



The Abuja Declaration: Ten Years On

2001 Promises of commitment and solidarity

In September 2000, 189 heads of state adopted the Millennium Declaration designed to improve social and economic conditions in the world's poorest countries by 2015. Subsequently, a set of eight goals were devised, drawing on the Millennium Declaration, as a way of tracking progress. Three of these relate specifically to health; two more have health components.

In April 2001, heads of state of African Union countries met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector. At the same time, they urged donor countries to "fulfil the yet to be met target of 0.7% of their *GNP* as official Development Assistance (ODA) to developing countries".¹ This drew attention to the shortage of resources necessary to improve health in low income settings.

At that time, the median level of general government health expenditure from domestic resources (GGHE-FS)² in African Union Countries was very close to US\$10³ with a thousand-fold difference between the minimum (US\$0.38) and maximum (US\$380). In terms of ODA, five of the 22 donors then reporting to the OECD were already giving at least 0.7% of their Gross National Income (GNI) with an average (unweighted) of 0.4 %.⁴

¹ The Abuja declaration quoted the target of 0.7% GNP but we recognize that many donor countries express their targets in terms of GNI.

² For the first time, this report presents GGHE from exclusively domestic financing sources (FS) using data collated from reports of national health accounts and official documents of ministries of finance, central banks and national census and statistics offices as well as mission reports and studies from the International Monetary Fund (IMF) and the World Bank. Health expenditures conform to the boundaries of National Health Accounts (NHA). Domestic financing resources come from the general government (not necessarily limited only to ministries of health) and exclude grants and other forms of official development aid. Other reports have generally referred to GGHE as a financing agent.

³ Expressed in real 2009 US\$

⁴ <http://www.oecd.org/dataoecd/43/56/2507734.pdf>

2011 Today's reality and potential

Table 1 shows progress since 2001 in the African Union countries for indicators for health⁵ and government health expenditures.

Table 1. Abuja Declaration and Health MDG Status Indicators, After 10 years							
	2009**>2000 health share of total spending of government as a source		2009**=2000 health share of total spending of government as a source		2009**<2000 health share of total spending of government as a source		Number of countries
	per capita>33US\$	per capita=<33US\$	per capita>33US\$	per capita=<33US\$	per capita>33US\$	per capita=<33US\$	
	Seychelles (MIC)***	Eritrea	Algeria (MIC)	Madagascar			
		Rwanda	Egypt (MIC)				
			Tunisia (MIC)				
			Cape Verde				
On track health MDGs	1	2	4	1	0	0	8
Off track health MDGs	7	17	2	5	0	7	38
	Botswana (MIC)	Burkina Faso	Mauritius (MIC)	Dem Rep Congo		Benin	
	Gabon (MIC)	Burundi	Namibia (MIC)	Ethiopia		Central African Republic	
	South Africa (MIC)	Cameroon		Kenya		Gambia	
	Swaziland (MIC)	Chad		Niger		Guinea	
	Angola	Comoros		United Republic of Tanzania		Malawi	
	Sao Tome and Principe	Congo				Mauritania	
	Lesotho	Côte d'Ivoire				Togo	
		Djibouti					
		Ghana					
		Guinea Bissau					
		Liberia					
		Mali					
		Mozambique					
		Nigeria					
		Senegal					
		Uganda					
		Zambia					
Number of countries	8	19	6	6	0	7	46

* Excludes Libya, Somalia, Equatorial Guinea, Sierra Leone, Sudan and Zimbabwe due to lack of data or difficulty in interpreting trend. Morocco not part of Abuja Declaration

** When 2009 data were not available, the latest available in the country were used

*** Health MDG status for Seychelles is based on "Seychelles Millennium Development Goals: Status Report 2010" and UNAIDS Country situational analysis (<http://www.unaidsrsta.org/regional-country-profiles-home/country-profiles/seychelles#key%20achievement>)

Only eight countries are on track with respect to the health Millennium Development Goals(MDGs). Most countries are achieving less than 50% of the gains that would be required to reach the goals by 2015, with progress on MDG 5 (maternal health) being particularly slow.

