REPORT OF THE SADC PF STANDING COMMITTEE ON HUMAN AND SOCIAL DEVELOPMENT AND SPECIAL PROGRAMMES (HSDSP) TO THE 56TH PLENARY ASSEMBLY

THEME: *"THE ROLE OF PARLIAMENTS IN RAISING, ALLOCATING AND SPENDING RESOURCES NECESSARY FOR PUBLIC HEALTH AND SRHR FINANCING"*

Mr. President, I beg to move that this Plenary Assembly do adopt the Report of the Standing Committee on Human and Social Development and Special Programmes (HSDSP) to the 56th Plenary Assembly Session of the SADC Parliamentary Forum, laid on the table on 11th December 2024.

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1.0 COMPOSITION OF THE COMMITTEE

As of 20th September 2024, the Committee comprised the following Members:

1.	Hon. Mope Khati ***(Chairperson)***	Lesotho
2.	Hon. Lynette Karenyi ***(Vice-Chairperson)***	Zimbabwe
3.	Hon. Luisa P. F. Damiao Santos	Angola
4.	Botswana (Parliament was dissolved pending General Elections)	
5.	Hon. Mbotema Mboyo	DRC
6.	Hon. Sen. Linda Nxumalo	Eswatini
7.	Hon. Fiarovana Lovanirina Célestin	Madagascar
8.	Hon. Rachel Zulu	Malawi
9.	Mauritius (Parliament was dissolved pending General Elections)	
10.	Mozambique (Parliament was dissolved pending General Elections)	
11.	Hon. Agnes M. Kafula	Namibia
12.	Hon. Kelly Samynadin	Seychelles
13.	South Africa (Had not yet nominated a Member following General Elections)	
14.	Hon. Kassim Haji	Tanzania
15.	Hon. Julien Nyemba	Zambia

2.0 TERMS OF REFERENCE

The Terms of Reference of the Standing Committee on Human and Social Development and Special Programmes (HSDSP) are articulated in Rule 42 (e) of the SADC PF Rules of Procedure which states as follows:
"To deal with human and social development issues pertaining to health and combating illicit drug trafficking, HIV/AIDS, human resource development, education, professional training, employment and labour, culture and sport, science and technology and humanitarian issues, among others".

3.0 NUMBER OF MEETINGS HELD, DATE AND THEME

The Standing Committee on Human and Social Development and Special Programmes (HSDSP) convened on the 19th and 20th of September 2024 at Radisson Hotel in Johannesburg, South Africa to discuss matters within its mandate. This meeting was held under the theme: *"The Role of Parliaments in Raising, Allocating and Spending resources necessary for public health and SRHR financing."*

4.0 BACKGROUND

In 2024, human and social development in the SADC region faces significant challenges, exacerbated by hyperinflation, health crises, and climate-related devastations. These threats persist against a backdrop of shrinking consumer spending and stagnant revenue sources, as most SADC countries continue to import more than they export, leading to enduring trade deficits. With rising expenditures and limited revenue growth, governments are often forced to cut costs, and public health budgets are frequently the first to suffer, resulting in gaps in health and SRHR services. Parliament plays a critical role in exercising

oversight and ensuring that health financing remains a priority on the Government agenda. According to the World Economic Forum's January 2024 report, closing the gender gap in health financing would require $1 trillion, highlighting the urgent need to address health inequities that affect both men and women. These inequities are costly to both the state—leading to loss of productivity and GDP—and to individuals, diminishing their potential to live healthy, productive lives. Health inequities alone are estimated to result in over $40 billion in lost productivity and efficiency.

At the regional level, the SADC Health and HIV Financing Initiative aims to advance Sustainable Development Goal 3 by dedicating around 10% of SADC's GDP to the health sector over the next decade. However, achieving this requires innovation, consistency, and strong political will. That is why the Standing Committee on Human and Social Development and Special Programmes convened from 19th to 20th September 2024 in Johannesburg, South Africa under the theme, *'The Role of Parliaments in raising, allocating and spending resources necessary for public health and SRHR financing.'* The import of this meeting was to highlight the crucial role that Parliaments play in shaping health financing policies and ensuring that resources are adequately mobilized, allocated, and spent effectively to achieve universal health coverage and meet SRHR commitments.

