HEALTH AND RELATED SOCIAL SERVICES:

A study on SADC Member States' Regulatory Regimes in preparation for SADC Trade in Services Negotiations

SOUTHERN AFRICAN DEVELOPMENT COMMUNITY (SADC) Short-term Assignment Report

Cooperation for the Enhancement of SADC Regional Economic Integration (CESARE) Programme





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ABBREVIATIONS

AfDB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrom
ANC	Antenatal Care
APIs	Active Pharmaceutical ingredients
ARVs	Anti-Retrovirals
AU	African Union
BIUST	Botswana International University of Science and Technology
CEO	Chief Executive Officer
CHAL	Christian Health Association of Lesotho
CHWs	Community Health Workers
CMT	Committee of Ministers of Trade
CPC	Central Product Classification
CTD	Common Technical Document
DALY	Disability-Adjusted Life Years
DHMTs	District Health Management Teams
DRC	Democratic Republic of the Congo
DTI	Department of Trade and
EHS	Essential Health Services
EML	Essential Medicines List (
EU	European Union
FIP	International Pharmaceutical Federation
GATS	General Agreement Trade Services
GCP	Good Clinical Practice
GDP	Gross Domestic Product
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GMP	Good Manufacturing Practices
GSK	GlaxoSmithKline
HDI	Human Development Index
HEIs	Higher Education Institutions



HIV	Human Immune Defficiency Virus	
HPCSA	Health Professions Council of South Africa	
HRH	Human Resources for Health	
HRSP	Human Resources Strategic Plan	
HSM	Health services management	
HVAC	Heating Ventilation, and Air Conditioning	
IPAT	Industrial Pharmacy Advanced Training	
IPTU	Industrial Pharmacy Teaching Unit	
KSP	Kilimanjaro School of Pharmacy	
KSP	Kilimanjaro School of Pharmacy	
LMIC	Lower and Middle-Income Countries	
M&E	Monitoring and Evaluation	
MCC	Medicines Control Council	
MDRA	Medical and Dental Regulatory Association	
MEDUNSA	Medical University of South Africa, known since 1 January 2015 as Sefako Makgatho Health Sciences University, Pretoria North, South Africa	
MHW	Ministry of Health and Wellness	
MoUs	Memoranda Of Understanding	
MRAs	Mutual Recognition Agreements	
MSA	Medical Schemes Act,	
MSs	Member States	
MUHAS	Muhimbili University of Health and Allied Sciences (), Tanzania	
NA	Not Applicable	
NCDs)	Non-Communicable Diseases	
NEPAD	New Partnership fof Africa's Development	
NGOs	Non-Government Organisation	
NHA	National Health Act,	
NHEMC	National Health Emergency Management Committee	
NTDs	Neglected Tropical Diseases	
ODA	Official Development Assistance n	
OECD	Organisation for Economic Cooperation and Development	
PCR	Polymerase Chain Reaction	
PEPFAR	U.S. President's Emergency Plan for AIDS Relief	
PESA	An independent think-tank advancing research on the political economy of development and regional integration in SADC and Africa	
PMPA	Pharmaceutical Manufacturing Plan for Africa	
PPE	Personal Protection Equipment	
PT	Proficiency Testing	



РТВ	Physikalisch-Technische Bundesanstalt
PTIS	Protocol on Trade in Services
QMS	Quality Management Systems
R&D	Research and Development
RHDs	Regional Health Directorates
RISDP	Regional Indicative Strategic Development
SADC	South African Development Community (SADC).
SAGMA	South Africa Generic Manufacturers' Association
SDG	Sustainable Development Goals
SDG	Sustainable Development Goals
SLP	Short Learning Programme
SPH	SADC Protocol on Health
SSA	Sub-Saharan Africa
ТВ	Tuberculosis
TMDA	Tanzania medical Devices Authority
TUT	Tshwane University of Technology
UHC	Universal Health Coverage
UK	United Kingdom
UNASUR	Union of South American Nations
UNCTAD	United Nations Conference for Trade and Development
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNICEF	United Nations International Children's Emergency Fund
US	United States
USP PQM	USPharmacopeia Promoting the Quality of Medicines Programme
WHO	World Health Organisation
WTO	World Trade Organisation
ZAZIBONA	Zambia-Zimbabwe-Botswana-Namibia Initiative



1 EXECUTIVE SUMMARY

1.1 Introduction

This study comes at a momentus time for the world, from which the Southern Africa Development Community (SADC) region is by no means excluded. The COVID-19 pandemic has dominated our lives since 2020 and created enormous health challenges that have taken understandable priority over many other policy issues that pre-pandemic would have taken a more central role in the context of sustainable economic and social development. In the early stages of the pandemic, the fear was that the virus would overrun national healthcare systems and cause many deaths, particularly in Africa where healthcare systems were widely thought to be unable to cope. Indeed, several countries reported capacity shortages, of intensive care hospital beds, equipment such as personal protective equipment (PPE) and ventilators, and healthcare workers (which we refer to frequently in this study as HRH, or human resources for health). In the event, although mortality rates in some countries was high (eg. South Africa), Africa as a whole did not suffer as much as had been expected. Nevertheless, the pandemic continues, with infections caused most recently by the Omicron variant.

Alongside healthcare policy, SADC has also been engaged for many recent years in negotiations to remove unnecessary barriers to trade in services. A first round of negotiations was concluded in 2019 in six sectors identified in the SADC Protocol on Trade in Services (PTIS) as priority sectors. At the time they were chosen, health services was not considered a priority sector for a trade agreement. However, SADC has now embarked on second round of negotiations, focusing on all sectors that were not included in the first round, and this therefore includes health and social services.

The key motivation for this study is therefore to examine the complementarity between health policy and trade policy, and to make recommendations on how healthcare systems in SADC MS can be strengthened while at the same time reviewing the scope, need and opportunity for SADC MS to increase trade in health services between each other.

1.2 Background

The service sector makes up half of Gross Domestic Product (GDP) in most SADC Member States (MSs). Policies that tend to improve the efficiency of the service sector are thus highly significant for economic growth. Services provide an important link in regional and global chains and can be a vital source of national competitive advantage as well as export revenues and investment. Service agreements tend to focus on maximising these gains by removing unnecessary barriers to trade and facilitating regulatory cooperation across countries. It is in this regard that SADC MSs agreed to adopt the PTIS which provides for progressive liberalisation of trade in services through removal of trade barriers across the membership. The PTIS came into force on 13 January 2022, having been ratified by eleven SADC MS. The exceptions are Angola, the Union of Comoros (which acceded to the SADC in 2018), the Democratic Republic of the Congo (DRC), Madagascar, and the United Republic of Tanzania.

The PTIS is meant to complement efforts undertaken in the context of the SADC Protocol on Health (SPH) which entered into force in 2004. The SPH provides for State Parties' commitments to cooperate in addressing health problems and challenges facing them through effective regional collaboration and mutual support. Among the specific objective of the SPH is to co-ordinate regional efforts on epidemic preparedness, mapping, prevention, control and where possible the eradication of communicable and non-communicable diseases; and progressively achieve equivalence, harmonisation and standardisation in the provision of health services in the Region. MSs have developed some regional programmes to address challenges in the health sector including joint efforts against communicable diseases, regional procurement pooling of essential medicines, currently



developing regional pharmaceutical value chain and most recently joint efforts aimed at minimizing the impact of Covid-19 in the region. The SADC Regional Indicate Strategic Development Plan (RISDP) 2020–30, adopted in August 2020, includes a target to strengthen and harmonise regional health systems for the provision of standardised and accessible health services to all citizens and addressing threats caused by health pandemics in the SADC region.

1.3 Purpose of study

This study was commissioned to make recommendations to strengthen both the national and regional health systems in their ability to respond to health services crises such as the COVID-19 pandemic and enable increased trade liberalisation through enhanced market access within the healthcare service industry under PTIS.

The purpose of this assignment is to provide a synthesis of the level of development of healthcare systems in the SADC region and MSs individually, taking into consideration the issues created by the COVID-19 pandemic, and provide recommendations for strengthening the ability of health systems to respond to health crises such as the COVID-19 pandemic, as well as facilitating increased trade liberalisation through enhanced market access within healthcare services and the pharmaceutical industry.

1.3.1 Objectives

The key objectives of this study are:

- 1. To establish the level of development of healthcare systems in the region;
- 2. To develop a status report on current practices among the SADC MSs in authorising foreign health professionals as well as the pharmaceutical profession to practise in the region;
- 3. To identify health system bottlenecks and trade barriers to provide key information that will enable:
 - a. MSs to prepare for trade negotiations covering liberalisation commitments;
 - b. Possible mutual recognition agreements in health services and pharmaceutical professionals.

1.3.2 Scope and approach

1.3.2.1 Scope

The scope of this study included review, analysis and synthesis of the following three inter-related aspects with the ultimate aim of establishing enhanced market access and trade liberalisation within the health sector among the Southern African Development Community (SADC) Member States (MSs) to enhance health systems' abilities to respond to routine needs as well as crises such as the COVID-19 pandemic:

- 1. Health systems development analysis based on:
 - a. internationally recognised tenets of health systems development;
 - b. issues faced by health systems due to the COVID-19 pandemic;
 - c. development and humanitarian modes of healthcare;
 - d. public and private segmentation and value within the larger healthcare systems of the MSs both within the development and humanitarian modes.
- 2. Review of the regulatory mechanisms, regulations and treatment of foreign healthcare professionals from the perspective of:
 - a. role of existing and/or the indigenous private sector within the larger healthcare systems of the MSs;



- value addition and/or potential benefits associated with foreign healthcare professionals to existing healthcare systems' effectiveness and efficiencies both from supply and demand aspects;
- c. barriers and constraints to enhanced/total market access and trade liberalisation within the healthcare services industry;
- d. Improving access to specialised services for the pharmaceutical industry.
- 3. Issues and constraints for complete market access and trade liberalisation in health services and recommendations for enhanced health systems effectiveness and efficiency in the SADC region.

1.3.2.2 Data collection and analysis

The study methodology involved data collection through a review of policy, strategic and various reports in the health and pharmaceutical manufacturing industry. Primary and complementary data was collected based on a set of detailed questions as in Annex 1. Those questions guided interviews (conducted virtually due to COVID-related travel restrictions) with selected key informants at regional and national levels as shown in Table 1.

At the regional level, the study interviewed representatives of the SADC Secretariat (Health Unit), the Medical and Dental Regulatory Association (MDRA), and the coordinator of the collaborative medicine registration initiative involving Zambia-Zimbabwe-Botswana and Namibia (ZAZIBONA). The interviews at national level were comprised of joint sessions with representatives of Ministries responsible for health, trade, labour and/or immigration and in some cases regulatory bodies or associations in the health sector. Also, some manufacturers and training institutions in the pharma sector were interviewed as shown in Table 1. A detailed list of the interviewees is provided in Annex 2.

SN	Institution/MSs	Interview date	
Regional st	Regional stakeholders		
1.	SADC Secretariat – Health Unit	05 Feb 2021	
2.	MDRA Secretariat	01 Apr 2021	
3.	ZAZIBONA Coordinator		
National stakeholders			
4.	Zambia	01-Feb-21 & 05-Mar-21	
5.	South Africa	01-Feb-21	
6.	Mauritius	09-Feb-21	
7.	Namibia	10-Mar-21	
8.	Malawi	08-Mar-21	
9.	Botswana	10-Mar-21 Mar-21	
10.	Seychelles	22-Mar-21	
11.	Democratic Republic of the Congo (DRC)	29-Mar-21	
12.	Zimbabwe	31-Mar-21	

Table 1: Interviews with Key Informants



SN	Institution/MSs	Interview date		
13.	Eswatini	01-Apr-21		
14.	MDRA	01-Apr-21		
15.	Lesotho	06-Apr-21		
Pharmaceu	Pharmaceutical sector			
Company/o	Company/organisation			
16.	Strides Pharma (Mozambique)	10-Feb-21		
17.	Chemical Process Technologies (south Africa)	08-Feb-21		
18.	Kiara Health (South Africa)	19-Feb-21		
19.	Plus Five Pharmaceuticals (Zimbabwe)	19-Feb-21		
20.	Shelys Aspen Pharma (Tanzania)	23-Feb-21		
21.	Zenufa Labs (Tanzania)	18-Feb-21		
22.	Muhimbili Univerisity of Health and Allied Science - R & D lab (Tanzania)	21-Mar-21		
23.	Kilimanjaro School of Pharmacy (Tanzania)	26-Mar-21		

1.3.2.3 Structure of the report

The following chapters present the main findings based on our analysis and recommendations to address the key issues. It may be noted that this report does not provide country-specific details obtained in response to the questions as the steer remains regional and findings are presented from a more regional perspective. Where specific countries are mentioned, the purpose is to provide examples and not to state that a particular finding is only true or not true for that country or countries. Similarly, for pharmaceutical organisations, the mention of parties is to exemplify a given finding and not to exclude others or include only the mentioned party.

1.4 Role of GIZ and GFA

Since 2010, GIZ has been providing technical support to the SADC regional agenda through the programme "Cooperation for the Enhancement of SADC Regional Economic Integration (CESARE Trade) 2018-2022". The current phase builds on the achievements of the previous phases, aims to enhance regional economic integration in in the areas of industrialisation, trade in goods and trade in services as well as peace and security. GFA Consulting Group is implementing a component of this programme covering trade in services, which is implemented by in consortium with DNA Economics. The component covers process-oriented assistance and technical support to SADC MSs in the implementation of the first round commitments and in preparations for the second round negotiations, including production of technical and research papers, such as the current study, to inform Member States' negotiating positions.



2 INTRODUCTION

2.1 Key data on the SADC region

The SADC region comprises 16 MSs. It covers an area of more than half million square kilometres and has a population of approximately 350 million. The aggregate Gross Domestic Product (GDP) annual growth rate for the region (in 2018) was 1.8% while GDP (2018) stood at \$ 721.3 billion. The region has an inflation rate of 7.1% and the average government debt as percent of GDP (in 2015) was 42.8%. Overall the region has a high HIV prevalence rate - 11.3% in 2018¹.

Using the Human Development Index² (HDI), Table 2 provides an overview of the present state of development in the SADC MSs: only one country, i.e. Mauritius, ranks high on this scale while more than one-third of countries are categorised as low on the HDI scale. The table also captures the state of ratification of the SADC Protocol on Trade in Services (PTIS) as at December 2021.

SADC MSs		Ranking in HDI (2019)
1.	Angola	0.581
2.	Botswana	0.735
3.	Comoros	0.554
4.	Dem Rep of Congo	0.480
5.	Eswatini	0.611
6.	Lesotho	0.527
7.	Madagascar	0.528
8.	Malawi	0.483
9.	Mauritius	0.804
10.	Mozambique	0.456
11.	Namibia	0.646
12.	Seychelles	0.796
13.	South Africa	0.709
14.	United Republic of Tanzania	0.529
15.	Zambia	0.584
16.	Zimbabwe	0.571

Table 2:	SADC MSs - HDI status
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<u>Legend</u>

Colour coding in HDI column reflects ranking: Red – Iow; Yellow – medium; Light Green – high; Dark Green – very high Source: HDI ranking: Human Development Report 2020, UNDP (see endnote 4)

2.2 Trade in services

Trade in goods and services constitutes a major area of cooperation in support of economic development and poverty eradication in the SADC. The regional GDP contribution by services stood at 59.4% in 2015 compared to industry at 20.3% and agriculture at 20.2%, making services critical to the economic growth and prosperity of the region. At the same time the region shows a perpetual decline in average GDP growth: from 6.8% in 2007 to 2.1% in 2017. During a similar period, government debt for the region as a percentage of GDP) has doubled: from 28.5% of GDP in 2007 to 56.1% of GDP in 2018³.

The service sector makes up half of GDP in most of the SADC MSs. Policies that tend to improve the efficiency of the service sector are thus highly significant for economic growth. Services provide an important link in regional and global value chains and can be a vital source of national competitive advantage as well as export revenues and investment.

Services trade agreements tend to focus on maximising these gains by removing unnecessary barriers to trade and facilitating regulatory cooperation across countries. The SADC trade in



services liberalisation programme consists of successive rounds of negotiations, conducted within the framework of the SADC PTIS, with the first round covering six sectors (communication, construction, energy-related financial, tourism and transport services)¹. On conclusion of the first round in 2019, the Committee of Ministers of Trade (CMT) directed MSs to embark on preparation of a second round of negotiations covering the remaining sectors. MSs were also directed to prioritise work on mutual recognition of requirements, qualifications, licences and other regulations necessary for granting effective market access for professional services.

2.2.1 SADC Protocol on Trade in Services

Mindful that services can play a crucial part in the transformation and sustainability of an economy, as well as assisting in the creation of employment opportunities, SADC Heads of State and Government signed the PTIS in August 2012. It will enter into force in January 2022 following the deposit of instruments of ratification by two-thirds (i.e. 11) of the MSs², in accordance with Article 30 of the Protocol. Of the five MSs that have not submitted their instruments of ratification, three rank low on the HDI and two rank medium, as referred to in Table 2 above.