Twenty-seven countries have increased the proportion of total government expenditures allocated to health (GGHE/GGE) since 2001. However, only Rwanda and South Africa have achieved the Abuja Declaration target of "at least 15% ". Meanwhile, seven countries reduced their relative contributions of government expenditures to health during the period. In the other twelve countries, there is no obvious trend upwards or downwards.⁶

The median level of real per capital government spending from domestic resources on health has increased from US\$ 10 to US\$ 14 over the decade, although the lowest observed level is still very low at US\$ 0.47. Interestingly, the upper level has fallen from US\$ 380 to US\$ 314. The governments of 32 countries currently spend less than US\$ 33 per capita on health⁷. Of the 14 countries that spend more than US\$ 33 per capita, 71% are middle income countries.

It is important to consider both the share of government spending devoted to health as well as the overall level of spending when considering the ability of a country to meet the health MDGs. The issue is less whether the ratio of GGHE/GGE is static, decreasing or increasing, than the fact that as long as per capita health expenditure is low, countries will not achieve the health MDGs. However, if both the ratio

⁵ Health MDGs are expressed as on or off track based on their expected trajectories. Scoring methodology uses that of the Center for Global Development <http://www.cgdev.org/content/publications/detail/1424377> applied on UN data on the following selected indicators: child mortality rate for MDG 4, maternal mortality rate for MDG5 and HIV prevalence for MDG6. Methodology is based on the % attained over expected and a score of 1 means attainment is as expected for the time period, assuming a straight line trajectory from 1990 to 2015. In this report, a score of at least 2 out of the three gets the country classified as on track for health MDGs.

⁶ Static means a change of less than 1%

⁷ half of the average expected expenditure needed to meet the MDGs for low income countries in 2009 based on estimates from the High level task force on innovative financing for health systems, expressed in 2009 US\$)

and per capita real spending increase, the financial constraints to reaching the health MDGs will obviously be reduced.

International support

The Abuja and MDG compacts were also opportunities for donor countries to express solidarity. Donor promises were again formalized in the 2004 G8 summit in Gleneagles, UK, with the G8 countries pledging to increase their levels of ODA to Africa and many of them pledging to reach the target of 0.7% of GNI devoted to ODA in total. The OECD secretariat estimated that the new pledges would increase aid from around US\$ 80 billion in 2004 to nearly US\$ 130 billion in 2010, at constant 2004 prices. This represents 0.36% of the estimated GNI of the G8 countries in 2010.

In 2009, however, overall net bilateral ODA to Africa was just US\$ 27 billion.⁸ Only five countries reached 0.7% of GNI devoted to ODA. Moreover, following the financial crisis, the dollar value of ODA disbursements fell between 2008 and 2009 for 11 of the 23 countries reporting to the OECD. In 2009, ODA represented just over 0.31% of GNI on average (unweighted) in these countries. This means that since 2001, overall ODA has actually decreased.

In the field of ODA in health, the picture is rosier. Disbursements per person in recipient countries⁹ tripled from an average of close to US\$ 5 in 2002 to US\$ 13 in 2008. However, the benefits are not spread evenly, with a few countries receiving relatively large contributions, and some virtually nothing. For example, the maximum received in one country in 2008 was US\$ 115 per person, while 12 countries received less than US\$ 5 per person.

Questions and the future: What has happened since 2001?

Funding targets are being missed, both domestically and in terms of international assistance. Many African Union countries are going to struggle to reach the health MDGs as a result. Those commitments are still badly needed. The targets are important guideposts. But the real issue is that the absolute level of resources available in relation to the health needs is well below what is needed. The lingering financial crisis in donor countries also means that some are likely to further reduce the dollar values of their disbursements until their economies start growing again. It is therefore important to consider ways to develop new sources of funds and examine more critically how to improve the efficiency of health spending, while always protecting the poor and vulnerable.

What specific steps can countries, whether donor or recipient, undertake?

- In recipient countries, increase priority given to health from general budget and/or debt relief funds. Specifically, from the analysis undertaken for this report, it is clear that some countries need to increase their own investments in health either through reallocation within their own general budgets or by making larger claims on their funds from debt relief¹⁰ which are to be preferentially allocated to social spending.
- In donor countries, encourage innovative funding sources to supplement, not replace, traditional bilateral assistance for health as suggested by the recent High Level Task Force on Innovative International Financing for Health Systems¹¹. In this respect, it will be important to consider ways to increase funding for the so-called "donor orphans", the countries in the AU that still receive very little external financial support.

