are not realised because of non-delivery on the commitments. The list is long. There is the right to health. There is the right to information. The right to development, particularly in relation to girls and women whose gains are being reversed by inadequate state actions. What about the right to a life of dignity? The important thing is to recognise that the implicit 'It is their fault they got infected' mentality is fundamentally flawed and must be rejected. Unless and until such a time that every African is knowledgeable about HIV&AIDS, has access to sufficient prevention services, is sufficiently empowered to independently determine his or her sexual lifestyle and not suffer unduly for the choices he or she makes to protect him/herself, governments cannot shift the blame to individuals. We need to be convinced that they have taken all the necessary measures to respect, protect and facilitate the fulfilment of the right to health.

The millions of people living with HIV&AIDS are in this position largely as a result of inadequacies in our past responses. Having failed them once we have the opportunity to redeem ourselves and act on their rights. The failure to give them access to medicines and treat opportunistic infections when this is within our capabilities and we clearly have the capacity to do more is a violation of human rights that highlights the governance shortcomings in Africa.

Governments are in place to serve people. The contract between state and individual is simple. Governments express a willingness to serve. Citizens elect them to serve their(citizens') best interests. This is the governance standard to which the governments must be held to account. In the Abuja Declaration measures that further the best interests of citizens in relation to health services were outlined. When they are not fulfilled the citizen's deserve to know why some other expenditures are more important than those identified by and agreed by the leaders in Abuja.

8.2. Improve monitoring of commitments

Civil society needs accurate and up-to-date information on actual expenditures to better hold the governments to account. A balance between intent and practice will be required. In some countries budgets are merely indicative and do not reflect final expenditures. In many countries final accounts on budget outturn lag behind by several years. Past trends in variance between planned and actual expenditures are needed to give an indication of how closely planned expenditures estimate actual expenditures.

8.3. Identify and lobby for specific investments!

Perhaps civil society should also realise that governments may be at a loss as to what the expenditure needs are. In each and every country it is important to identify specific investment requirements and lobby the governments to make these. We certainly do not want governments to simply know they need to do more but be unclear about what those priorities are!

8.4. Create space to bring the reality of non-fulfilment of the commitments to the doorsteps of leaders

Africa's leaders and development partners need to be reminded what the Abuja Declaration commitments are really about. The people whose lives are changed or cut short by preventable and manageable diseases. In addition to reminding governments that they must deliver the 15%, we ought to tell them what non-delivery does within their countries and be honest enough to state that non-delivery is a political choice they make. What is the point for example in promoting condom use and then failing to improve availability and access to the condoms. We need to remind ourselves of the true costs of our inaction. What is the cost of a condom stock-out in human lives and health care costs? What is the cost of tariffs in human lives lost due to failure to afford treatment of opportunistic infections? When all is said and done, are any of the reasons given for inadequate action sufficient to justify the unnecessary infection, disruption of livelihoods and loss of life? The answer can only be a resounding NO!