The PTIS has six primary objectives as set out in Article 2, which can be interpreted into one main objective, namely to level the playing field among SADC MSs by ensuring that industries and consumers take full advantage of a single regional services market⁴. The PTIS provides for progressive liberalisation of trade in services through the removal of trade barriers across the membership. Its scope extends to all government measures affecting trade in services, at all levels of government (central, regional, local). Services are generally understood to encompass twelve broad sectors as classified in the World Trade Organization (WTO) Services Sectoral Classification List, usually referred to by its short-hand document number "W/120". The twelve sectors are: business; communication; construction; distribution; educational; environmental; financial; health and related social; recreational, cultural and sporting; tourism; transport; and other services not listed elsewhere in the classification.

The PTIS envisages successive rounds of negotiations on liberalisation commitments during which MSs stipulate specific market access and national treatment conditions applicable for each of four "modes of supply". The final adopted lists of specific commitments are annexed to and an integral part of the PTIS.

The first round of SADC trade in services negotiations began with six priority sectors (communication, construction, energy-related, financial, tourism and transport services) and was concluded in 2019. Professional services such as medical and dental, nursing, midwifery, etc.), as well as health and related social services, were not negotiated in the first round but are included in the second round of negotiations. The CMT directed the MSs to prepare for the second round of negotiations, prioritising business services and distribution services given their linkage and relevance to the SADC Industrialisation Agenda and Roadmap (2015-2060). MSs were also directed to prioritise negotiations on mutual recognition of requirements, qualifications, licences and other regulations necessary in granting effective market access for professional services.

One of the service sectors included in the second round are health and social services. Under the PTIS, negotiations will focus on measures affecting the free movement of health services, health-related personnel and associated social services in the region.

2.3 Healthcare systems in SADC

Generally, healthcare systems in the SADC region are largely under-developed and, like many countries in the sub-Saharan African region, face challenges ranging from a shortage of qualified

¹ Energy-related services ae not included as a stand-alone sector under the W/120 Classification List as such services are found in other parts of the classification, SADC MSs nevertheless agreed to negotiate it as an individual sector.

² As at December 2021, the PTIS had been ratified by eleven (11) MSs namely Botswana, Eswatini, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Zambia and Zimbabwe. The eleventh MS to do so was Malawi on 13 December 2021.



staff, under-equipped facilities, poor services and limited investments, as well as counterfeit pharmaceuticals.

This situation has been further exacerbated by the COVID-19 pandemic which has put a further strain on the already weak healthcare systems across the region. Faced at the onset of what was a rapidly spreading and potentially deadly virus without substantial experience or research behind it, the SADC Secretariat issued guidelines on the movement of transport and trade facilitation and recommendations on testing of and protection for health workers, as an early response to the COVID-19 challenges. Although the effects of COVID-19 have been lower in Africa than in other parts of the world, MSs still faced critical shortages of hospital capacity, health professionals, and equipment, including personal protection equipment (PPE). The measures put in place to curb the pandemic in the region and elsewhere have also led to disruption of supply chains for pharmaceuticals and other lifesaving commodities. As governments have turned to vaccination, access to COVID-19 vaccines continues disproportionately to affect SADC MSs and the African region as a whole. The pandemic has highlighted the urgency and need for the region and MSs to tackle capacity challenges both in the health sector and pharmaceutical manufacturing in response to the current and any future pandemic but also promote trade and investment in the health sector.

2.3.1 SADC instruments and programmes related to health

In August 1997 SADC included health in its Programme of Action, prompted by the realisation that regional co-operation was critical to address the health problems of the region. The ensuing Health Sector Policy Framework Document⁵, approved by the SADC Council of Ministers in September 2000, provided the basis for the SADC Protocol on Health (SPH), approved by the SADC Heads of State in August 1999 and entered into force in August 2004. The objectives of the SPH are to "co-operate in addressing health problems and challenges facing [State Parties] through effective regional collaboration and mutual support under this Protocol for the purposes of achieving the following objectives:

- 1. to identify, promote, co-ordinate and support those activities that have the potential to improve the health of the population within the Region;
- 2. to co-ordinate regional efforts on epidemic preparedness, mapping, prevention, control and where possible the eradication of communicable and non-communicable diseases;
- 3. to promote and co-ordinate the development, education, training and effective utilisation of health personnel and facilities;
- 4. to facilitate the establishment of a mechanism for the referral of patients for tertiary care;
- 5. to foster co-operation and co-ordination in the area of health with international organisations and co-operating partners;
- 6. to promote and co-ordinate laboratory services in the area of health;
- 7. to develop common strategies to address the health needs of women, children and other vulnerable groups;
- 8. to progressively achieve equivalence, harmonisation and standardisation in the provision of health services in the Region; and
- 9. to collaborate and co-operate with other relevant SADC sectors."

In addition, the Regional Indicative Strategic Development Plan (RISDP) 2020-2030, adopted in August 2020, targets strengthened and harmonised regional health systems for the provision of standardised and accessible health services to all citizens, and addressing threats caused by health pandemics in the SADC region.



2.3.2 SADC Health Workforce Strategic Plan, 2020-2030⁶

To facilitate the operationalising of the SADC Protocol on Health (SPH) 1999, in 2006, SADC developed a Human Resources Strategic Plan (HRSP) 2007-2019 with an ultimate goal "to ensure adequate production, recruitment and retention of the required Human Resources for Health in the region by 2019". Following the completion of the HRSP, an intensive consultative process was initiated by the SADC Human Resources for Health Technical Committee revived by the SADC Health Ministers' Meeting in March 2018 for development of a Human Resources for Health (HRH) strategy for the SADC region. After extensive consultations, in November 2020 the SADC Health Workforce Strategic Plan (HWSP) 2020-2030 was endorsed.

The HWSP provides a comprehensive strategy and framework to address critical health workforce issues across the SADC region. It recognises that the biggest challenge for ensuring equitable access to health services for all is the persistent shortage and availability of skilled health and social care workers across the region. It notes that between 2005 and 2015 there was a 13% increase in the number of nurses, doctors and midwives. However, the region continues to face a critical shortage of health workers as 11 MSs had as few as 2.3 doctors, nurses and midwives per 1,000 population by the end of 2015.

Whereas the concept of a 'shortage' of professionals is based on World Health Organzation (WHO) provider-user ratios, the actual requirement for various 'types' of health professionals needs to be determined by the scope, type and volume of health services to be provided to address the health issues of a country. Resource and capacity constraints of health systems, country-specific health issues and poverty, in addition to the extent to which a country faces humanitarian circumstances, all determine how many and what type of healthcare professionals are required.

The HWSP recognises that COVID-19 has had, and continues to have, a devastating health and economic impact, including on lower and middle-income countries (LMIC), while those experiencing fragility, violence and conflict have been affected the most. This has highlighted the need for countries to develop robust health systems, strengthen primary health care capacity, and build public health preparedness and response capability.

The HWSP makes a very important point that health workforce gaps across the region are generally determined based on existing staff establishments and/or funded posts. However, these approaches to workforce planning may not present the true picture for SADC MSs when measured against their need-based projections for delivering universal health coverage (UHC) and meeting their 2030 Sustainable Development Goals (SDG) targets. The HWSP concludes that a regional response and comprehensive HRH strategy is therefore needed.

The HWSP recognises that data gaps related to HRH in the region make it difficult to estimate the actual numbers of HRH in various cadres. This indicates various challenges including unequal production capacities, unharmonised conditions of employment, e.g. remuneration, poorly managed migration of health personnel, and less than optimal funding of the health systems in MSs.

Based on the observed trend of increases in HRH at the rate of 13% between 2005 and 2015, the HWSP projects that HRH (doctors, nurses, midwives and associates) would increase from 689,342 in 2018 to 728,698 in 2020 to 975,791 in 2030. While the HWSP recognises the margin of cross-country variations, it seems to assume that there will be no change in HRH strategies or resources in the MSs related to the various HRH types. It is quite probable, however, that MSs may initiate alternative strategies to address HRH shortages.

The HWSP notes that the biggest challenge for the government health sector with respect to shortages of HRH is limited available funding. Despite availability of quality curricula in MSs, the quality of training remains a challenge due to lack of resources. There are concerns regarding variations in the quality of training and the requirements for professional recognition / registration for similar health worker categories across the SADC region.

There is a list of milestones⁷ which the SADC Secretariat and MSs will target to achieve over the period of the HWSP. For example, strategic direction 4 (enhanced health workforce governance



and regulation) provides for the development of mechanisms for reciprocal recognition of health professionals' education and qualifications, exchange programmes and multi-sectoral collaboration, and public-private partnerships for sharing HRH. These milestones are key in enhancing the cross-border enabling environment for health professionals (such as through trade in services Mode 4).

It is noted that the HWSP considers the possibility of paradoxical surplus due to poverty in MSs which may not be able to pay for recruiting the HRH likely to be produced by 2030. This assumes that governments are, and will likely remain, the key employers for HRH. It does not consider the growing role of the private sector in the supply of health services – thus absorbing more of the HRH – while governments may be more suited to become purchasers and regulators, with alternative healthcare financing mechanisms. The HWSP notes that some regulatory bodies, under the auspices of SADC, have begun to work towards harmonising their regulatory frameworks for the licensing of health professionals.

The HWSP assumes that an effective health workforce is the panacea for most, if not all, of the issues and challenges in the SADC MSs health systems. However, the more fundamental components and functions of health systems, such as analysis, prioritisation, approach, socioeconomic factors and resources, could have been given more prominence in addressing the underlying issues that both lead to or result from shortages in health human resources. While the plan draws a rather linear relationship between lack of funding and lack of HRH, it could have included a more rigorous analysis of core issues underlying HRH shortages in the region. Also, it proposes strategies to address the HRH gaps and refers to innovative financing mechanisms through other stakeholders such as the private sector and development partners. However, it does not venture into exploring entrepreneurial solutions to sourcing healthcare financing and HRH.

2.4 Pharmaceutical sector

The development of the pharmaceutical sector is among the priority regional value chains according to the SADC Industrial Development Policy Framework and, in this regard, the availability and ease of mobility of skilled pharmaceutical personnel are considered crucial. Further, the SADC Pharmaceutical Business Plan 2015-2019, which is currently under review, has identified supporting and retaining human resources as critical for the sector.

2.5 Linking health and trade policy in SADC

The SPH does not specifically address issues related to economic cooperation in the health sector. The main SADC framework for this is the PTIS, which sets the trade in services agenda for the region and stipulates the general trade rules, principles and MSs' obligations. Whereas the PTIS provides an opportunity for MSs to work together towards an agreement to facilitate international trade in health and social services including creating opportunities for foreign investment in additional healthcare capacity and mutual recognition of professional health qualifications, the SPH, on the other hand, provides a platform for harmonisation, standardisation and coordination on matters relating to the health sector development and pharmaceutical manufacturing.

During a WTO Services Seminar held in 2020, MSs called for increased collaboration between trade and health stakeholders towards operationalising standards for health workforce migration by creating the necessary link between the WHO codes and trade agreements. Codes provide for ethical principles of international recruitment of health personnel, discourage active recruitment from countries with a shortage or weak health systems and encourage countries to work together to address the shortage to ensure the sustainability of both health workforce development and health systems. It is also noted that SADC MSs, including South Africa in particular, have been pressing for a WTO intellectual property rights waiver to allow developing countries to gain access to technologies in the manufacturing of COVID-19 vaccines.

The PTIS negotiations in the health sector provide MSs with an opportunity to respond to health and health systems issues, especially those relating to facilitating the movement of health



professionals across the region in order to meet capacity gaps, as well as by enhancing the scope and depth of health services that may not be otherwise available in some of the MSs.

2.6 Discussion

In a comparative analysis of the Union of South American Nations (UNASUR) and SADC, Riggirozi⁸ notes that SADC has traditionally relied, and not wrongly so due to poverty and barriers to development, on donor resources for health programmes, and therefore focuses more on policy. It is particularly noteworthy that, unlike UNASUR, SADC creates space for dialogue and discussion among the MSs which is key to ensuring that MSs fully participate and own the SADC mandate. The PTIS and HWSP 2020-2030 are excellent examples of the engagement and openness that SADC provides to the MSs in the area of health. Although SADC engages with civil society, there is need to engage more with non-state partners, both from the perspective of the health sector and trade in health services, in recognition of the role of private sector. It is important for the PTIS negotiations on market access and mutual recognition agreements (MRAs) for health professionals to build on the efforts under the HWSP.

The approach enshrined in the HWSP has largely been driven by specific diseases (e.g. AIDS and TB given their high prevalence in the region) and less attention has been given to health systems strengthening. While the COVID-19 pandemic has created major challenges for the health systems and services in the entire region, at the same time opportunities have opened up for reviewing and reforming the region's health systems and services in order to better respond to current and future health challenges.

The HSWP generates some interesting questions that are worth reflecting on:

- How is the conclusion reached that the answer to HR shortages is a regional response?
- Implicit in milestones of the proposed five strategic directions is the assumption that demand will continue to rise. Can there be strategies to actually reduce demand without compromising health outcomes at least in the long term?
- Can there be any technological tools/innovations/possibilities to enhance HR production and productivity or reduce costs and various timelines in planning, production and productivity of HR?
- What are the resources that will be needed to enable the workforce to be more effective and efficient as the emphasis is on producing more HRH - how will they be absorbed and enabled to address the health issues?
- What are the priority technical streams for which HRH is needed how many and where is there a mapping of HR available?
- How do cross-MS HRH exchanges address issues? Will there be area of specific production in given MSs? Or will some MSs be able to produce more HRH? Will they also pay their own nationals to go and work in other MSs? How will the recipient MSs of HRH be able to pay foreign health professionals? What are the incentives and attractions for foreign HRH to live and work in another MS?
- Which type of HRH have the biggest gaps? What are the actual gaps?



3 HEALTH SYSTEMS IN SADC

The health systems in the SADC MSs are comprised of large public and small private health sectors. However, in all the MSs interviewed, while the central ministry of health remains the custodian of health policy, planning, financing and accountability the private sector plays a significant role in the provision of health services. Sub-national structures and bodies translate policy into action and thus are responsible for the provision of health services to the public.

3.1 Levels of healthcare

Generally, MSs' health systems comprise of three levels of healthcare, i.e., primary, secondary and tertiary, explained as follows:

3.1.1 Primary

Primary healthcare is the largest level and is closest to the community, i.e. the facilities and health workers are close to the largest proportion of populations in non-urban and rural areas. This level involves the provision of basic healthcare addressing the preventive and promotive health needs of people. There is typically a large outreach component and implementation of so-called vertical programmes that take place at the primary level. Correspondingly, there is also typically a large contingent of health workers present at this level; doctors are usually fewer, if at all present.

3.1.2 Secondary

The secondary healthcare level is a step above the primary level in terms of sophistication, scope and resources. It is usually the level where referrals from the primary level are received for health issues that cannot be addressed at the primary level. This is where the transition from healthcare to more medical care is seen. The number of secondary health facilities are therefore far fewer than at the primary level but offer more advanced medical care, i.e. more concentrated with medically proficient personnel, equipment, infrastructure and financial resources.

3.1.3 Tertiary (+specialised)

The tertiary level is the smallest and offers the most advanced care in the value chain. Tertiary care also has in many instances more specialised treatment facilities. This is where most specialists and top-level medical personnel are positioned and are equipped with the most modern and expensive equipment, infrastructure and facilities that the country can afford. The number of tertiary health facilities is very small as only the most complicated cases are expected to be referred to and/or treated with advanced medical and specialised care. Figure 1 represents the state of health systems in the SADC region. It shows the size of various levels of healthcare in terms of population reached, cost of service provision and numbers of health human resources needed at these levels.



Figure 1: Healthcare levels overview in SADC region



Some MSs have arrangements of sending their patients abroad for treatment as they lack the necessary services. For example, Mauritius, Namibia and Zimbabwe have existing agreements with other countries both within and outside SADC for the provision of advanced medical services to their patients for which the patients are sent abroad. The study findings on health systems structures and functions are summarized below.

Botswana: There are several tiers between the frontline health provision and the top-level Ministry of Health and Wellness. The ministry provides policy guidelines and oversight of the health system and the District Health Management Teams are the delivery arms of the public health system. Below the District Health Management Teams are the district hospitals, clinics, medical stores and other services providers at the community level. The ministry has four major functional areas/departments: (1) Policy, planning and health financing; (2) M&E and quality assurance; (3) Corporate services which look at corporate and ministry management issues; and (4) Health services management (HSM). The regional health teams are under HSM and there are 18 regions (districts) where service delivery takes place. (As a result of reforms, the previous 27 districts are being reformed into 18 regions to align with the existing administrative and local structures.) In the past, service delivery and policy functions were very centralised and now a process of deconcentration is underway within the Ministry of Health and Wellness. This will allow locally responsive health services. The government is not ready for complete decentralisation and responsibility is therefore deconcentrated to the district/regions while authority is maintained at the central level. All districts/regions will submit their annual work plans and budgets for approval.

Malawi: The public health system is structured at three levels: (1) Primary healthcare – comprised of services provided at the health centres in the 28 districts; (2) Secondary healthcare level – comprised of district government hospitals or the health offices; and (3) Tertiary healthcare level - comprised of 4 referral hospitals.