Ministers of health and ministers of finance can enhance governance of the official development funds that are flowing into the country for health. Today, as much as 50% of these funds do not flow through the government. External partners are frequently reluctant to report to the recipient government how these

⁸ http://www.oecd.org/document/11/0,3746,en_2649_34447_44981579_1_1_1_1,00.html

⁹ From the OECD CRS website. Donors, including bilaterals, multilaterals (development banks and UN agencies) and some major foundations (GAVI, BMGF and GFATM) have reported to OECD their yearly disbursements to recipient countries, tagged by codes indicating the purpose of the aid (some of which are health codes). In their project descriptions, donors also tag the channels of implementation including government. As only one tag is allowed per amount, the attribution is to the more general code or biggest recipient.

¹⁰ Table 12: Classification of African countries by HIPC status (January 30, 2010); Assessing Progress in Africa toward the Millennium Development Goals, MDG Report 2010; UNECA/AU/AfDB/UNDP

¹¹ *Raising and channeling funds: Working Group 2 report*. Taskforce on Innovative International Financing for Health Systems, 2009 (http://www.internationalhealthpartnership.net/CMS_files/documents/working_group_2_report:_raising_and_channeling_funds_EN.pdf).

funds are spent, so it is difficult to know if they are being spent efficiently and if they are being spent according to national priorities. Moreover, a considerable proportion of the funds donors claim to have disbursed may be spent before they even enter the country by external contractors with high transaction costs. It is important that recipient governments increase their capacities to track all health expenditures in the countries, including donor funds, using internationally agreed methods.

WHO estimates that if all the ODA that donors report they are disbursing for health and population activities actually arrived in the recipient countries for them to spend according to their priorities, when it is added to the existing levels of government spending, almost US\$ 61 per capita would be available. This is close to what the the High Level Task Force estimated was required to reach the MDGs in the world's poorest countries.

Greater attention to prioritizing and coordinating spending could yield considerable efficiency gains as well. Ways to do this include increasing use of in-country or south-south technical expertise; integrating the provision of in-service training; and improving supply chains and other initiatives funded by disease-specific grants so they benefit the wider health system.

Efficiency in domestic health spending can also be improved in most countries. The World Health Report 2010, *Health Systems Financing: the Path to Universal Coverage*, outlined ten common causes of inefficiency in health systems, which together might mean that between 20% and 40% of all health resources are being wasted.¹² Not all will be present in every country, but the list offers ideas as to where countries can look first. More efficiency offers more health for the money.

Where resources remain very scarce, efficiency gains alone will not reach the MDGs. The World Health Report also provides suggestions on how more money for health could be raised domestically and how people could be better protected from the financial consequences of ill health.

A final issue is that external funds that flow through the government are intended to be disbursed and spent according to the budget and purpose for which they are allocated. A report of the International Monetary Fund's (IMF) Internal Evaluation Office in 2007 showed that on average, for every dollar the IMF transferred to sub-Saharan Africa relating to its poverty reduction global facility from 1999 to 2005, only US\$ 0.27 were spent, while the rest was used for domestic debt reduction or building foreign reserves.¹³ While it is certainly important to have prudent fiscal and monetary policies, it is also important to discuss and debate about whether an increased proportion of the available aid could be spent to improve people's well being.

Conclusions

Most AU countries are not yet on track to achieve the health MDGs and part of the explanation can be found in the lack of financial resources available to them. The Abuja Declaration recognized this as a potential problem ten years ago, highlighting the importance for governments in AU countries of giving greater weight to health in the allocation of government revenues, while at the same time urging donor countries to increase their funding levels.

In the 10 years that has passed since the Abuja Declaration, there has been progress towards increasing the availability of financial resources for health at least in terms of dollar values. However, there has not been appreciable progress in terms of the commitments the AU governments make to health, or in terms of the proportion of GNI the rich countries devote to ODA.

While it is important to reiterate the need for governments to be committed to improving the health of their populations, something that is increasingly becoming a political issue in countries, it is also important to look for additional ways of moving more rapidly towards the MDGs. The World Health Report 2010 provides some ideas in terms of ways of raising new global and domestic funds for health, ways of increasing financial risk protection relating to health, and ways of becoming more efficient in the use of external and domestic resources used for health.

Time is short, but solutions do exist.

¹² <http://www.who.int/whr/2010/en/index.html>

¹³ <http://www.ieo-imf.org/eval/complete/pdf/03122007/report.pdf>