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Poverty reduction and regional integration Policy Brief

SADC and Unasur health policies

- Inadequate access to health care and medicines is a persistent issue among impoverished populations in low-income countries in Southern Africa.
- Most vulnerable population are disproportionately affected by lack of or poor health care and access to medicines
- The poorest people living in less developed areas in the region still suffer from a group of unique neglected diseases linked to extreme poverty
- These are recognised social determinants of ill-health, poverty and social exclusion in Southern Africa.
- The high incidence of HIV, Malaria and Tuberculosis, as well as inadequate treatments for these diseases create opportunities for national and regional actors across Southern Africa to develop improved policies and methods tackling illness and the causes of disease.

Inside This Issue

Poverty reduction is a stated goal of the Southern African Development Community (SADC) and Union of South American Nations (UNASUR).

What can regional organisations do as SADC? Are they targeting the real problem?

Background: Disease poverty burden in the region

In Southern Africa, social exclusion and inequity remain leading obstacles to inclusive human development. They pose barriers to poverty reduction strategies, and hinder social unity and improved health conditions of populations. Social exclusion and inequity are further compounded by racial and gender discrimination. Consequently, the poorest of the poor are often affected by worst health indicators.

Swaziland and Zambia are amongst the poorest countries in Southern Africa. Both countries are similar in terms of poverty-related disease burden with weak institutional health systems.

Poverty and disease in the SADC region

The major problem facing the SADC region is the high prevalence of AIDS in each member country, considering the rapid growth of the pandemic in Southern Africa. In 2009, nine member states were experiencing adult HIV infection levels in excess of 10%, with three of those states with an HIV prevalence of above 20%. SADC member states account for approximately 42% of the 2.1 million AIDS related deaths globally (SADC, 2008, WHO, 2011, WHO/UNICEF, 2006, UNAIDS, 2010, SADC, 2009).

Tuberculosis is one of the major challenges in the region, as a standalone disease and because of its prevalence in HIV positive people in the region (AIDS.gov, 2013, CDC, 2013, SADC, 2007). The SADC Draft Strategic Plan for the Control of Tuberculosis (2007-2015) outlines current challenges posed by Multi-Drug Resistant (MDR) and Extensively Drug Resistant (XDR) tuberculosis, in an effort to control the spread of the disease in the region (SADC, 2007). A number of SADC states form part of the "high burden countries" that contribute more than 80% of global TB cases (SADC, 2007, World Bank, 2012).

Child survival and development are key problems in the SADC region. In 2009, more than one million children under the age of 15 years were estimated to be living with HIV in SADC member states. Rates of mother to child transmission (MTCT) in 2010 resulted in 176 000 new infant infections. Percentages of MTCT in the SADC region range from 3% to 37%. TB remains high, with five member states classed among the 22 global high burden TB countries (SADC, 2012)

SADC ACTION ON HEALTH: OPPORTUNITIES FOR PRO-POOR POLICIES

The SADC Health Protocol is the first regional health document in Southern Africa

SADC capitalises on a long history of regional cooperation in health to achieve the following:

- Promoting common policies, activities and cooperation
- Strengthening Ministries of Health
- Identifying critical determinants and promotion of intersectoral policies and actions, such as food security, healthy environments etc.
- Strengthening institutions structuring health systems of members
- Providing services and regulatory frameworks
- Supporting schools of public health, education and training institutions

The SADC Health Protocol

The SADC Protocol outlines commitments to combatting communicable and non-communicable diseases in the SADC region, amongst other concerns. As such, a number of declarations, plans and strategies have developed from the protocol, detailing specific goals to combatting the disease burden in the SADC region.

The SADC Code on Social Security

SADC regional commitment to poverty reduction through health initiatives looks specifically at the Code on Social Security. The Code provides guarantee for rights to social security, social insurance and social assistance. It guides other social protection mechanisms, including healthcare, maternity, paternity, death and survivor benefits, retirement and old age, unemployment, underemployment, occupational injuries, diseases, political conflict and natural disasters. The Code focuses specifically on vulnerable persons, including women, people with disabilities, families, children, youth, migrants, foreign workers and refugees (SADC, 2008).

The Code contains essential provisions for the development of social security in SADC at a country level. The Code provides guidelines, principles, standards, a monitoring framework and a mechanism for social security coordination and convergence. The Code specifically addressed marginalised groups, including females, the disabled, families, children and youth, migrants, foreign workers and refugees (SADC, 2008, Olivier, M, 2009).

Zambia and Swaziland have both made efforts, in partnership with donors, to establish pro-poor social protection programmes. National policies are looking towards including pro-poor programmes as part of national discourse.

- *Can the regional-national connexion help?*
- *Are these pro-poor policies?*
- *Can regional policies contribute to the health priorities of these countries?*

"Investment in health is fundamental to economic growth and development. Threats to health compromise a country's stability and security" (Oslo Declaration 2007)

We examine the regional integration-poverty nexus through the lens of health, and specifically in relation to access to health care and medicines, for two principal reasons. First, poor health and poverty coincide, are mutually-reinforcing, and are socially-structured by gender, age, class, ethnicity and location (CSDH 2008; Haines et al 2000; Marmot and Wilkinson 1999; Waelkens et al 2005). Inadequate access to health care and medicines is a social determinant of ill-health (Marmot 2005; Maclean, Brown and Fourie 2009) and is disproportionately borne by women and girls. Access is a a significant issue in peri-urban informal settlements and rural areas, many of which are often border areas where there is much scope for innovation in cross-border regional policy coordination in support of universal access to healthcare. Second, SADC and UNASUR have both developed institutional competences in health policy and poverty reduction, although their policy development practices and methods may take quite different forms.

Poverty reduction is a stated goal of regional integration in Africa and South America, but little is known about whether poverty reduction agendas and goals are in practice being progressed through regional health cooperation and if so, how. Research on the regional integration-poverty nexus (Schiff and Winters 1996; TeVelde 2006) has focused on the liberalisation of foreign trade, foreign direct investment, and labour migration.

Workshop
2 June 2014, South African Institute of International Affairs, Johannesburg, South Africa.

PRARI's CONTRIBUTION

Policy research on regional public goods, for its part, has not specifically examined health, or whether and how regional organisations' policy commitments are being implemented and embedded in domestic social institutions and policy formation (Deacon et al 2010; UNDP 2011)

The project investigates whether and how UNASUR and SADC practices and methods are generative of committed and embedded pro-poor health strategies, will, inter alia, enhance understanding of the conditions under which regional frameworks structure policies and practices in the interests of poverty reduction – and the ways in which they do so. What regional institutional practices and methods of regional policy formation are conducive to the emergence of embedded pro-poor health strategies? How do regional organizations engage with poverty issues and/or miss opportunities to do so? Which actors are mobilized in the process? To what effect?

FIELDTRIP TO ZAMBIA AND SWAZILAND

Our first SADC workshop will be held in Johannesburg on 2 June 2014. We will be starting our fieldwork phase in July of 2014. PRARI will investigate, in relation to the nature of the regional-health-poverty nexus. After that, we will continue with the analysis of the data collected and move on to comparison of results and creation of monitoring indicators.

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