Mauritius: The health system is founded on the WHO health system framework. It comprises 143 primary healthcare institutions for a population of 1.2 million, of which 64% have universal health coverage. There are 5 regional hospitals and other specialised hospitals that provide free services, including some complicated cases, at the expense of the government as they also have memoranda of understanding (MoUs) with foreign hospitals. Since independence in 1968, the government has sustained free healthcare services from primary healthcare to hospital services including specialised services and "sub-specialities" for example Endocrinology within Internal Medicine. The government places health services at the top of its socio-economic agenda.

Namibia has 12 health directorates at the national level, that are responsible for providing services. There are 14 Regional Health Directorates (RHDs), responsible for health services in those regions, and every region is sub-divided into districts totalling 35 Health Districts in the country. Regional management teams are responsible for the overall coordination of the health services in their region and Districts Health Coordinating Committees are responsible for the implementation of the health services or overseeing the health services and facilities in the respective districts. The facilities are mostly staffed by nurses, and doctors are mostly posted at higher levels. Every district has outreach teams providing both preventive/promotive and curative services. The outreach teams collaborate with the Community Health Workers (CHWs) who are the foot soldiers for the Health Ministry providing health education and health promotion services from house to house.

Given the very small population in the **Seychelles**, the delivery of health services is organised into primary health care, which is delivered through a network of 17 health facilities on the three main islands where the majority of the population lives. In addition to secondary and tertiary care which is delivered through a hospital, an extended basic or minimum health service package is delivered at the front line. The health sector comprises the Ministry of Health and its subordinate agencies, schools, councils and the non-government health sector.



South Africa: The public health sector is divided into primary, secondary and tertiary health services provided through various health facilities located within and managed by the different provincial departments, under monitoring by the National Department of Health⁹.

3.2 Decentralisation

Some degree of decentralisation exists in almost all MSs, but the type and form of decentralisation varies from MS to MS. However, in all cases the central ministry of health maintains overall policy and financial control even though implementation of health programmes and the provision of healthcare remains the responsibility of the decentralised levels ranging from sub-national to smallest administrative units in the country.

For example, in South Africa decisions are typically made centrally and then have to be implemented at the district level with central monitoring and control being exercised from head office. Fund allocations from the national budget take the form either of conditional (programme specific) fund allocations or appropriated (equitable share) fund allocations. The limited interactive arrangement of programmes inhibits consultation and sharing of knowledge among officials (healthcare managers and healthcare workers) and other stakeholders¹⁰. Hence, due to the lack of complete autonomy at the decentralised levels, resource allocations, interpretation of policy and translation into action, proximal and timely responsiveness to local issues and data management, reporting and accountability remain significant challenges.

3.3 SADC health systems – key issues

From the interviews and literature review, it was found that almost all MSs' health systems face several challenges. The health systems can be typically considered to be weak in many ways except perhaps for Mauritius which invests significantly more in her health system than other MSs. It will not be an incorrect inference that significant improvements are needed to enable these health systems adequately to meet the health needs of their populations.

The key challenges that the SADC health systems face are as follows:

3.3.1 Resource constraints

Within the tax-based economies of the SADC region, with the majority of MSs at very low or low HDI, it is not surprising to see a persistent dearth of resources in all sectors including health.

In 2016, the WHO noted that in Zimbabwe most programmes that showed positive trends were heavily dependent on support from development partners, which raised serious concerns about the sustainability of critical health programmes when the external support ends. Rising poverty remains a major concern, and with the widespread droughts and lack of inputs into agriculture, the socio-economic outlook for Zimbabweans is likely to worsen over the short to medium term. The negative macro-economic situation has affected the health sector in the country in a variety of ways¹¹.

A study published in 2020 in BMC Health Services Research¹² concluded that in South Africa, the major overall public health system challenges involved fragmentation of services, staff shortages and financial/cash-flow problems. To effect health systems strengthening there was a particular need to improve integration and address human and financial deficiencies in this setting.

The WHO report on Improving Health System Efficiency in the DRC points out that in the aftermath of proliferative donor funding, the increased health staff were partially being paid by reverse financing through user fees charged at public health facilities¹³. This process deepened the impact of poverty on those already suffering from a lack of resources and identifies resource deficits in the public sector despite overseas development assistance.



3.3.2 HRH shortages

Since the health sector is a human resource intensive sector, the most significant effect of low resources is on the number, capability and placement of HRH.

The HRH shortage is most pronounced in the non-urban areas, i.e. within the primary and secondary healthcare levels. This is particularly pronounced at the primary level and means that basic health needs and provision of basic preventive, promotive and curative health services are more profoundly affected by the dearth of HRH at this level than at the higher secondary or tertiary levels. The primary healthcare workforce shortage is therefore also largely dependent upon the number of people interested to work as health workers in rural areas.

It may be argued that specialist doctors and health professionals are also in short supply to meet the advanced medical needs of the population but in real terms, the actual numbers of people being negatively affected by the lack of HRH is more in the non-urban and rural areas with large proportions of the population. The higher level of health professional cadres such as nurses and doctors also have a preference to live and work in urban areas. Although this preference aligns with the requirements of the secondary industry healthcare, it leads to concentration of doctors and nurses in the urban settings.

Both Zambia and Zimbabwe recognise that the HRH shortage is deeper in rural areas while in urban areas the concentration of HRH is high which is reflected in the pronounced HRH shortage at the primary level as compared to the tertiary care.

In addition to under-funding, the HRH shortages are grounded in systemic weaknesses such as lack of strategic health planning and use of health plans to steer the planning, production and management of HRH. Other contributory factors include non-attractive remuneration offered by the public sector and lack of adequate training facilities.

The significant dearth of HRH at the primary healthcare level cannot be met by health professionals from other countries. This is because the numbers required are far too large to be met by foreign health professionals and the remuneration packages are significantly low as compared to what may be attractive for any foreign health professional to come and work in another country. HRH shortages at higher levels are more amenable to be responded to by foreign health professionals.

There are significant gaps in service provision in almost all MSs as a result of HRH shortages. These gaps affect the coverage of large segments of the population by basic healthcare but also the sophisticated health services which are related to more advanced HRH cadres such as specialists, doctors, nurses and pharmacists. For example in South Africa, the inequity in distribution of skilled health professionals between the public and private health sectors exacerbates HRH shortages in the public health sector that takes care of the majority of the South African population, with an extraordinarily complex disease burden. The Zambia *Health Strategic Plan 2017* – 2021 notes that HRH shortages are more pronounced in the public health sector.

A few countries are reported to have surplus HRH, however. In Zimbabwe this is due largely as a result of enhanced training facilities and opportunities, as well as more recent spikes in HRH production. In the DRC this has come in the wake of extraordinarily increased donor financing for health and the consequent proliferation of local private health training institutions¹⁴. Mauritius has also reported an excess of doctors, however their availability for other MSs in the region is not clear. Surpluses can be absorbed by better HRH planning and placement to meet the needs in areas with inadequate HRH.

Zimbabwe reported having remarkably stabilised the brain-drain phenomenon of the last decade - mainly by training more health personnel. Nearly all the public sector posts which were established in the early 1980s have been filled. Increasingly though, there is a surplus of trained health professionals who cannot be immediately absorbed when they are released from the training institutions. With adequate consultations involving all Government ministries and other sectors, the surplus health workforce could still be absorbed to serve the needs of the population¹⁵.

It is widely reported that the COVID-19 pandemic has exacerbated an already well-known and longstanding critical shortage of healthcare professionals in sub-Saharan Africa. For example, even



before COVID-19, WHO statistics indicated that over 40% of countries had fewer than 10 medical doctors per 10,000 population. Africa suffers more than 22% of the global burden of disease but has access to only 3% of healthcare workers, and less than 1% of the world's financial resources. Figures 2 and 3 show the recent density of major health professionals (doctors, nurses and midwives) per 10,000 population in the SADC region as per WHO, although comprehensive/up-to-date data for doctors is not available for all MSs¹⁶.



Figure 2: Doctors per 10,000 population in SADC MSs (available data 2015 to date)^{xv}



Figure 3: SADC Nurses + Midwives per 10,000 population in SADC MSs (available data 2016 to date) XV



Table 3 shows the density of pharmacists in the region according to WHO data. As visible from the table, it may be noted that up-to-date and comprehensive data for pharmaceutical industry professionals is not available¹⁷.

Country	Year	Pharmacists/10,000 population
DR Congo	2016	0.051
Madagascar	2016	0.002
Malawi	2018	0.056
	2016	N/A
Mauritius	2016	4.073
	2015	3.946
Mozambique	2018	0.103
	2015	0.072
Namibia	2018	2.443
Seychelles	2016	4.702
South Africa	2016	2.716
	2015	2.85
Zambia	2018	0.444
	2016	0.708
Zimbabwe	2018	0.968
	2016	0.156
	2015	0.102

Table 3: SADC Pharmacists per 10,000 population in SADC MSs (available data 2015 to date) xv

The WHO estimates a projected shortfall of 18 million health workers by 2030, mostly in low and lower-middle-income countries. However, countries at all levels of socio-economic development face, to varying degrees, difficulties in the education, employment, deployment, retention, and performance of their healthcare workforce. ^{18, 19}

HRH planning, production and management

All the SADC MSs have some formal approach to HRH development i.e, planning, production and management. For example, Namibia has a Strategic HRH plan, while South Africa has issued a 2030 HRH strategy. In Zimbabwe, the health services board and MoH engage in joint HRH planning while the health services board manages the HRH. However, the capacity to assess HRH issues and gaps in the MSs seem to lack formal approaches; weaknesses in health management information systems and HRH management systems pose challenges in taking actions to address HRH issues and gaps that have been discussed above.

Training facilities for HRH in the MSs are significantly less than the need for HRH, therefore the supply of HRH remains persistently inadequate both in terms of numbers and types of health personnel needed. Various MSs have employed different strategies to address this HRH shortage issue. Some MSs such as Namibia, Seychelles and Zambia send students abroad to receive medical education supported by the government - in Namibia up to 85% of doctors are supported through government funding for training abroad. On the other hand 100% of nurses and other health workers are trained in-country. Zimbabwe has government to government agreements with Cuba, China, DRC to fill the HRH gaps. Some MSs, e.g., Mauritius, Namibia and Zambia, have reported that training facilities are growing with the support of the private sector.



3.3.3 Healthcare financing

Inadequate healthcare financing is one of the major challenges in the SADC region. In addition to HRH shortages discussed above, this contributes to the shortage of medicines, equipment and supplies that are reportedly a persistent feature of underfunded health systems.

Currently African countries spend \$8 to \$129 per capita on health, compared to high income countries that spend above \$4,000. Even though many African countries have marginally increased health spending overall, only a handful of countries have met the target of the Abuja Declaration of investing at least 15% of the government budget allocation in the health sector in any given year. In 2018, only two countries met the target²⁰. In sub-Saharan Africa (SSA), health spending as percentage of GDP, which was estimated at 5.2% in 2017, is expected to decrease to 5.1% in 2030 and this is still lower compared to global average of 9.7% in 2017, which is expected to increase to 10.5% by 2030²¹,²². In addition, about 22% of total health expenditure in Africa is in the form of Official Development Assistance (ODA), with some countries dependent on donor funding, as high as 50%²³, to finance their health sector. Most people in SSA pay for healthcare out of pocket and very high health expenditures have been documented as being rampant and a major cause of poverty²⁴.

Most SADC MSs have not achieved the 15% GDP health spend as per Abuja commitment 2001. For example, as reported by key informants, although Namibia has an aggregate spend of 13% on its healthcare, more than 8% of this relates to spending within and through the private sector. Similarly, health expenditure in Zambia was reported to be 8.8%. While Mauritius spends relatively higher on health, 60% of the national health expenditure is attributable to the private sector with residual total government health expenditure ranging from 6 to 9% of GDP. Ironically, South Africa was noted to have 15% of the government budget allocated to health but critics think that the value for money for this level of government health expenditure was not being delivered²⁵. The DRC represented a different scenario of extremely low public health expenditure but revenue from user charges supports the government health sector, which is an example of reverse funding.

Table 3 provides a summary of health expenditure in SADC MSs as percentage of GDP since year 2000 published by World Development Indicators database.

SADC MSS	2000	2005	2010	2015	2016	2017	2018
Angola	1.9	2.9	2.7	2.6	2.7	2.8	2.5
Botswana	5.8	5.0	6.2	5.7	5.6	6.1	5.8
Congo, Dem. Rep.	1.5	4.2	3.7	4.0	4.4	4.2	3.3
Comoros	7.3	5.8	5.1	4.7	4.7	4.6	4.6
Lesotho	5.9	5.1	7.6	8.5	8.0	8.9	9.3
Madagascar	5.2	6.0	5.3	5.7	6.0	5.5	4.8
Mozambique	2.6	4.9	5.8	7.2	7.8	8.1	8.2
Mauritius	2.9	3.6	4.6	5.7	5.7	5.7	5.8
Malawi	3.4	6.1	7.2	9.3	9.7	9.6	9.3
Namibia	9.8	10.3	9.7	9.7	8.9	8.3	8.0
Eswatini	4.6	7.4	8.6	7.0	6.8	6.9	6.5
Seychelles	4.6	5.0	4.8	4.6	5.2	5.0	5.1
Tanzania	3.4	6.3	5.2	3.6	4.0	3.6	3.6
South Africa	7.4	6.7	7.4	8.2	8.1	8.1	8.3
Zambia	7.2	6.9	3.7	4.4	4.5	4.4	4.9
Zimbabwe			10.5	7.5	7.6	5.8	4.7

Table 4:	Current public health expenditure (% of GDP)
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Source: World Development Indicators (WDI) Database



Expenditure on health in the DRC was low at US\$ 12–13 per capita per year between 2008 and 2012. Total health expenditure was US\$ 876 million in 2009, declining to US\$ 830 million in 2010, with a partial recovery to US\$ 843 million in 2012 (2). Households have been the largest contributors to total health expenditure, closely followed by multilateral aid. The central government contributes 11%. The proportion of health in the national budget has remained below the commitments made in 2001 in Abuja. The budget execution has also remained considerably low. However, in absolute terms, the budget has been growing²⁶.

3.3.4 Capacity and mechanisms

One of the key issues that the health systems exhibit in most MSs is the relative lack of capacity within the decentralised levels of the health sector in the disciplines of health planning and management. This leads to issues related to the translation of health policy into action. Thus, whereas the national health policies are professionally articulated and (in principle) responsive to the health needs of the population, the implementation of these policies remains dependent upon the ability of platforms such as regional health coordination teams or district health management teams. The overall health systems in many MSs exhibit fragmentation and challenges in their ability to meet the needs of the population due to gaps in capacity, under-funding, weaknesses in health information systems and accountability.

In South Africa, health policies are issued from the national level and the interpretation and implementation is at the provincial level. Reportedly sometimes the interpretation is quite different which creates issues and challenges in the performance of the overall health system.

Almost all the interviewed MSs identified capacity gaps in the overall management and governance of health systems and services. These capacity gaps exist at all levels but seem to be more pronounced at the level of decentralised units. It is critical to recognise that the capacity gaps being referred to are not technical health and diseases-oriented skills and knowledge but pertain to the disciplines of health policy, planning and management including human resource management, financial management and logistics management. These disciplines constitute the overall governance function and enable health systems to become sensitive to the needs of their populations and provide responsive services. Additionally, health governance and mechanisms are important to embed accountability within the system and to the communities that the system is supposed to serve. Figure 5 presents simplified view of the relationship between health providers and the organisation or institution where the governance functions are vested. The quality of health services also depends upon the capacity and governance functions that these system custodians play.



Figure 4: Role of health governance and capacity in health systems



3.3.5 High burden of disease

The SADC region has some of the highest rates of morbidity and mortality in the world. The main diseases that contribute to the high morbidity and mortality, apart from the COVID-19 pandemic, have remained Tuberculosis, Malaria and AIDS. Reproductive health-related morbidity and mortality also remain significantly high in the region. Table 5 shows that 9 of the 10 countries with the highest level of HIV prevalence in the world are SADC MSs.

Rank	Country	HIV/AIDS Prevalence
1	Swaziland (SADC)	27.20%
2	Lesotho (SADC)	25.00%
3	Botswana (SADC)	21.90%
4	South Africa (SADC)	18.90%
5	Namibia (SADC)	13.80%
6	Zimbabwe (SADC)	13.50%
7	Zambia (SADC)	12.40%
8	Mozambique (SADC)	12.30%
9	Malawi (SADC)	9.20%
10	Uganda	6.50%

able 5:	Countries with	highest p	prevalence o	f HIV (a	s at 21 J	anuary	2019)	27
							/	

Source: WorldAtlas

South Africa is facing a quadruple burden of disease including a dual HIV-TB epidemic (about 17% of global burden), high maternal and child mortality (about 1% of global burden), high levels of violence and injuries (about 1.3% of global burden), and increasing non-communicable diseases (about 1% of global burden)²⁸.