5.0 EXPERT PRESENTATIONS

During the meeting, the Committee received expert presentations and submissions from the following persons:

i.	Dr Matiko Riro	Clinton Health Access Initiative;
ii.	Ms Vivian Joseph	SAYoF; and
iii.	Ms Caroline Kwamboka	Citizen

6.0 REFLECTIONS AND BRAINSTORMING SESSION BY MEMBERS OF THE COMMITTEE

The Committee considered this session through group discussions during which the Members brainstormed and reflected on key questions concerning health financing. The goal was to gather country-specific experiences on how Parliaments can play a proactive role in ensuring that Governments raise, allocate, and spend resources efficiently and effectively to achieve universal health coverage (UHC). The group discussions were guided by the following key thematic questions:

6.1 What are the main ways in which resources for public health are mobilized at country level, and what is the approximate ratio of donor to Government funding?

During the discussions, it became clear that in most SADC member states, three primary sources of health financing dominate: public financing through the national budget, support from development partners and donors, and private spending, primarily through out-of-pocket expenditure. It was also

highlighted that in the majority of member states, the government serves as the primary source of health funding, with public financing making up over 50% of total health spending. However, despite this, Members expressed concern that budget allocations were often insufficient to meet the growing health demands, including achieving key international commitments such as the Abuja Declaration, which sets a target of at least 15% of national budgets being allocated to health. This shortfall in funding has led to significant inequities and inequalities in access to quality health services, with rural and underserved populations being disproportionately affected. Members emphasized the need for Parliaments to take a more assertive role in advocating for increased health financing, ensuring that the limited resources are allocated and spent effectively. They also called for stronger oversight mechanisms to monitor government spending on health and push for policies that would address inefficiencies and improve the overall health system performance across the region.

6.2 Where is the bulk of allocations on health directed to, and is it sufficient?

During discussions on budget allocations and allocative efficiency, Members noted a concerning trend in most member states where financing is disproportionately directed toward curative services rather than preventative care. This prioritization neglects essential preventive measures that are crucial for maintaining public health and mitigating future health crises. Furthermore, several member states highlighted that their budget allocations fail to account for emerging health challenges, such as the rising incidence of pandemics and epidemics, including COVID-19 and Mpox. Additionally, it was mentioned that the budgets often overlooked pressing issues like mental health and sexual and reproductive health and rights, which are increasingly recognized as vital components of comprehensive healthcare. Members expressed frustration over the inconsistency between allocated and disbursed funds, indicating that even when budgets are set, the actual financial support often falls short, leading to gaps in service delivery and further exacerbating health inequalities. This variance in funding not only undermines the effectiveness of health systems but also diminished the capacity of Governments to respond adequately to the evolving health needs of their populations. Members emphasized the need for more equitable and responsive budgetary practices that align funding with both current health realities and future health priorities.

6.3 Is Parliament sufficiently capacitated to identify the gaps in health financing and to exercise oversight on public authority in view of closing same?

Regarding the role of Parliament in identifying gaps in health financing and effectively discharging their oversight mandate, there was a consensus that most member states have established various mechanisms to fulfil this responsibility. Notably, many national Parliaments have select committees dedicated to health issues, which play a crucial role in driving the health

agenda. These committees provide policy guidance and contribute to shaping the health budget, ensuring that health concerns are prioritized in national discourse. However, Members acknowledged a substantial limitation in their oversight capabilities. While these mechanisms exist, the role of Parliament is often confined to making recommendations; the final decision to adopt these recommendations lies primarily with the Executive branch. Consequently, the influence of parliamentary committees on shaping the health budget can sometimes be more ceremonial than substantive, undermining their potential impact on improving health financing and addressing critical health challenges. Members emphasized the need for a more empowered Parliamentary role that enables them to actively influence health budget allocations and ensure that funding decisions align with the pressing health needs of their populations.

7.0 EXPERT PRESENTATIONS

7.1 Presentation on the Role of Parliaments in raising, allocating and spending resources necessary for Public Health and SRHR financing

The presentation was done by Dr. Matiko Riro from the Clinton Health Access Initiative (CHAI) who provided an insightful analysis of health financing, categorizing it into four distinct types: public funding, prepaid health insurance, external support, and out-of-pocket expenditure. He emphasized that the current health financing landscape in many countries was marked by low levels of public investment, heavy reliance on external funding, and a high burden on individuals through out-of-pocket expenses. This imbalance negatively impacted health outcomes, particularly in countries with limited public health spending. He highlighted South Africa as an example, where government spending of $527 per capita correlates with a significantly lower maternal mortality rate (138), in contrast to countries with lower health expenditure. Additionally, the presenter also stressed the urgent need to remove both financial and physical barriers to healthcare access, especially for vulnerable populations. He pointed out the competing priorities governments face, especially in contexts of limited financial resources, and urged that equity should be at the forefront when allocating and distributing health resources, with a particular focus on underserved areas and vulnerable populations.