Zimbabwe has experienced a gradual decline in HIV prevalence among adults aged between 15 and 49 years, from a peak of 29.7% in 1997 to 18.1% in 2006; and 16.7% in 2014, predominantly as a result of behaviour change. Despite these gains, the current prevalence rate is unacceptably high. Noncommunicable diseases and conditions continue to pose a growing public health challenge. Diabetes, hypertension, cardiovascular conditions, cancer and mental health conditions continue to afflict a growing number of Zimbabweans²⁹.

The health status of the population in the DRC is alarming. The seven principal causes of disability-adjusted life years (DALY) lost are malaria, diarrhoeal diseases, protein-energy malnutrition, lower respiratory tract infections, HIV, preterm birth complications and tuberculosis. Non-communicable diseases associated with epidemiological transitions account for 21% of the national burden of disease, although this proportion is rising³⁰.

The region, like many other parts of the world, is experiencing the epidemiologic transition of an increase in non-communicable diseases (NCDs) that are associated with changes in lifestyle, nutrition and poor personal and community habits. This epidemiologic transition has added to the disease burden in the region. Health systems and services more traditionally geared to addressing communicable diseases are struggling to accommodate the additional burden of NCDs, with the caveat that authentic information on the actual (and growing) prevalence of NCDs is only now beginning to become available.

It is also worth noting that although TB, AIDS and Malaria are in high prevalence in the SADC region, due to more international attention and funding targeted at these diseases the more locally prevalent diseases collectively known as Neglected Tropical Diseases (NTDs) have remained relatively overshadowed and call for a more locally responsive set of health services.



3.3.6 Reliance on public health services

The large majority of the population depends heavily upon health services provided by the public health system. The vast majority of the population in almost all MSs live in non-urban and rural areas where primary and some lower secondary healthcare is positioned. As evident from the key informant interviews and relevant literature, primary healthcare services tend to be provided in the shape of basic health service packages.

3.4 Basic health package

The typical set of services at the primary healthcare level in most MSs is comprised of basic curative, promotive and preventive services for mother, child and newborn health, immunisation, malaria, diarrhoea and TB, and in most cases HIV, in addition to other common ailments. Also, there are attempts to provide basic medication at the primary care level. For any issue or condition that cannot be managed at this level the person is referred to a higher level of healthcare.

Traditionally this primary level of healthcare is run by a large contingent of primary healthcare workers that are known by various names such as Village Health Workers, Outreach Workers or Community Health Workers. This level is where most vertical or single disease-focus health programmes, such as Malaria control or TB control or immunisation, etc., are also implemented.

One of the most important features of such basic health packages and the level at which they are provided is that this is the level and scope of services to which the poor have access. Since most MSs have huge segments of the population that are poor who live in rural areas, it is obvious that if the basic health services package is not of good quality, or subject to inadequate supply, or its scope is not adequate for the needs of the poor, the poor will go without healthcare. Even in this scenario access to these health services remains a big challenge for the poor due to distance, lack of service providers, lack of adequate medicines and supplies or sometimes due to availability of these services at a time when most people have to work to earn a living. Thus despite the provision of these basic health packages, the poor do not necessarily get the services they need or the quality of services that must be provided.

Many MSs reported that basic health services are poorly staffed even though in some cases these services do not require doctors or even nurses. This means that the biggest dearth of HRH is largely within this segment by sheer numbers.

Evidence reinforces the importance and effectiveness of community-based service providers including community doctors and nurses, associate health professionals, and a range of less-skilled health workers. In 2015 it was noted that SSA accounted for a 4% share of the global health workforce but shouldered 24% of the global disease burden, a situation that had remained virtually unchanged for a decade³¹. Due to the generally weak education systems and opportunities in the SADC region, the overall health resource production tends to remain generally low. There is a need to ensure that education and training fees are affordable³².

3.5 Universal Health Coverage

According to the WHO, Universal Health Coverage (UHC) means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course³³. The WHO contends that the delivery of these services requires adequate and competent health and care workers with optimal skills mix at facility, outreach and community level, and who are equitably distributed, adequately supported and enjoy decent work. Thus, the concept of UHC is highly equity-oriented and pertains to access to good quality health services — promotion, prevention, treatment and rehabilitation — that are needed for everyone, without the risk of financial hardship as a result of having to pay to access these services³⁴. Achieving UHC is one of the targets set in the SDGs in 2015.

All MSs interviewed affirmed that their health services are UHC-oriented. The MSs are providing a set of integrated basic health services under the title of essential health services (EHS) that are



provided mostly at the primary healthcare level. EHS also exist at higher levels of health care and vary in terms of components of health services made available (usually added) at these levels. However, the meat of EHSs is positioned at the primary healthcare level. The responses from the interviews were as follows:-

Lesotho: The mission of the NHSP 2018/19-2022/23 is to improve health system performance through strengthening the core health system functions with renewed efforts to implement peoplecentred solutions and stay resilient to external shocks. The supply of EHS will be ensured through implementing the district essential health package to pave the way towards UHC in the context of the SDGs. The NHSP also places great importance on health system strengthening as the means of moving towards health security and UHC.

Malawi: EHP coverage claimed to be adequate. Malawi promotes UHC but is far from achieving UHC especially for people living in hard-to-reach areas who do not get services.

Mauritius: Despite being a high-income country only 64% of the population is covered by UHC.

Namibia: Respondents claimed that their EHS is equity-oriented as it addresses the needs of the poor and that EHS drives the HRH need. However, the major challenge in the adequacy of coverage is the vast sparsely-populated area in the country that is hard to reach where supplying adequate HRH is insurmountable. Also, the Namibian health system faces significant aid cuts and therefore the health programmes, especially TB programmes, are massively underfunded.

Despite the UHC orientation of most MSs, the actual provision of UHC is far from adequate. The biggest challenges that UHC faces in MSs include the following:

- underfunded government health programmes that constitute EHS;
- shortages of HRH, which create challenges in the adequacy of supply of EHS and coverage of which, therefore, remains drastically inadequate;
- insufficient EHS that forms the backbone of UHC due to resource and capacity constraints, depriving people of necessary and quality services.

Since the poor are not adequately provided with health services that they need, in case of severe health issues they are forced to seek either private healthcare or access higher levels of healthcare in urban sites, at a significant cost. In addition, some government healthcare facilities may charge premium fees for bypassing the normal referral channels.



Figure 5:

Scope and coverage of UHC

All in all, regardless of the UHC-orientation proclaimed by MSs, the poor remain uncovered by adequate, appropriate and quality health services and remain at risk of both impoverishment and catastrophic expenses in an attempt to obtain necessary healthcare when needed. Although the private sector may seem to contribute to the UHC coverage, that is somewhat questionable as private healthcare is utilised by only the small fraction of the population who can afford to pay for private healthcare and as such do not risk impoverishment or catastrophic payments, as depicted in Figure 6. Therefore, the extent to which MSs can provide adequate and quality UHC is an area for further exploration and strengthening.



3.6 Inequities in healthcare

The state of provision of health services at the lowest level, which is what most poor people can get and is free in many MSs, signifies considerable equity issues. Since the higher levels of services are mostly located in the more urban settings, while tertiary and specialised care services only exist in large urban centres, access to these higher levels of healthcare is largely limited to those who are generally well-off or at least are not poor and have ease of access.

The poor state of health in MSs is therefore clearly partly due to the less than satisfactory quality and adequacy of public (primary and secondary level) services as there is a large undeniable contribution of health services in the determination of the health status of a community.

It is also clear that jumping the referral queue is only possible if the person/household can afford it. In many instances, this may not even be possible, leading to prolonged illness and/or death. In other instances, high costs of treatment lead to the deepening of poverty.

Several MSs have health insurance schemes, but they are largely for people in employment both in the government and corporate sector. Those in neither of these sectors are free to purchase health insurance for themselves. Health insurance normally gives access to and benefits of private healthcare without having to wait for long periods. However, health insurance schemes in SADC normally do not behave as safety nets for the poor as they generally benefit the already well-off. This contributes to inequity in healthcare, as the poor still have to rely on public health services at the lowest level of care. The inequities in healthcare are not only due to poorly funded health services and shortages of HRH but also due to poor performance of health systems which includes issues already discussed such as fragmentation, inadequate decentralisation, weak health governance mechanisms and capacity and poor accountability systems.

While South Africa had been spending more on health than any other African country, health outcomes had been noted to be not commensurate with spending³⁵. Despite its modernised approach it is facing major health system challenges including negative staff attitudes, long waiting times, unclean facilities, medicine stock-outs, insufficient infection control and compromised safety and security of both staff and patients³⁶.

3.7 Conclusion

The health systems in MSs in the SADC region are at different stages of development. However, almost all face issues related to resource constraints and governance. Most health systems are decentralised - largely delegated - as central ministries of health maintain policy and financing roles.

At the decentralised level, the capacity for translating policy into action in terms of evidence-based, need-based and responsive health planning. Also, implementation is less than sufficient and compounded by persistent shortages in HRH, supplies and medicines and poor infrastructure.

Primary healthcare level is the most critical for maintaining adequate provision of essential healthcare but remains weak as it suffers from the above-mentioned systemic weaknesses and therefore, despite the UHC-orientation of health services, the coverage (of population) with an adequate range of quality essential health services is far from acceptable.

Data and reporting systems are weak and need careful attention. This includes the capture and availability of critical data from the private sector as well (see private health sector below). Given the weakness of health management information systems in the SADC region, accountability of the system actors requires significant improvements.

Systemic capacity issues prevail in the SADC region and largely pertain to health governance functions such as evidence, planning, implementation, management, quality and accountability. In addition to under-funded health systems and services, a persistent dearth in HRH is one of the more proximal concerns. Whereas health systems are concerned about shortages of specialist HRH, the largest dearth of HRH exists among the largest cohort of health professionals at the primary healthcare level: community/village health workers in the rural areas. This dearth of HRH cannot be met by foreign health professionals alone and demands local solutions. Also, the need



for HRH is not limited to service providers but significantly includes health system planners, designers and epidemiologists.

HRH development (planning, production and management) remains an area of considerable concern in all MSs. Training opportunities for HRH are inadequate forcing some MSs to send their students abroad to receive training.

With the high burden of disease and epidemiologic transition in SADC MSs, the inequities in health have become enhanced. The poor already face several challenges in accessing healthcare and remain at risk of having to make catastrophic and impoverishing payments for obtaining needed health services, pushing them further into poverty.



4 PRIVATE HEALTH SECTOR

The private sector plays a very important role within the wider health sector in all MSs. Different types of actors comprise the private sector in the SADC region with distinguishing features explained below.

4.1 Not-for-profit non-government health providers

Within the donor-based/not-for-profit category in many MSs, large-scale faith-based health providers make a significant contribution towards the overall health systems. They form service provider networks that typically operate based on MoUs or service level agreements with the government and are also funded for staff and supplies by the government. They usually operate in areas where government health facilities are non-existent and therefore play a crucial role in effect as an extension of the public health sector. Also, these networks are the largest employers of the HRH and their work and presence of socio-economic significance in the MSs.

The faith-based networks contribute to national and sub-national health policy, and planning and government health expenditure is inclusive of the expenditure incurred through this channel. However, due to their independent management, including human resource management and programme implementation, the faith-based networks remain an important part of the private sector and may be seen as a form of public-private partnership.

Typically, the faith-based private sector is regulated in the same manner as the public health sector. Also, these networks align themselves with the data collection and reporting systems, formats and channels defined and required by the government, and therefore client statistics, disease reporting, logistics and health information systems are available to and used as part of the whole by the government.

Lesotho: the Christian Health Association of Lesotho (CHAL) provides services through 23% of all health centres and 38% of all hospitals in the country as compared to 42% of health centres and 57% of hospitals under government control.

Malawi: The Christian Health Association of Malawi (CHAM) is the largest non-governmental healthcare provider and the largest trainer of healthcare practitioners in Malawi. CHAM provides 30% of Malawi's healthcare services and trains up to 80% of Malawi's healthcare providers.

Other types of entities that exist within the not-for-profit category are non-government and civil society foundations, trusts and philanthropic organisations providing healthcare services. The key feature of this set of actors is that they are typically donor or benefactor funded, and they provide health services that are in line with their main organisational missions. In this case, the health services provided do not necessarily fall within the mainstream health service packages as defined by national health policies, and can include niche services such as drug detoxification and rehabilitation services, physical rehabilitation services and prosthetics for the disabled, aged-care etc. that address specific areas not always addressed by large-scale government or above-mentioned faith-based networks. The motivation is to take forward the organisation's agenda, and services are usually paid for or subsidised by funding made available to the service providers. Like the faith-based networks, such health services complement the mainstream government health services, however their proportion is quite small as compared to the faith-based networks mentioned above or the private-for-profit providers discussed below.

4.2 For-profit private health providers

The other main category of non-government actors comprises for-profit health care providers, including small single-health providers, small clinics, hospitals, diagnostic facilities and homebased care providers. This segment of the private sector is what might be called the commercial face of healthcare provision. The private sector typically provides curative and diagnostic services. In some cases the role of the private for-profit sector extends to the provision of frontline preventive



services; in Zambia, for example, there is no segregation between public and private as a matter of policy for provision of preventive healthcare.

The main feature of the for-profit private sector is that the providers are driven by profit and commercial interest. Health providers charge high user fees and cater to the needs of those who can afford to pay for their services. Additionally, there are some private medical insurance schemes available for those who can pay which enable them to access private healthcare as and when needed.

Most for-profit providers are concentrated in urban settings where the affluent tend to live. Rural areas are typically devoid of private for-profit providers as the local populace cannot afford their high fees, etc. MSs noted that the private for-profit sector typically provides critical services that are not available in the government sector, such as diagnostic services, and therefore maintain some degree of monopoly over such services. This makes the private sector almost an unavoidable partner in the overall healthcare provision of the country.

The private for-profit sector does not operate on the basis of referrals from doctors surgeries or clinics. Patients who choose private health services can access healthcare from a private health facility by paying the fees. In many MSs, however, government facilities can and do refer patients to private health providers.

Respondents from Zimbabwe and Zambia indicated that the *private sector thrives on weaknesses and gaps in the public health system.* However, in Mauritius where the public sector is well organised and provides services on a par with the private sector, affluent people are still willing to pay high fees to access private healthcare in the belief or expectation that service quality will be higher.

The for-profit private sector is small, attractive in terms of availability, and offers more competence compared to the public health sector. Most high-class consultants (including those working for the government in some MSs) offer private services, short waiting times, and increased ease of access to multiple services, usually under the same roof. The convenient and comfortable consultation and treatment environment, and a sense of control among other aspects, keep the private sector firmly stable in all MSs. Clients perceive the enhanced comfort features as part of the quality of health services which they feel are far better than in the public sector.

Despite their comparatively small size, the private sector in some MSs employs more HRH than the public sector and, in most instances, accounts for a significant proportion of the entire nation's HRH employment. In Namibia, for example, the private sector represents about 18% of the overall healthcare system but employs 70% of all doctors and 50% of nurses in the country. Usually, the HRH in the private sector are more technically capable and academically accomplished except in MSs such as Mauritius where the public sector is more advanced. It is noted that HRH shortages are relatively lesser in the private sector than in the public sector and, in many instances, the HRH capture by the private sector contributes to the HRH shortage in the public health sector.

Regulation of the private sector presents a mixed picture. In Zimbabwe, for example, the private sector is said to be self-regulating through the health professional authority and councils, creating a sort of peer-regulated private health system. Zambia, on the other hand, has a small and disconnected private health sector. Mauritius maintains an open health sector - there is a rich mix of private and public healthcare and freedom for the private sector to operate in various areas that they choose. The public and private sectors cooperate, and governments support the existence and functioning of the private for-profit health sector in all MSs. Mauritius notes good collaboration between the public and private sectors. Another facet of this collaboration is visible in Zambia where health professionals are allowed to practise in both private and public sectors simultaneously.

Many MSs report that patients are referred from the public to private sector and vice versa. This arrangement is protected by and lobbied for by government-employed health professionals. It enables them to reap the dual benefits of both government employment and private practice. Whereas allowing private practice for government employees is commonplace in many MSs, the practice itself has the potential to perpetuate poverty. Government-employed health professionals charge high fees in their private practice to patients who choose to or feel compelled to 'go private'



since public health services fail to provide timely and appropriate care to them. The same health professionals who do not have the time or motivation to provide health services through the government structures give undivided attention to the same patients when they seek private consultation. Often, these practitioners send their patients back to government healthcare institutions to access sophisticated investigations or even undergo surgery at a nominal cost while being treated preferentially as referred patients from the private practice of the same healthcare professionals. Since such patients use up subsidised public healthcare on a preferential basis, they implicitly cause delays for other (poorer) patients at public healthcare facilities who in turn may be forced to go through the same process of having to pay private fees to access timely healthcare.

Data sharing by the private sector in respect of their clients is a persistent challenge. While in some MSs the private sector is more open to sharing data, in others such requests are not serviced creating challenges for generating accurate statistics reflecting the burden of disease, prevalence and treatment success, etc. MSs however generally appreciate the role private sector plays in distribution of medicines especially Anti-Retrovirals (ARVs), which shoulders the work of the public sector. It is not clear if the distribution actually enhances reach in areas where there is critical need. Private-public sector collaboration has also been acknowledged by the government in the COVID-19 response. Agreements in Zambia, for example, are in place with the private sector for laboratory services, screening for COVID-19 and vaccination.

4.3 Public-Private mix

Respondents insisted that the private (for-profit) health sector is largely based on the entrepreneurship of investors and professionals who exploit opportunities. However, it was also recognised that the private sector plays an important part in the larger healthcare landscape as some specialised services are not present in the public health system. While private-sector regulations were in place, the extent to which compliance was maintained was not clear. In addition to professional practice licences from relevant regulatory authorities, a private practitioner is also required to obtain business registration, local authority licence and meet other statutory requirements such as social security, tax and national insurance scheme registration. The requirements varied from MS to MS in their scope and strictness for compliance.

The study did not find any clear strategy in any of the MSs for an appropriate balance of private and public services. Establishment and productivity in the private sector is driven by market forces, whereas the public sector works within the provisions and constraints of public policy and resources. Therefore, without a strategy that lays down the required roles of the public and private sectors, management and performance enhancement of the overall health sector cannot be achieved.

4.4 Regulatory environment

Each MS has an existing legal and regulatory framework for HRH. There are some variations in the scope of these frameworks. In general, the same regulatory frameworks apply to both public and private sectors and are implemented by the following categories of health sector regulators:

- Health Professional Councils
 - a. Medical and Dental Councils
 - b. Nurses and Midwives Councils
- Allied Health Professional Councils
- Pharmacy Boards

South Africa example: Each of these bodies is established through relevant acts of parliament, the key legislation which regulates the provision of healthcare goods and services is (a) the National Health Act, 2003 (NHA)150, whose purpose is "to provide a framework for structured uniform health system within the Republic; (b) the Medical Schemes Act, 1998 (MSA)151, which regulates the funding of healthcare services; and (c) the Medicines and Related Substances



Act, (1965), 152 which regulates the provision and supply of medicines and devices. The relevant regulatory authorities include the Department of Health, the Health Professions Council of South Africa (HPCSA), the South African Nursing Council, the Allied Health Professions Council, the South African Pharmacy Council and the South African Dental Technicians Council. Healthcare professionals are regulated by various statutes as outlined in Box 1.

Box 1: Various statutes that regulate healthcare professionals in South Africa

- Pharmacy Act, 1974 (Act No. 53 of 1974); Provides for the regulation of the pharmacy profession, including community service by pharmacists.
- Health Professions Act, 1974 (Act No. 56 of 1974); Provides for the regulation of health professions, in particular medical practitioners, dentists, psychologists and other related health professions, including community service by these professionals.
- Dental Technicians Act, 1979 (Act No.19 of 1979); Provides for the regulation of dental technicians and for the establishment of a council to regulate the profession.
- Allied Health Professions Act, 1982 (Act No. 63 of 1982); Provides for the regulation of health practitioners such as chiropractors, homeopaths, etc., and for the establishment of a council to regulate these professions.
- Nursing Act, 2005 (Act No. 33 of 2005); Provides for the regulation of the nursing profession.
- Medicines and Related Substances Act, 1965 (Act No. 101 of 1965); Provides for the registration of medicines and other medicinal products to ensure their safety, quality and efficacy, and also provides for transparency in the pricing of medicines.

In some MSs such as Zambia, the regulatory mandate for the Health Professional Council is much broader, and includes doctors, dentists, pharmacists, biomedical engineers. The Botswana Health Professions Act regulates all health professionals except nurses and midwives who are under the Nurses and Midwife Act. In Malawi, the Medical Council of Malawi regulates doctors, dentists, biomedical engineers, radiologists, nurses and midwives while the Pharmacy Board regulates both personnel and medicinal products.

Tanzania has a parallel regulatory system for Tanzania Mainland and Zanzibar which involves several regulatory bodies, all of which are established by Parliaments Acts of the respective jurisdictions. In Tanzania Mainland: the Tanzania Medicines and Medical Devices Authority - regulates medicines and devices, while professionals are regulated by the specialised professional bodies such as Pharmacy Council, Medical Council of Tanganyika, Tanzania Nurses and Midwives Council, Environmental Health Practitioners Registration Council, Health Laboratory Practitioners' Council, and the Traditional and Alternative Health Practice Council. On the other hand, Zanzibar Food Drugs Agency regulates pharmacists and medical products while professionals are regulated by the Medical Council of Zanzibar and Zanzibar Nurses and Midwife Council.

4.5 Conclusion

The private health sector is a critical part of the national health systems in the SADC region. The not-for-profit providers and their networks function within the government policy and fiscal space. They also bring in significant contributions in terms of capacity and volume of service provision especially in areas where government health facilities cannot reach.

Despite being generally a poor region, the private for-profit sector is well established in the SADC MSs. The private sector contributes significantly to the overall health expenditure in most MSs. However, its contribution can be deceptive as it is mostly due to high priced services available to a select small percentage of populations and does not apply as an average to healthcare provision to the vast majority of poor in the MSs.

Regulation of and information from the private sector remain significant challenges. In many instances, since government (health/medical) staff earn high fees from private practice the weaknesses in regulation are not completely overcome. The capture influence of the private forprofit sector on the HRH is quite pronounced in several MSs. Training and retention of health professionals in the public sector, therefore, is one of the biggest challenges.



5 COVID-19 AND SADC

The SADC region was more severely hit by the COVID-19 pandemic than other regions of Africa. It accounted for more than half of all COVID-19 cases being reported in Africa by 31 December 2021.

When COVID-19 struck initially in March 2020, public health experts predicted that it would be particularly devastating in sub-Saharan Africa. It was feared that up to 3.3 million Africans might die in the worst-case scenario considering poverty, governance issues, and stressed health systems. However, the sub-Saharan Africa region appeared to have a significantly smaller COVID-19 burden than other parts of the world, attributed to the relatively young population and effective public health measures taken.

In SADC, all MSs reportedly took stringent measures from the early stages of the COVID-19 pandemic in an attempt to break the transmission and control the spread of the coronavirus. National and sub-national lockdowns were enforced by most of the MSs and cross-border movement was discouraged through border closures except for returning citizens and residents, and quarantine upon arrival³⁷.

Despite these measures, South Africa was severely hit by the pandemic, contributing over 40% of sub-Saharan Africa's COVID-19 deaths. However, South Africa also exhibited the best data management system in the region. It is possible that due to weak health management information systems and Civil Registration and Vital Statistics systems, actual statistics of the disease in some other MSs may not have been accurately reported³⁸.

In February 2021, the chairperson of SADC, Filipe Nyusi, President of Mozambique, stated that more than 50% of all new daily infections of COVID-19 on the African continent were in the SADC region. At least four SADC MSs lost 10 high-profile politicians to the virus including Prime Minister Ambrose Dlamini of Eswatini and various Ministers. Chairperson Nyusi emphasized that the SADC region needed to intensify cooperation and collaboration between MSs through increased data sharing; policy harmonisation and standardisation; pooled procurement of essential medical and non-medical equipment to address the pandemic more effectively. He recommended that the SADC Committee of Ministers of Health establish a strong regional collaborative strategy that pools resources together to acquire the vaccine urgently for distribution to citizens, setting priorities per the level of risk³⁹.

The WHO global pulse survey covering more than 150 countries in five regions (March to June 2020) found that 90% of countries around the world had reported disruptions to essential health services since the start of the COVID-19 pandemic. Low- and middle-income countries suffered the greatest impact compared to high-income countries. The survey highlights the gaps in health systems such as disruptions in health services, lack of health supplies and medicines and dearth of personnel to respond to the needs, but it also serves to inform new strategies to improve healthcare provision during the pandemic and beyond.

It found that almost invariably all responding SADC MSs encountered average disruptions in 50% of a set of 25 tracer services. The most disrupted services included outreach services (70%), facility-based services (61%), non-communicable diseases diagnosis and treatment (69%), family planning and contraception (68%), treatment for mental health disorders (61%), and cancer diagnosis and treatment (55%). Fortunately, no major potentially life-saving emergency services were reported to have been disrupted in SADC countries.

SADC has, over the years, stressed the need to strengthen the region's general preparedness against natural disasters such as droughts, cyclones and floods. These multiple hazards have highlighted the importance of cooperation and coordinated response, as well as the need to come up with innovative mechanisms to strengthen resilience, preparedness and responsiveness to disasters, including pandemics, epidemics and related hazards⁴⁰. A new SADC Humanitarian and Emergency Operations Centre (SHOC) is being established with responsibility for facilitating and coordinating enhanced regional disaster risk preparedness, response and early recovery to support MSs affected by disasters. The SHOC will be hosted by Mozambique. In May 2021, the SADC Committee of Ministers Responsible for Disaster Risk Management "noted the threat of the ongoing


health food and nutrition crisis in the SADC posed by several disease outbreaks including the COVID-19 which continues to claim lives and disrupt livelihoods across the globe". While this may imply that the SHOC will have a future role in enhancing the region's preparedness for pandemics such as COVID-19, it is worth noting that none of the study Key Informants mentioned the SHOC in their responses.

5.1 COVID-19 situation in the SADC region

The COVID-19 case load among SADC MSs has risen and fallen since the start of the pandemic, as new waves have hit the region. The impact of the pandemic has been greatest in South Africa, which has accounted for almost 50% (47.8%) of cases in Africa and almost 70% of cases in the SADC region, as shown in Table 5.

Member State	Cases - cumulative total	Cases - cumulative total per 100000 population	Cases - newly reported in last 7 days	Cases - newly reported in last 7 days per 100000 population	Deaths - cumulative total	Deaths - cumulative total per 100000 population	Deaths - newly reported in last 7 days	Deaths - newly reported in last 7 days per 100000 population
Africa	7164485		290321		155675		1002	
South Africa	3424534	5774.085	92526	156.007	90854	153.188	366	0.617
Zambia	238383	1296.691	19360	105.309	3716	20.213	31	0.169
Botswana	212482	9035.532	7781	330.877	2439	103.715	14	0.595
Zimbabwe	207548	1396.414	9780	65.801	4940	33.237	121	0.814
Mozambique	175648	561.976	13123	41.986	1976	6.322	19	0.061
Namibia	146459	5764.049	6941	273.17	3613	142.193	30	1.181
Angola	76787	233.635	10849	33.01	1757	5.346	19	0.058
DRC	74793	83.51	5466	6.103	1205	1.345	79	0.088
Malawi	72135	377.079	5969	31.202	2343	12.248	30	0.157
Mauritius ⁴	66929	5262.674	0	0	762	59.917	0	0
Eswatini	64873	5591.709	2779	239.535	1292	111.364	27	2.327
Madagascar	50279	181.572	2984	10.776	1027	3.709	31	0.112
UR Tanzania ⁵	29306	49.061	2823	4.726	737	1.234	3	0.005
Lesotho	28195	1316.14	2191	102.276	665	31.042	0	0
Seychelles	24546	24958.565	349	354.866	126	128.118	0	0
Comoros	6043	694.916	1366	157.084	154	17.709	2	0.23

Table ³6: Daily cases and deaths by date reported to WHO

Source: WHO COVID-19 Dashboard. Geneva: World Health Organization, 2020.

³ Available online: <u>https://covid19.who.int/;</u> Last cited: 4 January 2022.

⁴ Note WHO figures for Mauritius are inconsistent with those recorded by other sources, such as Worldometer, Our World in Data, or Reuters

⁵ The data quoted for Tanzania need to be used with caution as the country stopped reporting COVID-19 in April 2020



Countries such as South Africa, Zambia, Zimbabwe, Mozambique, Namibia, Angola, DRC, Malawi, Eswatini and Lesotho are currently experiencing a pronounced fourth wave, as shown for South Africa in Figure 7 (other MSs mentioned have similar profiles but lower numbers), due to the rise in infections from the Omicron variant. Case numbers are also rising in Botswana and Mauritius, albeit with different case load profiles due to avoiding the earlier apeaks in 2020, and are approaching their winter 2021 peaks experienced in August. In Madagascar, Omicron cases represent a third wave. Only in Seychelles are case numbers still largely suppressed.



Figure 6: Daily new cases in South Africa

Source: Worldometer. Available online: https://worldometers.info/coronavirus/ Last cited: 4 January 2022

5.1.1 Active cases

In terms of active cases, South Africa accounts for the highest number, although numbers has been falling since Christmas Day 2021 as the effects of the Omicron variant start to subside due to its milder effect despite higher transmissibility.





Figure 7: Number of confirmed active COVID-19 cases in the SADC region

Source: Worldometer. Available online: https://worldometers.info/coronavirus/ Last cited: 4 January 2022

It remains to be seen what effect the Christmas and New Year holidays will have on the data.

5.1.2 Recoveries

Analysing the percentage of known cases who recovered, most MSs exhibit a high recovery rate, led by Seychelles (97%), while Mauritius, South Africa, Eswatini and Botswana all show recovery rates in excess of 92%, as shown in Figure 9. The low recovery rate in Lesotho (54%) is a matter of concern, while data for Tanzania are not available.



 Figure 8:
 % of MSs' COVID-19 infected population recovered, in SADC region (4 January 2022)

 Source: Worldometer. Available online: https://worldometers.info/coronavirus/ Last cited: 4 January 2022



5.1.3 Mortality rates

Concerning mortality rates, despite a relatively low number of cases Mauritius appears recently to have the highest mortality rate in SADC at 3.2%, followed by Malawi at 3.1%, based on data published by Worldometer, Our World in Data, and Reuters, as shown in Figure 10. The cumulative case numbers quoted by these sources (23,602) are inconsistent with those published by the WHO (as in Table 5 above), although data for other countries are comparable. Using WHO data, which is based on cumulative cases of 66,799, the case fatality rate for Mauritius is 1.15%.

Elsewhere, mortality rates are lowest in Seychelles, Mozambique, Botswana Zambia and the DRC ranging from 0.5% to 1.6%. The rates in other MSs are within the 2-3% range.



Figure 9: % of deaths among COVID-19 infected population, in SADC region

Source: Worldometer. Available online: https://worldometers.info/coronavirus/ Last cited: 4 January 2022

5.1.4 Vaccinations

The situation with vaccinations is also somewhat mixed. Only seven African countries were able to meet the WHO target of vaccinating 40% of their populations by the end of 2021, of which three – Seychelles, Mauritius and Botswana – are SADC MSs.

Figure 11 below indicates vaccination rates based on the number of vaccination doses reported to have been delivered to the MS concerned, and the percentage of the population who could be fully vaccinated assuming that every person needs two doses (excluding now the additional requirement for booster jabs to provide additional protection from the Omicron variant).





Figure 10: SADC MSs' COVID-19 Vaccination Rates (%)

Source: Reuters. Available online: <u>https://graphics.reuters.com/world-coronavirus-tracker-and-maps/countries-and-territories/</u> Last cited: 4 January 2022.

In practice, some segments of the population (e.g. vulnerable or elderly people) may have received booster jabs, which would reduce the total percentage fully vaccinated. For example, Our World in Data records that Seychelles has fully vaccinated 79.5% of its population, Mauritius (71.9%) and Botswana (43.9%), as shown in Figure 12.





Figure 11: SADC MSs' COVID Vaccination Rates (%) – Full and partial vaccination

Source: Our World in Data⁶

5.2 Impact of COVID-19 on MSs

5.2.1 Healthcare services

MSs reported an abrupt rise in morbidity and mortality due to COVID-19 especially in patients with co-morbidities. The provision of health services was disrupted in most MSs. Several MSs had disruptions in regular health services and a period of intense uncertainty which led to a rise in morbidity due to non-COVID-19 illnesses especially as services were inaccessible or medical supplies were inadequate. However, MSs such as Mauritius responded better as they routinely keep medical stocks for several months ahead. Seychelles faced many supply challenges as she relies entirely on imports for pharmaceuticals the supply of which became a challenge during lockdowns. This may be a feature of minimal contingency planning and preparedness for any disasters and negatively affects the resilience of health systems and services.

Botswana reported disruptions of routine health services, e.g., scheduled operations, cardiac disease treatment, etc. There was a substantial derailment of routine health services which could not operate properly. Patients and healthcare providers experienced delays in seeking approval from District Health Management Teams (DHMTs) and thus treatments were postponed. Hence, most of the COVID-19 deaths were in patients with unattended chronic conditions (co-morbidities) due to the disruption of services. The most affected service areas included surgical procedures. Also, due to economic closure Botswana experienced a decline in revenues, e.g. from tourism, which reduced funding for health, further deepening morbidity. The health workforce was extremely strained as the impact was two-fold. Personnel were doing double duties – their own and COVID duty and some of the programme drivers based at headquarters were taken to work at the operational level.