Regarding the role of Parliaments in health resource allocation, four key perspectives were outlined. First, the legal perspective, where legislative measures can be taken to safeguard the right to health and ensure adequate financing for overlooked areas like sexual and reproductive health and rights (SRHR). Second, the advocacy perspective, where Members of Parliament must advocate for enhanced support for underserved and vulnerable groups in discussions about universal health coverage (UHC). Third, the health systems perspective, where Parliamentarians should ensure that health budgets address the WHO's six building blocks of health systems to achieve UHC. Lastly, the economic perspective requires MPs to understand the

necessary trade-offs to achieve health goals, with a focus on equity and reducing high out-of-pocket expenses. During the plenary session, Members questioned the effectiveness of the Abuja Declaration and sought interventions to increase domestic health financing beyond the 15% target, as well as ways to reduce rising healthcare costs. It was explained that the 15% target was a rallying point, not a solution on its own. Beyond meeting this target, countries needed to ensure effective allocation, accountability, and integration of health system components. On rising healthcare costs, the issue was attributed to the heavy reliance on imported health commodities like vaccines and medicines. To address this, governments were urged to invest in local health value chains to meet and exceed domestic demand. Members also inquired about the possibility of implementing innovative financing mechanisms, such as sin taxes on alcohol and tobacco. In response, it was noted that several countries had already introduced such measures. For example, Ghana set aside 2% of its VAT for health, while Gabon implemented a 10% levy on airtime. However, it was highlighted that while many countries have sin taxes, these funds are often not earmarked specifically for health. The importance of directing these taxes towards health financing was emphasized as a way to bolster domestic resources for the sector.

7.2 Presentation on allocating and spending resources for Health, SRHR financing and the Role of Parliaments

In this presentation, the Committee learned that once resources are mobilized, it is crucial for governments to spend wisely. Five key considerations for spending were proposed:

- Prioritizing services and establishing a benefits package to ensure essential health services are accessible.
- Implementing sustainable health insurance schemes to shift from out-of-pocket payments to prepayment systems, thereby reducing catastrophic health spending.
- Redistributing resources through pooling to enhance equity in healthcare access.
- Linking payments to outputs or needs, which can increase value for money by aligning spending with health outcomes.
- Building strong institutions to ensure that funds are utilized efficiently, equitably, effectively and transparently for long-term sustainability.

Members were encouraged to shift their perspective on donor and development partner support, viewing it not as a primary source of health financing but as a complementary fund. This approach, he affirmed, would ensure that adequate domestic funds are always prioritized for the health sector. It was also emphasised that resource mapping and expenditure tracking were critical to avoid duplication and promote a more cohesive and coordinated approach to development partner support. Members were urged to enact laws that require better coordination of aid from development

partners, with Malawi highlighted as an example of countries that have successfully implemented such measures.

8.0 COMMITTEE'S OBSERVATIONS AND RECOMMENDATIONS

Following the brainstorming session by Committee Members and expert presentations, the Standing Committee on Human and Social Development and Special Programmes made the following observations and recommendations to be presented to the 56th Plenary Assembly:

RECOGNISING the critical importance of health financing as a fundamental pillar for achieving universal health coverage (UHC) in the SADC region, particularly in ensuring equitable access to healthcare services for all populations, including women, children, and vulnerable groups.

NOTING that many SADC Member States face significant challenges in mobilizing sufficient domestic resources for health, with heavy reliance on external sources of funding and high levels of out-of-pocket spending, which disproportionately affects low-income households.

AWARE that poor health systems, limited access to affordable healthcare, and the growing burden of diseases such as HIV, TB, malaria, and emerging epidemics continue to exacerbate household poverty, driving families further into financial distress.

HOWEVER, CONCERNED that women are disproportionately affected by these systemic health gaps, with many spending a significant portion of their lives in poor health, particularly due to insufficient investment in sexual and reproductive health and rights (SRHR), maternal health, and mental health services.

FURTHER CONCERNED that despite the presence of national health frameworks, the persistent high reliance on external funding has led to unsustainable health systems in the long term, and there remains limited political will to prioritize health in national budgets across the region.

RECOGNISING the urgent need to reduce the region's overdependence on external support and the need to strengthen domestic resource mobilization, improve efficiency in health spending, and ensure that health financing is sustainable and equitable.