⁶ Available online: <u>https://ourworldindata.org/explorers/coronavirus-data-explorer?zoomToSelection=true&time=2022-01-03&facet=none&picker-Sort=desc&pickerMetric=total_vaccinations_per_hundred&Metric=People+vaccinated+%28by+dose%29&Interval=Cumulative&Relative+to+Population=true&Align+outbreaks=false&country=AGO~BWA~COM~COD~SWZ~LSO~MDG~MWI~MUS~MOZ~NAM~SYC~ZAF~TZA~ZWE/_Last cited: 4 January 2022</u>



Malawi reported a negative impact on morbidity, mortality and other associated factors; mortality had been significantly associated with co-morbidities. The negative economic impact was severe in terms of job losses and business closures. However, with time the country developed a deeper understanding of the disease and provision of healthcare. COVID-19 took precedence over other diseases and interventions such as Antenatal Care (ANC), diabetic clinics etc., regular health services as the focus was only COVID-19. With the heightened focus on COVID-19, the HRH shortage for other interventions became severer which also contributed to disrupted services. Also, there were disruptions in the management of other diseases as the country switched to panic mode and services had been disrupted. There were more talks on how to adjust and continue with regular services, but resumption need resources. The country intended to incorporate COVID-19 as one of the diseases to allow refocus on other diseases as well.

5.2.2 Pharmaceutical industry

The COVID-19 pandemic had an unprecedented impact on businesses across the world, disrupting global supply chains and distorting demand for goods and services. The long-established delivery channels linking vendors and end-users was jolted while the demand for products used in the prevention, management and control of COVID-19 surged. The global supply chain for active pharmaceutical ingredients, finished pharmaceutical products, equipment and other health commodities was severely disrupted. The interviewed local pharmaceutical industry indicated that the initial lockdown was not very disruptive to most companies in the region. This is because they normally have a lead time of three to six months on raw material stock holding. However, the prices of active pharmaceutical ingredients (APIs) went up significantly with some products such as chloroquine rising from \$ 60 to \$ 300 per kilogram while freight delays and cancellations impacted on operations. Also, there were demand surges for COVID-related products such as paracetamol, azithromycin, intravenous fluids and doxycycline, among others.

Some companies faced a delay in the scheduled servicing of critical equipment and machinery. For example, Plus Five Pharmaceuticals in Zimbabwe reported that it had to ship its water treatment system to the supplier due to lockdown for repairs which took three months for a repair normally done within days on-site. Also, the qualification of heating, ventilation, and air conditioning (HVAC) systems, which has to be done annually, has proved to be costly during the pandemic period due to the increased cost of travel. Shelys Aspen, Tanzania, indicated a delay in upgrading their facility as the 75 good manufacturing practices (GMP) compliant doors ordered from India could not be delivered in time. As a result, the company could not get a current GMP licence for use in supplying Ethiopia, one of its export markets. The company also experienced supply chain disruption for both the inputs and movement of finished products to the market.

Companies in Tanzania experienced shortages of blister packs and had to negotiate with the regulator to supply paracetamol in tins, a practice that is normally not allowed. Seychelles, which relies entirely on imports for pharmaceuticals, mostly from South Africa, ran out of stock for some drugs. The initial lockdown in South Africa created many difficulties to move the products from manufacturers or from distributors to the airport.

Also, the Ministries of Health encountered supply chain disruptions for both pharmaceuticals and non-pharmaceuticals. Accessing PPE was a challenge in particular but local suppliers quickly stepped in to fill the void. There were concerns about the quality of both the locally produced and imported PPE as the national regulators did not have sufficient expertise. The MSs accorded preferences to local companies to supply emergency commodities where local capacity existed, however in the majority of cases they had to resort to imports. For example, Eswatini granted preferential procurement rights to South African companies in absence of local manufacturing capacity. The MS expressed the need to build local capacity for the production of essential medicines given the experience of COVID-19 disruption on supply chains and the region's unhealthy reliance on imports.



5.3 Features of MS level responses to COVID-19

As noted above, COVID-19 halted, at least in the early months of the pandemic, routine health services and put health systems under extreme pressure. Procurement and logistics had been among the major challenges. Consequently, health gains made in the MSs over the past several years might have been put at risk of reversing although no study is yet available on the impact of COVID-19 on other health issues.

Namibia: At the beginning of the pandemic during the lockdown, Namibia faced a number of challenges, particularly in the area of procurement. The biggest challenge was the availability of commodities and equipment that was needed for the COVID-19 response. The supplies were inadequate and being a small nation it was challenging to book orders as countries with bigger populations were given preference by suppliers due to the size of their orders. Additionally, flights were not easily available to bring in the supplies and the prices of commodities sky-rocketed as the demand was very high. Nevertheless, through development partners and embassies abroad, Namibia was able to bring in some of the needed supplies for effective response. The COVID-19 pandemic responses added pressure on the health system. It intensified the shortage in human resources of skillsets in the local market that existed even before the pandemic. It became further difficult to bring in those skillsets from other countries as most countries were affected and nobody wanted to release their staff members.

The biggest issue perhaps was the lack of preparedness and uncertainty due to lack of knowledge about the disease, health staff being equally at risk and governments not knowing how to respond. After an initial phase of uncertainty, with the build-up of international knowledge base, science and support, the health systems in SADC MSs also started resuming their functions as much the situation allowed. Even now full functionality has not been resumed while at the same time health systems are re-purposing their structures and functions to accommodate COVID-19 testing, treatment and now vaccination. This additionality is putting heightened pressure on existing limited resources and other essential health services are being compromised in many instances.

The breakdown of supply chains was yet another huge challenge associated with the COVID-19 pandemic's early phases with price escalation of supplies and medicines due to extremely high demand and low production. However, with time the supply chains, production and distribution responded and by the time this study was conducted most issues had been ironed out.

Technical capacity is another critical issue that persists and had been particularly severe in the early phases of the pandemic. Since COVID-19 was not completely understood as a disease, medical professionals were at a loss on how to treat patients. With growing knowledge and research, the various forms and types of the disease complex have begun to unravel but there still is considerable ambiguity about the exact nature of the disease and treatment regimens. As with other aspects, there is learning every day and responses are becoming more focused and better equipped. In early 2021, what became known as the Beta emerged in South Africa and was treated as a "variant of concern". Subsequently, the Delta variant first identified in India became the then dominant global variant and brought new challenges to the science and practice of management of COVID-19. Most recently, the Omicron variant was detected in Southern Africa and has since replaced the Delta variant as the dominant global strain, more infectious but milder than Delta.

Botswana: the coordination platform led by MHW, consisting of UN organisations and civil society organisations, faced challenges in its functioning due to COVID restrictions. However, public and private health sectors cooperated for COVID-19 surveillance, contact tracing and technical assistance needed for national COVID-19 response. At the beginning of the pandemic, the pharmaceutical industry faced shortages in medical products as countries were prioritising their populations. Botswana imports wholly from South Africa. Also, there had been an inadequate supply of commodities: test kits and reagents, machinery, technical capacity. In face of financial and operational issues, the recovery was slow. Currently (as at 30 December 2021), Botswana has fully vaccinated 42.3% of its population, one of only seven African countries to meet the 40% target set by the WHO.

Malawi: The government did its best to provide testing services and expanded testing sites. Isolation centres were established and the capacity for Oxygen therapy was improved nationally.



The provision of PPEs for health workers was improved and sensitization of the public about infection prevention measures was ramped up.

Mauritius provides free health services to its entire population of 1.2 million people. This is one of the basic reasons that COVID-19 could be contained in the country. Currently (as at 30 December 2021), Mauritius has fully vaccinated 71.5% of its population, the second highest in Africa.

Namibia: MoH has good collaboration with the private sector, especially when it comes to a pandemic, like COVID, or any epidemic as there are structures in place to launch an appropriate response. The National Health Emergency Management Committee (NHEMC), a multisectoral committee that also has a constitution at the regional level, works on the 10 pillars established in response to the COVID-19.

Seychelles: Currently (as at 30 December 2021), Seychelles has fully vaccinated 79.5% of its population, the highest in Africa.

5.4 SADC regional response to COVID-19

Initially, the SADC regional epidemic was mainly driven by South Africa, Mauritius, the Democratic Republic of Congo (DRC) and Madagascar whose caseload represented 93% of all cases reported in the region.⁷ SADC MSs' initial response to the pandemic was to introduce states of emergency and lockdown. Borders were quickly closed and remained closed except for movements of essential goods. Flights between countries were suspended apart from carriage of essential cargoes.

At the regional level, SADC launched a regional response from the early stages of the pandemic, comprising of recommendations to MSs to:

- 1. Scale up the testing of health workers exposed to COVID-19;
- 2. Develop a protocol for health worker infection management;
- 3. Provide high standard PPE, safer working environment etc. for frontline health workers to motivate them for their selfless commitment to their patients.

SADC also focused on the need to improve contact tracing processes to allow the rapid identification and isolation of secondary cases, which was considered key to breaking transmission chains and slowing down the spread of the outbreak.

In relation to education, SADC and the United Nations Educational, Scientific and Cultural Organisation (UNESCO) put together an action plan on ensuring continuity of learning in the context of COVID-19, making distance learning possible for all learners at all levels; creating awareness on the importance of health and hygiene, and on COVID-19 prevention through age-appropriate information about coronavirus and other infectious diseases.

The Secretariat also engaged with the African Development Bank (AfDB) and the Government of the Federal Republic of Germany through Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) to compile a consolidated list of Member States needs for essential medicines, medical supplies and medical equipment, especially testing kits, personal protective equipment (PPE) and ventilators, and mobilise resources for acquiring them. It also instituted a process for developing a regional database of pharmaceutical manufacturers in the SADC region.

Subsequently, the SADC focus moved to vaccine initiatives and testing, easing of lock down measures, and the economic impact of COVID-19 including the implementation of the SADC Guidelines on Trade and Transport Facilitation.⁸ With regard to cross-border trade, the SADC Secretariat introduced *Guidelines on Harmonization and Facilitation of Movement of Essential Goods and Services across Borders during the COVID-19 Pandemic*, which MSs and other

⁷ https://www.sadc.int/files/6815/8758/9636/BULLETIN_2-SADC_Response_to_COVID19_ENGLISH.pdf

⁸ https://www.sadc.int/files/1916/0398/2311/COVID-19_14th_Report_EN_mail.pdf



stakeholders such as SADC Business Council, Private Sector Transport Operators and Corridor Management Institutions, aligned with national laws and procedures.

However, despite the reported shortages of HRH in MSs as well as hospital capacity, the issue of how MSs might address such shortages was not advanced, partly because all MSs were suffering from such shortages and spare capacity was not available.

In its August 2020 publication, PESA⁹, a regional political and economic think-tank in SADC, noted that the public health response to COVID-19 had initially lagged, even though most SADC governments were swift in ordering national lockdowns to slow the spread. Rates of public testing had been sluggish, and there was a concern that countries had not prepared enough beds to deal with the inevitable rise in infections when MSs eased the public health restrictions. Prolonged national lockdowns were also not viable as they were feared to destroy livelihoods, firms and national economies. Hence, the pressures to re-open economies, undermining the public health response to reduce economic devastation, had resulted in a sharp rise in infections, particularly in South Africa⁴¹.

MSs reported varying degrees of knowledge of, and therefore participation in, SADC regional responses and/or influences on their national responses to COVID-19. Some expressed awareness of regional COVID-19 responses and expressed appreciation of the support, but others were not aware of any regional COVID-19 response. For example, Botswana were aware that regional cooperation facilitated travel and logistics, and that regional guidelines helped strengthen national guidelines for COVID-19 responses. Respondents in Malawi and Mauritius were not aware of the SADC regional response to COVID-19, however.

Botswana: Medicines' regulators established a platform to share key information, discuss COVID-19 related activities including clinical trials in the region as well as import constraints, in which they helped each other remove supply chain bottlenecks. Common travel and logistical documents were agreed upon by SADC that led to generally uniform ways to address travel restrictions across MSs. After the initial disruptions, the situation improved and the region started to work together; regional meetings were held and issues were addressed as a region.

Malawi: the health sector representative was not aware of any regional response specific to the SADC level. Malawi developed collaboration at AU level for provision of testing kits and PPEs; negotiation for provision of supplies and also for vaccines, from China to countries in AU which had been embraced by SADC MSs.

The responses above show that although the regional response to COVID-19 by SADC helped MSs in streamlining some of their technical and human resource issues, much more was expected and perhaps should have been done. This could include, for example, a regional database of COVID-19 cases and case reporting, their migration within their countries or abroad, regular sharing of up to date experience and knowledge, as well as of latest information on prevention, treatment and capacity building interventions for improved treatment modalities. Additionally, facilitating the movement of healthcare professionals to MSs with a high need of HRH could have bolstered the response. Lastly, negotiating for the provision and distribution of essential medicines and supplies for and on behalf of the MSs would have been quite beneficial.

5.5 Support by foreign health providers for COVID-19 response

No significant role of foreign health professionals was found within the COVID-19 response and interventions in MSs. There were no government-to-government agreements that addressed capacity issues created by COVID-19 in the MSs. Apart from South Africa that brought in health care workers from Cuba, there was no evidence that other MSs hired foreign experts to boost their HRH capacity in response to the COVID-19 pandemic.

⁹ PESA is an independent think-tank promoting regional integration in SADC and providing research on the political economy of development in Africa: <u>About PESA (politicaleconomy.org.za)</u>



The private sector played a small but meaningful role in the COVID-19 response by MSs. There were incidences when private sector entities offered support but governments did not have adequate mechanisms to support and enable the private sector to participate better in the COVID-19 response within the MSs.

Botswana: No foreign health providers extended support to Botswana for COVID-19 response. Botswana however received support from bilateral and multilateral organisations in her COVID-19 response. For example, South Africa supported PCR testing from early to about mid-2020, the United States (US) Government supported the strengthening of COVID-19 surveillance, capacity building for community health workers and lab personnel, development of quality management systems (QMS) for laboratory, development of emergency supply chain structures. Similarly, China helped in hospital pairing mechanisms - between the Fujian Provincial Hospital in China and Nyangabgwe Referral Hospital - to fight COVID-19 and in the provision of lab equipment, testing kits and PPE. Japan provided medical equipment; India donated COVID-19 vaccines; Korea provided PPE. Additionally, institutional research partnerships were working to strengthen Botswana's COVID-19 response, such as York University, Australia, in collaboration with BUIST; Botswana Harvard Partnership for laboratory testing, research; Rutgers University – Coordination of COVID-19 at health facilities.

Thus there was clear collaborative effort related to restrictions on movement in the region and clear cooperation and support from other countries.

Malawi: Corporate partners helped with PPE, test kits and equipment. The corporate sector is working with the government in sensitisation campaigns. Development partners including United Nations International Children's Emergency Fund (UNICEF), United Kingdom (UK), US and other donors are also assisting.

5.6 Conclusion

COVID-19 not only shines a light on all the problems of modern society such as inequality and the importance of UHC, but it also raises the urgency to deal with such issues. The global economy is widely connected, making it impossible for one country to make improvements without the cooperation of others.

As true for many other parts of the world, analysis of the progression of COVID-19 and response at the MS and regional levels point to significant gaps in the resilience of health systems and communities within the SADC region. The disruptions, lack of strategic steer, knowledge, communication, capacity, supplies and frameworks to predict scenarios and develop responses are areas that have exhibited weaknesses in the region as a whole as well as at the individual MSs level albeit with varying degrees and types of impact.

Many commentators have cautioned that, with the world focused on COVID-19, funding that has often been available for disaster relief will become harder to come by. The Ebola outbreak in the DRC in June 2020 was contained but fears of an epidemic breaking out during the pandemic are still high⁴². This makes it important to appreciate that the current focus on COVID-19 is likely to lead to funding challenges for responding to other life threatening diseases. It is also pointed out that the pandemic will cause fiscal deficits to widen and divert funds from developmental projects⁴³ creating deeper issues with critical essential services such as healthcare.

5.6.1 Perspective on health system resilience

Resilience is not a new concept; it can be understood as the ability of systems and communities to resist, absorb, accommodate and recover from calamities so that the communities continue to survive and thrive. However, its relevance and applicability is now being increasingly recognised across the world. Health system resilience is relevant in all countries facing health shocks—whether sudden (e.g., COVID-19, earthquakes, floods, terror attacks, refugees), slower-moving (new pathogens becoming pandemic, endemic or epidemiologic transition), or the more chronic stresses that characterise even times that seem calm (drug shortages, loss of key health personnel, smaller outbreaks of endemic diseases).



Health systems resilience and community resilience are connected segments in the same spectrum. Strong systems are required to build resilient communities and households and individuals. Community resilience depends upon knowledge, abilities, behaviours and resources which are all dependent upon policies, strategies, plans and implementation of interventions to build and support community resilience. Therefore, health system resilience and community resilience both require robust systems.

5.6.1.1 Development vis-a-vis humanitarian context

Development-based systems for health and population (as well as other systems) are largely aimed at addressing issues grounded in poverty and issues that are 'routine' in nature. Systems are more or less structured with an integrated set of services based on priorities, policies, service providers and generally defined users. They depend on fixed resources and budgets for specified periods and the scope of services. The typical development-based systems are slow(er) moving and highly regulated. They follow bureaucratic procedures and resource mobilisation takes time. On the other hand, humanitarian situations which include disasters, conflicts and infectious diseases require an urgent and targeted response which the development systems are unable to provide. The development 'system' does not fully respond to the humanitarian needs as it is not geared to responding to large scale emergencies and typically has a lot of slow(er) moving parts.

Consequently, the system breaks down and switching to crisis mode is the only choice. It must be noted that 'system breakdown' does not necessarily mean that the various components of the system disappear but these components cannot perform their routine functions which result in disruption of activities. During the humanitarian crisis mode, the focus is on short-term delivery of lifesaving services which typically operate independently of each other and from development efforts. The limited resources and capacity to address long-term development efforts aimed at reducing chronic poverty and/or vulnerability are disrupted and can erase a generation of health, economic and social gains. The effectiveness and efficiency of system functions are severely impaired. Community-embedded outcomes are halted or reversed and at the same time rebuilding the system is not straightforward. The entire system does not necessarily break down in humanitarian crises since parts of the system or the entire system may still be somewhat operational. However due to the non-alignment of systems to tackle crises the provision of short-term urgent services remains siloed and are typically costly.

5.6.1.2 Protracted crises and resilience

The critical issue is that crises do not neatly end as there may not be clear-cut boundaries of end of crises and (re)start of development conditions. Once crises start, they tend to continue in a more or less diluted fashion with characteristics of low(er) level ongoing emergency. Such conditions are typically seen in ongoing armed conflict, continued infectious diseases, the fallout of natural disasters - where needs (of community) change and large-scale rebuilding is needed. In such conditions, the vulnerability of certain groups to emergency issues continues and the need is higher and more urgent – yet the development services are still needed. There are no clear fixed points that signify the end of crisis or the start of development.

The *Transition Approach* had been considered to be a response enabling the switch from humanitarian mode back to development mode. However, it has not actually worked well due to lack of clear demarcation of crisis-development boundaries and differences in approach of the humanitarian and development modes. The underlying assumption that bouncing back to precrisis mode is the best route does not hold especially when the pre-crisis system had anyway not been effective and/or efficient. Questions that need to be considered during the mixed humanitarian/development context are:

- Status of health and population-based outcomes in the community?
- How to ensure that community-based outcomes continue to be achieved?
- What will happen in the next breakdown and the next?



5.6.2 Guidelines for movement of health professionals in a health crisis

The study recognised that the movement of health professionals raised many challenges during COVID-19 pandemic. Not only was the shortage of HRH widespread across the SADC membership, but even where surplus HRH could have been identified the entry and qualification requirements maintained by MSs would have frustrated such movements across borders. It was clear from our interviews that MSs would not want to allow untrained or unqualified medical personnel to treat COVID patients, or treat them unsupervised, yet application of strict requirements in a pandemic would do nothing to address the acute HRH shortages that were being reported by MSs at the height of their pandemic waves.

Similar to the SADC *Guidelines on Harmonization and Facilitation of Movement of Essential Goods and Services across Borders during the COVID-19 Pandemic*, the study considered that *Guidelines on the Movement of Health Professionals during the Pandemic* would also encourage MSs to cooperate with each other over taking a more flexible stance on admission of foreign health professionals in order to increase HRH availability during the health emergency. In our interviews with MSs, some recognised that such guidelines could have a place in encouraging an orderly sharing of HRH. But others noted that requirements for full qualifications, including recognition procedures as well as procedures for work and residency permits, would still be required in order not to create subsequent rights or expectations of being able to remain in the country.

In the event, it was unlikely that surplus HRH could be found in many MSs to assist those MSs most in need, e.g. South Africa, which bore the brunt of COVID mortality in the SADC region. Nevertheless, a starting point would have been a regional mechanism for MSs to indicate where their needs for additional HRH lay, in order to allow MSs with possible surpluses to declare their willingness to assist those with shortage. This would emphasise that the movement of health professionals was demand, rather than supply, driven. This could have been supported by the application of flexibility on the part of demanding MSs in relation to their entry and recognition requirements. For example, applications for permits could have been fast-tracked in accordance with the agreed guidelines, and some latitude could have been exercised over recognition of qualifications by allowing trained health professionals to practise within the scope of the qualifications already obtained that were relevant for COVID treatment, even if a full course had not been completed.

Annex 3 sets out some suggested draft recommendations for the development of such guidelines so that MSs may consider them not only in the context of the current pandemic but also future health crises.

5.6.3 Lessons learned from the COVID-19 pandemic

The study drew the following lessons from the COVID-19 pandemic experience across the region:

 Sharing the right information at the right time is extremely important and helpful for the regional response;

Information shared by the SADC Secretariat's health sector on COVID-19 helped Namibia to refine its response.

- Surveillance systems, community engagement and risk communication are foundational to an effective response.
- The need for various professionals for effective response has been heightened entry and exit of health professionals from within the region to contribute to response in MSs may need to be facilitated by the SADC, and guidelines for the movement of health professionals in a health crisis would help guide and motivate cooperation amongst MSs with regard to supply of health professionals to MSs with HRH shortages, notwithstanding the rules applicable in "normal times" (see next section).



6 FOREIGN HEALTH (INCLUDING PHARMA) PROFESSIONALS

This section explores the present and potential role of foreign health professionals in the SADC MSs in "normal times". It highlights the barriers and supporting factors that influence the movement of foreign health professionals across the region. Also, it establishes the scope of trade in the health services sector by examining the market demand/trend and MSs GATS commitments in the sector. The cross border movement of health professionals has different implications on HRH depending upon whether a professional is entering into (immigrating) or going out (emigrating) to work in another country.

Most of the interviewed MSs considered the inbound movement of health professionals important in meeting HRH shortages in the receiving country - a source of skills transfer to locals and of expertise that is not available locally. It must be noted that movement of foreign health professionals in the region is largely through government-led initiatives to address HRH shortages in government institutions or programmes compared to movement relating to own/private practice.

6.1 Regulation of foreign health professionals

All MSs are open for foreign health professionals to enter to provide health services as long as they meet the admission criteria set by the receiving MSs. The openness to foreign health professionals is largely passive, however - foreign health professionals taking the opportunity to search for opportunities in other countries and apply for jobs, rather than a proactive policy to recruit health professionals for work in foreign countries (which is discouraged by the WHO Code of Practice – see Box 2 below). Some governments do actively seek to fill HRH gaps in the public sector where the recruitment and placement are more proactively supported by recipient governments, but our impression was that this occurs only in a limited number of cases and is guided by bilateral government-to-government agreements.

Although each MS has specific requirements for licensing of health professionals, the following constitutes the basic minimum applicable in all countries;

- The authenticity of qualifications/certificates;
- Requirement for recognition of the training institution by the regulatory authority;
- Language proficiency, e.g. English, French, Portuguese or other national languages as applicable;
- Certificate of Good Conduct in the country of origin or previous practice.

Typically, the conditions to be met by foreign health professionals to enable them to work in the government sector in the SADC MSs include satisfying a labour market test, and registration with the relevant health professional body which assesses their professional qualifications. The same procedure is followed regardless of whether a foreign professional is recruited to work in the private or public sector including where there are government-to-government agreements. In most MSs, foreign professionals are required to obtain a professional licence as a first step and thereafter apply for a work visa/permit. The processing of work visas may take months except for government-to-government arrangements, in which case the process is fast-tracked. In some MSs background academic checks are also carried out. When all these requirements are met work permits are issued. Generally, the work permit in most MSs allows the holder to provide services only under the entity/employer who applied for the permit – often governments restrict crossing over from public to private sector unless a new work permit is granted.

Foreign health professionals are also required, unless exempted, to pass a professional examination to be able to work in some MSs and, in addition, they must meet country-specific language requirements. Some MSs require foreign graduates to complete internships in the receiving MSs before they are allowed to practise. It is observed that some national regulations provide for provisional registration of foreign professions which, after assessments by local health professional councils, can be upgraded to full registration. A fully registered foreign professional



can operate like a national and there are no differences in the way they are regulated. Once a foreign healthcare worker is licensed, they are accorded national treatment and no preferential treatment for SADC citizenships in any MSs.

6.2 Regional Medical and Dental Regulatory Association (MDRA)

The formation of the MDRA in 2014/15 was inspired by the need to come up with standards for cross-regulation (of health professionals) among MSs. Among the reasons for establishing the MDRA was to create more equal standards and opportunities for medical professionals across the region, medical schools in various MSs should have similar standards. It was felt that advocacy was needed for commonalities to reduce the need for retraining in case of practice in another MS. Additionally it was considered that private practice also needed to be regulated across the region for which standards are required.

The MDRA's current priorities include:

- Identifying medical schools of excellence to start specialising hospitals;
- Providing guidance in areas related to the scope of MDRA;
- Reduction of brain drain;
- Training and harmonisation of training and professional standards.

The achievements of the MDRA thus far are reported to be:

- Support to the Mozambiquan medical regulatory body;
- Training of students in other countries details not available;
- Harmonisation of internship programmes across SADC.

The formal adoption of the MDRA by the SADC Committee of Ministers of Health is a positive move as the association will provide a platform for addressing several regional issues related to harmonisation of standards and facilitation of regional movement of health professionals. However, the intention for a rotational secretarial role may pose some challenges in its proper and sustainable functioning. Currently, as the study was informed, the MDRA's Secretariat is hosted by the Malawi Medical Council with the intention that the host role will rotate, annually, among the regulatory bodies of the MSs. To ensure continuity, the founding Chair indicated the need for the current host to continue with the role until the MRDA is fully established. However, there will still be a need to ensure proper staffing, financial support and ownership within the host organisation. A five-year strategic plan needs to be developed, adopted and supported by SADC along with budget allocations/funding.



6.3 Movement of health professionals

The cross-border movement of HRH has major challenges including the stability of healthcare systems ranging from brain drain, severe HRH shortage to health and socio-economic welfare around the world, especially in low-income countries. In 2010, WHO MSs adopted the WHO Global Code of Practice on the International Recruitment of Health Personnel¹⁰ - a comprehensive, multilateral framework (non-binding) that advances cooperation and information sharing on health worker migration. It establishes ethical principles and practices for the international recruitment of health personnel and discourage active recruitment from countries with a shortage or weak health systems and encourage countries to work together to address the shortage to ensuring the sustainability of both health workforce development and health systems.

Box ¹¹2: WHO Global Code of Practice on the International Recruitment of Health Personnel

1. Objectives

The Code aims to establish and promote voluntary principles and practices for the ethical international recruitment of health personnel and to serve as a reference for all Member States.

2. Scope

The Code is global in scope, and sets out to guide governments of all Member States and interested stakeholders in matters relating to the international recruitment of health personnel.

3. Ethical international recruitment

The Code discourages the active recruitment of health personnel from developing countries facing critical shortages of health personnel.

4. Fair treatment of migrant health personnel

The Code emphasizes the importance of equal treatment for migrant health workers and the domestically trained health workforce. All health personnel should have the opportunity to assess the benefits and risks associated with different employment positions.

5. Health personnel development and health systems sustainability

Countries should implement effective health workforce planning, education, training and retention strategies to sustain a health workforce that is appropriate for the specific conditions of each country and to reduce the need to recruit migrant health personnel.

6. International cooperation

The Code encourages collaboration between destination and source countries so that both can derive benefits from the international migration of health personnel.

7. Support to developing countries

Member States are encouraged to provide technical assistance and financial support to developing countries or countries with economies in transition that are experiencing a critical health workforce shortage.

8. Data gathering

Member States are encouraged to strengthen or establish health personnel information systems, including information on health personnel migration, in order to collect, analyse and translate data into effective health workforce policies and plans.

9. Information exchange

Member States should periodically collect and report to the WHO Secretariat data on laws and regulations related to health personnel recruitment and migration, as well as data from health personnel information systems. Member States are encouraged to promote information exchange on international health personnel migration and health systems both nationally and internationally.

¹⁰ <u>https://www.who.int/hrh/migration/code/code_en.pdf?ua=1</u>

¹¹ Source: WHO; "User's Guide to the WHO Global Code of Practice on the International Recruitment of Health Personnel". Accessed at <u>https://apps.who.int/iris/bitstream/handle/10665/70525/WHO_HSS_HRH_HMR_2010.2_eng.pdf;jses-</u> sionid=0C7B7C2A439914EAF54B30A654127352?sequence=1



The African Union estimates that about 70,000 skilled professionals emigrate from Africa annually. The loss of doctors and nurses is more extreme — for example, the AU Capacity Development Plan Framework shows that the emigration of doctors from Mozambique currently stands at 75% of all trained physicians; Angola (70%), Malawi (59%), Zambia (57%) and Zimbabwe (51%); while the numbers are higher for nurses. The United Nations Conference for Trade and Development (UNCTAD) estimates that each migrating African professional represents a loss of \$184,000 to Africa. Paradoxically, Africa spends \$4bn a year on the salaries of 100,000 foreign experts. Annually, it is estimated that Africa loses around \$2bn through brain drain in the health sector alone. Many doctors and nurses cite better health infrastructure and other incentives, e.g. better remuneration packages, intellectual stimulation, wider career structures, and personal security, that draw them out of Africa. But each has a palpable desire to be able to contribute to the continent of their birth and/or ancestral origins.⁴⁴

Although the study could not obtain comparable and up-to-date statistics on HRH migration across the SADC MSs, reports by the Organisation for Economic Cooperation and Development and the WHO indicate that some SADC HRH mobility exists within and beyond the region. Generally, HRH mobility is a global and complex phenomenon. Generally, HRH mobility is a global and complex phenomenon. A WHO project on the implementation of their Codes in five MSs (India, Ireland, Nigeria, South Africa and Uganda), drew very complex patterns of mobility in the health sectors as shown in Figure 13. The report shows the globalisation of health education as well as both South to South and North to South health HRH mobility including intraregional movements. For example, during 2010-2015 over a half of emigrant graduate professionals from Uganda moved within Africa, primarily to Southern and Eastern Africa, with Namibia and Kenya as leading destinations; while the largest four sources of migrant doctors to South Africa were Nigeria, UK, Cuba and DRC. At the same time about a third of the graduate professionals registered in Uganda were trained and held nationalities in North America and Europe. In addition, the report indicated a 60% rise in the number of migrant doctors and nurses working in the Organisation for Economic Cooperation and Development (OECD) countries during 2005-2015.



Figure 12: Patterns of Mobility: five selected WHO MSs

Source: EC document WHO/HIS/HWF/BrainDrain/EC/2017.112

¹² <u>https://www.who.int/hrh/HWF17002_Brochure.pdf</u>



Also, an OECD paper issued in 2020 indicated that the average share of foreign-born doctors rose from 21% in 2000 to 27.1% in 2018 while the number of nurses increased from 11.5% to 16.2%; while the number of foreign-trained doctors rose from 13.7% in 2000 to 18.2% in 2018 and nurses from 6.7% in 2016 to 7.4% in 2018. SADC countries such as Eswatini, Malawi, Mozambique and Zimbabwe appear among the top 25 sources of home-trained emigrant doctors while Mauritius, Seychelles and Zimbabwe are among the top 25 sources of emigrant nurses⁴⁵.

6.3.1 Need for foreign health professionals

Generally, respondents recognised the need for foreign health professionals within their countries. Some MSs, i.e. Mauritius and South Africa, were identified as attractive for health professionals within the region as they offered attractive compensation. In addition, Mauritius reported that India, China and Australia were sources of migrant HRH to the country based on existing free trade agreements, including for health professionals, with these countries.

However, with the exception of South Africa, no MS could demonstrate any stated policy that addressed the need or issue of foreign health professionals for their country and most intakes are based on a combination of needs identified at the institutional (such as hospitals) or programmatic (such as HIV, TB, COVID-10) levels.

South Africa is the only country in the region that has put in place an approved national Policy on the Recruitment and Employment of Foreign Health Professionals in the Health Sector. This policy was introduced to improve the flow of health professionals into South Africa. The policy was crafted such that it is complementary to the Immigration Act and other laws and is consistent with the country's Constitution. In addition, the following existing policies and strategies take into consideration foreign health workforce: Human Resource Strategy 2001; Scarce Skills Allowance 2003; Remunerative Work Outside Public Service 2002; Human Resources for Health Planning Framework 2006; Policy on Remuneration of Health Professionals Working in Public Health Service 2007; Policy on the Recruitment and Employment of Foreign Health Professionals in the South African Health Sector 2008 (approved in 2010)⁴⁶.

The HRH policies of MSs also appeared to be reticent on foreign health professionals. The demand for foreign health professionals was seen to be limited as they are most needed in more superspeciality and higher levels of healthcare roles, but also for addressing gaps in capacity for providing training to in-country HRH. HRH shortages at the primary healthcare level were not recognised as possible to be filled by foreign health professionals. It was noted that doctors, nurses and pharmacists are the cadres most needed for which foreign health professionals were frequently sought. Some MSs prioritise specialist doctors, e.g., Seychelles and Mauritius indicated that they require transplant and plastic surgeons owing to their focus on developing niche healthcare services. The DRC prioritises neurosurgeons and cardiologists, while Namibia is guided by labour market tests in granting work permits to healthcare professionals. Generally, healthcare professionals move of their own accord in response to available opportunities in other countries. The study did not identify a systematic analysis in any MS which could inform an evidence-based mix of foreign-local professionals.