ACKNOWLEDGING the role of Parliament in advocating for increased domestic investment in health, ensuring accountability in health spending, and pushing for innovative financing mechanisms such as earmarked taxes and sustainable health insurance schemes to mitigate high out-of-pocket expenses.

NOW, THEREFORE, the Committee resolved to recommend that the 56th Plenary Assembly should:

i. **URGE** national Parliaments to prioritize health financing in national budget allocations, ensuring that domestic resources dedicated to health are increased in line with the Abuja Declaration target of at least 15% of national budgets.

ii. **ENCOURAGE** national Parliaments to advocate for the establishment of national health insurance schemes to reduce out-of-pocket health spending, protect households from catastrophic health expenditures, and ensure equity in access to healthcare services.

iii. **SUPPORT** the implementation of innovative health financing mechanisms, including earmarked taxes on harmful products (e.g., tobacco, alcohol) and levies on other sectors, ensuring that these funds are transparently allocated to improving healthcare services, especially in underserved areas.

iv. **URGE** the SADC PF Secretariat to monitor and evaluate health financing in Member States, ensuring that resources are spent efficiently, and that development partner funding complements, rather than substitutes, domestic health investments.

v. **CALL UPON** national Parliaments to strengthen their oversight roles in health spending, ensuring that funds are allocated equitably, particularly in areas of SRHR, maternal health, and mental health services, which disproportionately affect women and children.

vi. **ENCOURAGE** national Parliaments to promote the inclusion of vulnerable populations in health financing policies and advocate for gender-sensitive budgeting that addresses the unique health needs of women and girls in the SADC region.

vii. **URGE** national Parliaments to enact policies and frameworks that support the decentralization of health services, ensuring that resources reach the most underserved and rural areas, thus reducing geographical barriers to accessing quality healthcare.

viii. **ENCOURAGE** Member States to collaborate in regional health financing initiatives, such as pooled procurement of medical supplies and shared investments in regional health infrastructure, to reduce costs and improve access to essential medicines and healthcare technologies across the SADC region.

ix. **URGE** the SADC PF Secretariat to facilitate Member States in developing sustainable health financing strategies that reduce reliance on external funding and encourage long-term investment in local health value chains, such as pharmaceutical production and health infrastructure.

9.0 CONCLUSION

The deliberations of the Standing Committee on Human and Social Development and Special Programmes recognised and emphasised the urgent need for Member States to prioritize health financing in order to address the persistent challenges facing the SADC region. It is imperative that national Parliaments exercise their oversight role effectively to ensure that health financing becomes a central focus of government agendas, driving equitable, sustainable, and accessible healthcare for all. Through coordinated regional efforts and robust political will, the region is poised to achieve the vision of universal health coverage and improved health outcomes.

In this regard, the Committee would like to submit its recommendations contained this report to the 56th Plenary Assembly for adoption.

Hon. Mope KHATI	Mr. Joseph MANZI
CHAIRPERSON	**COMMITTEE SECRETARY**

10.0 APPENDICES

LIST OF OFFICIALS

1.	Ms. Boemo Sekgoma	SADC PF Secretary General
2.	Ms. Paulina Kanguatjivi	SADC PF Secretariat
3.	Mr. Ronald Windwaai	SADC PF Secretariat
4.	Ms. Samuel Bokosi	SADC PF Secretariat
5.	Dr Moses Magadza	SADC PF Media Consultant
6.	Mr Toivo Mwaala	SADC PF Secretariat
7.	Mr Unaro Mungendje	SADC PF Secretariat
8.	Mr Allan Bokosi	SADC PF Secretariat
9.	Mrs Maria Mombola	Parliament of Namibia
10.	Dr Cleopas Gwakwara	Parliament of Zimbabwe
11.	Ms Idah Combe	Parliament of Tanzania
12.	Ms Maryline Muinyo	Parliament of Namibia
13.	Mr Jeff Zulu	Parliament of Zambia
14.	Ms Pamela Nyikavaranda	SADC PF M&E Consultant
15.	Mrs Rachael Mundilo	SADC PF Secretariat
16.	Mrs Samueline Kauvee	SADC PF Secretariat
17.	Mr Sheuneni Kurasha	SADC PF Secretariat
18.	Mr Joseph Manzi	Committee Secretary
19.	Ms Caroline Kwamboka	Citizen
20.	Ms Vivian Joseph	SAYoF
21.	Ms Maria de Lurdes Gomes	Parliament of Mozambique
22.	Dr. Matiko Riro	Clinton Health Access Initiative