6.3.2 Drivers and benefits

The key drivers for foreign health professionals to move to another country for work are considered largely to be grounded in prospects of better earning, better work and living environments and growth potential. The receiving country recounted several benefits including the new or rare and specialised skills as well as in filling the HRH shortage. For example, epidemiologists were especially required during response development and assessment of pandemics. Foreign health professionals are considered to stimulate investments in the health sector and this supports economic growth. A few respondents were also of the view that the presence of foreign health professionals also fuels motivation for improved healthcare in the country. Although remittances received from the diaspora are considered to be beneficial for the recipient country it was interesting to note that fees and charges for service provision by foreign health professionals come from a weaker economy, they cannot (comparatively) earn more and send remittances home. This also



establishes the gradient along which foreign health professionals will move, i.e., from a weaker economy to a stronger economy so that they can earn more. Indeed, the desire to move also exists even among those who are already present in the country, exacerbating the shortage of HRH.

6.3.3 Barriers

According to interview responses, once a foreign health professional meets the statutory requirements mentioned in section 5.1 of this report, there are no further regulatory barriers to the movement of foreign health professionals across the SADC region. However, it was indicated that lengthy processing times for obtaining or renewing licences and work permits – which may take up to one year to obtain in some MS – are very demotivating and difficult to navigate and constitute *de facto* barriers encountered by foreign health professionals. It is noted that the process and duration are reduced significantly where the recruitment is done by the government through bilateral cooperation agreements between governments. It was pointed out that the temporary nature of work permits issued by some MSs also serves as a deterrent in some cases.

Recognition of foreign qualifications is one of the main issues that affect the movement of foreign health professionals. Regulatory bodies have a due diligence responsibility to verify professional qualifications before authorising practice by a foreign professional. This is necessary for ensuring that appropriately qualified personnel are admitted. Where the verification process is unduly lengthy and bureaucratic and becomes costly, it may demotivate the foreign professional and thus also affect the speed with which needed skills/expertise in the host country is met.

However, in addition to immigration and licensing issues, other requirements act as *de facto* barriers to foreign practice. For example, some MSs require foreign qualified professionals to work under the supervision of a locally registered professional for prescribed durations before they can practise. There was also concern raised by some respondents that foreign qualified professionals would be disincentivised unless the host MS allowed accompanying families of the professional a safe and sociable life including quality education facilities for children.

Some interviewees expressed concerns that these issues would still lead to lack of availability of expertise and skillsets needed in particular MSs, or that some skilled HRH would avoid working in particular MSs in the SADC region.

6.4 Conclusion

SADC MSs do not appear to have a clear strategy on the role and contribution of foreign health professionals in their domestic healthcare services. Unlike other parts of the world, e.g. the Middle-Eastern countries, EU, Australia etc., where governments take formal and strategic approaches to determine HRH gaps for which foreign health professionals are needed, most of the interviewed MSs were not able to demonstrate government-level analysis of the HRH situation that drives the approach to source foreign health professionals. As a result, the liberalisation of trade in health professionals in SADC MSs lacks strategic direction and is mostly dependent upon entrepreneurs, investors and private market forces.

Most MSs are not able to offer remuneration packages and or infrastructure that are sufficient to attract foreign health professionals, even those from the SADC region. Therefore, most SADC health professionals largely prefer to seek opportunities in western countries in search of better livelihoods and lifestyles. Despite this trend, there is evidence of intra-regional movement of HRH but also some MSs seem to have attracted health care practitioners from beyond the region as shown in Figure 13.

As indicated above, the formal adoption of the MDRA into the SADC health sector structures is a positive move as the association will provide a platform for addressing several regional issues related to harmonisation of standards and facilitation of regional movement of health professionals. However, the intention for a rotational secretarial role may pose some challenges in its proper and sustainable functioning, and there will still be a need to ensure proper staffing, financial support and ownership within the host organisation.



One of the key lessons from the interviews is that the understanding of the benefits of movement of health professionals across borders varies from one MS to another. The interviews suggest that Ministries of Health do not take into account the movement of health professionals (both incoming and outbound) in their health planning and implementation, even though the regulatory frameworks permit. Foreign health professionals constitute a very small percentage of the health workforce in any country but the proportion becomes significant especially at the tertiary care level. There is a need consciously to build this option into health sector health planning and budgets.

At the national level, there was no evidence of coordination on trade policy in the health sector. Most of the interviewed MSs indicated that ministries of health, immigration/home affairs, labour and trade do not usually collaborate and/or consult each other on a regular basis to establish the need for foreign health professionals and to strategise how to address HRH gaps and need by utilising foreign health professionals. This siloed approach creates bottlenecks in the overall management and processing of permits and licences, creating barriers for aspiring foreign health professionals to move or practise in other MSs.

Most foreign health professionals move on their own initiative and have to navigate the complex process of obtaining permits on their own; some may opt to pay private agencies to assist in these areas. Under some instances such as humanitarian emergencies, MSs offer special provisions to facilitate humanitarian health professionals but these situations are generally mediated by UN agencies, international NGOs or development partners.

It is important to note that the need for foreign health professionals in MSs is not limited to core service providers such as pharmacists, nurses or doctors but is also specifically related to health system planners, designers and epidemiologists. As the region is struggling to get back on track after the COVID-19 pandemic, there is a clear need for specialists in the 'back-end' or system-level sciences to help reshape and strengthen health systems and services.

Table 7 highlights the key drivers and barriers for the movement of health professionals in SADC.

 Table 7:
 Drivers and barriers for the movement of health professionals in SADC

Drivers		Barriers	
1. 2. 3. 4.	To address HRH skills gaps in-country. Transfer of skills to local personnel including provision of training. Better terms of service e.g., compensation package benefits. Peace and stability, improved quality of life.	1. 2. 3. 4.	Temporary nature of work permits and long lead times for processing of applications. Language and cultural barriers in recipient countries. Process and delays in recognition of professional qualifications. Disruption of social life of migrant families.

Due to existing poverty and weak economies, MSs are unable to offer attractive remuneration packages to foreign health professionals to facilitate them to work in the region. There is no harmonisation of compensation packages for health professionals across SADC that enables stronger economies to create a pull factor for health professionals, and this creates distribution issues.



7 TRADE IN HEALTH AND SOCIAL SER-VICES

Tradable health-related services are those that can be exchanged cross-border generating export or investment income for the supplying country. Under both the GATS and the SADC PTIS, such services fall under four so-called "modes of supply", namely:

- 1. from the territory of one Member (State) into the territory of any other Member (State) (referred to as "Mode 1");
- 2. in the territory of one Member (State) to the service consumer of any other Member (State) ("Mode 2");
- 3. by a service supplier of one Member (State), through commercial presence in the territory of any other Member (State) ("Mode 3");
- 4. by a service supplier of one Member (State), through the presence of natural persons of a Member (State) in the territory of any other Member (State) ("Mode 4");.

Applying these descriptions to health-related services, the following examples, in Table 8, illustrate how such services can be traded:

Mode of supply	Short description	Method of trade	Example
1	Cross-border	A company in Country A supplies services to a consumer in Country B without establishing a commercial presence	Internet-based / digital services, such as telemedicine, e.g. remote diagnostic services
2	Consumption abroad	A consumer in Country B travels to Country A and consumes services locally	"Health tourism", where a patient travels abroad for treatment in another country
3	Commercial presence	A company based in Country A supplies services in Country B through a locally established operation	A private healthcare service provider based on one country establishes a private hospital in another country
4	Presence of natural persons	A company based in Country A supplies services in Country B through the presence of "natural persons"	A private healthcare company supplies services by sending individual healthcare professionals to work in another country, either still employed by that company (known as "intra- corporate transferees") or through the performance of a contract ("contractual services suppliers"); or through the movement of independent professionals

Table 8: Illustrative example of trade in health-related services

7.1 Health services

Normally a tradeable service will generate a profit for the service supplier. While a private healthcare provider may well wish to expand the healthcare capacity of a country by establishing private hospitals, it is motivated by its articles of association to generate a profit to remain in business. Profits come from revenue generated either through medical insurance or other such assistance schemes or direct payment by the patient. In Africa, such private healthcare services are much more expensive than public services, and therefore aim at a different market from public services, such as ex-pats or those with higher incomes.

Conversely, a public or government-run hospital will generally aim at offering affordable healthcare services to low-income groups. According to Article I:3 of the GATS (and replicated in Article 3 of the PTIS), the term "services" (as in "trade in services") includes any service <u>except services</u> supplied in the exercise of governmental authority; and "a service supplied in the exercise of



governmental authority" means any service "which is supplied neither on a commercial basis nor in competition with one or more service suppliers". Thus, services supplied by the public sector, or not-for-profit organisations such as charities or organisations e.g. Médecins Sans Frontières (MSF)¹³, will generally not be generating profits and will not, in consequence, be considered to be providing tradeable services.

Since such services are mainly funded through taxation or donor contributions, without a profit motive. Moreover, the quality of public services tends to be lower, with potentially long waiting periods. As such, while some services are chargeable, they are not run on a commercial basis, and cannot be said to compete with private services. Consequently, it will generally be considered that such services fall outside the scope of trade agreements.

Note that this study focuses on human health-related services and excludes veterinary services, although the latter is covered by the PTIS along with almost all other tradeable services.¹⁴

7.2 Social services

Social services include non-hospitalised care services such as for the elderly or disabled, or people of any age suffering from such illnesses as mental retardation, mental health illnesses or substance abuse. These may be provided with accommodation, such as through residential care homes, or non-residential, i.e. delivered at home. They also include vocational rehabilitation services.

While many countries, especially developed ones, have long operated residential care homes (often privately run) for senior citizens and incapacitated persons, some developing and nondeveloped countries are still lagging in providing such services. In the SADC region, the concept is relatively and largely new; cultural influences tend to dictate that senior citizens are taken care of by their families despite the challenges that the family members face in caring for them, although the trend is starting to change. For example, there is one such old-age home centre operating in Botswana i.e. the Boikhutsong old age home centre, registered as a Non-Governmental Organisation (NGO) in 2011¹⁵.

A WHO report on long-term care systems in sub-Saharan Africa¹⁶ sheds some light on the supply and demand for care home services in some SADC MSs as follows:

Mauritius had about 25 charitable homes operated by NGO's and funded by the government providing nursing and medical care on-site. Access to these facilities is first-come, first-served and based on means. Also, there is an increasing number of private retirement homes, for those who can afford them. Given the increasing demand for long term care facilities, the government has planned a 52% increase in publicly funded residential bed capacity by 2030.

Seychelles has several government-funded long-term care services are available, including both home care and residential services. Long-term care provision remains mainly in the public sector, with some involvement of civil society and limited participation of the private sector. The country's home care scheme was established in 1987. This programme makes it possible for people to remain at home rather than using residential or institution-based care. Caregivers are chosen by the beneficiary, usually a family member of the older person. The care is focused on assisting and enabling older people with activities of daily living in their

¹³ MSF is a field-based movement engaging MSF volunteers and staff from all over the world in a shared commitment to medical humanitarian action. Through MSF associations, members have the right and responsibility to voice their opinions and contribute to the definition and guidance of our social mission. The associations bring together individuals in formal and informal debates and activities - in the field, in general assemblies at national and regional levels, and in an annual international assembly. See https://www.msf.org/how-we-are-run

¹⁴ Some services such as air transport services are excluded from the scope of the PTIS, but such exclusions are not relevant to this study.

¹⁵ Source : BOPA. Author : Mary Mofaladi, Location : MOCHUDI, Event : Interview, Date : Oct 09 Thu, 2014. <u>http://www.dailynews.gov.bw/mobile/news-details.php?nid=15027&flag=</u>

¹⁶ World Health Organisation, 2017. Towards a Long-term Care System in Sub-Saharan Africa. WHO Document Production Services, Geneva. WHO series on long-term care ISBN 978-92-4-151338-8 <u>https://www.who.int/ageing/long-term-care/WHO-LTC-series-subsaharan-africa.pdf?ua=1</u> Accessed on 06/07/2021



homes to maximize their functional capacity. Nurses and allied health professionals provide complimentary home health care.

South Africa: Overall coordination of long-term care is lacking and clinical-level integration of health and social care is limited. Old-age pensions are means-tested and distributed to people according to financial need. All older people can access primary health care services free of charge but hospital care is free only to those who are indigent. Traditionally, long-term care has been seen as a family responsibility yet few schemes are in place to support family caregivers. Private retirement villages cater mainly to older people with financial means. The villages operated by Rand Aid are an example of the multidisciplinary and stepped care that is generally available to residents. Publicly funded long-term care is available to only a small fraction of the older population. The majority of this type of care is provided in residential facilities which tend to be clustered in urban settings. Applicants are subject to a comprehensive assessment of their current living situation, family support, financial means and care needs. Only those who meet the criteria are eligible for admission. Individual care homes usually have their admission policies and procedures, in addition to the formal criteria for obtaining public financial support. South Africa's population aged 60 years or older is expected to increase from 7.7% to 15.4% of the total population, from an estimated 4.2 million people in 2015 to 10.1 million people over the next 35 years. There are an estimated 1,150 residential facilities for older persons, but only 415 of these are registered with the Department of Social Development, and only eight are state-managed and fully subsidised by the government. Countrywide there are also more than 1,000 private residential facilities and retirement villages where residents are responsible for the full cost of their accommodation.17

Tanzania: HelpAge International is implementing the Better Health for Older People in Africa programme in the country. The project was funded by the UK Department for Interntional Development (DFID) from 2014 to 2017 and aimed at improving access to home-based services for poor older people, thereby reducing their vulnerability to illness and worsening poverty. The programme supports approximately 4,500 older people in four districts across three of the country's regions. Care is provided by 425 trained volunteers who, either directly or through linkages with other services, ensure that clients' physical, emotional, social and spiritual needs are addressed. Coordinators (typically registered nurses or clinical officers) provide supervision and monitor the volunteers. Volunteers are selected in consultation with older people's fora and local community and health leaders. They usually live near the people they serve and are assigned no more than 15 households at a time. Individualised care plans are developed in consultation with clients and families and may include assistance with activities of daily living such as eating, dressing and bathing; bedsore management; medication assistance; companionship and support; and escorts to medical appointments. Clients are visited in their homes two or three times per week and provided with care services as necessary. All care activities are documented on patient cards. Monitoring forms are submitted monthly to the coordinator at the nearby health facility, who reports to national health authorities. Screening, health services, and medications are free of charge to those older people participating in the programme.

¹⁷ Yasmin Mahomedy. 2017. Residential Facilities for Older Persons, South Africa. Available <u>https://www.whoownswhom.co.za/store/info/4495?seg-ment=Community+and+Personal+services</u>



7.3 Classification of services relevant to the healthcare sector

For purposes of trade in services, the SADC MSs agreed to use the WTO Services Sectoral Classification List (W/120) which is derived from the UN Central Product Classification (CPC) for services. The W/120 List classifies healthcare-related services into two distinct areas of activity:

- 1. professional services categorised under the business services sector; and
- 2. health and related social services shown in Table 8.

The SADC Negotiating Guidelines for the Second-Round of Negotiations require MSs to schedule their commitments using the W/120 Classification List and, where necessary, refer to the latest UN CPC (currently, this is Version 2.1) for detailed explanations of each sector or sub-sector. It further requires them to ensure that the commitments constitute an improvement to their existing GATS commitments (referred to as "GATS Plus").

Noting that most of the existing GATS commitments refer to the CPC Provisional version from 1991, MSs are therefore expected first to convert their GATS commitments into the latest version, and to ensure GATS Plus by avoiding backtracking on their existing commitments. In this regard, the study provides a comparison of the two CPC versions, in Annex 3, to enable MSs' preparation of their offers in the health sector. The changes under CPC Version 2.1. can be observed at a 5-digit level and all involve the introduction of new sub-sectors as a result of the separation of certain types of services activities that had been categorised with related services under CPC Provisional. For instance, sub-sector 93191 under CPC Provisional, covering deliveries and related services, nursing services, physiotherapeutic and para-medical services is a divided into three sub-sectors in CPC Version 2.1, i.e. childbirth and related services, nursing services; and physiotherapeutic services.

7.4 GATS commitments

Eight of the 15 SADC MSs that are WTO Members have some GATS commitments covering healthcare services, as shown in Table 8 at Annex 4. The majority of the commitments are in medical and dental services (8), followed by services provided by midwives, nurses, physiotherapists and paramedical personnel (6), hospital services (4), other human health services (2), other social human health services (1) and other professional services: specialised medical services (1). The commitments by the DRC, Malawi, Seychelles and Zambia reflect open market regimes guaranteeing no market access limitations and national treatment. More restrictive commitments have been made by Botswana, Eswatini, Lesotho and South Africa for certain modes of supply.

The limitations observed in medical and dental services commitments are as follows:

Botswana's offers in Modes 1 and 4 are "Unbound", while in Mode 3 there is encouragement to form joint ventures in while restricting employment of foreign persons and in national treatment foreign hospitals are required to employ locals. Also, Botswana's Mode 3 entry for other specialised medical services is "only medicals can supply medical services" which suggests that Mode 3 is not permitted/guaranteed.

Eswatini's entries are Mode 1: "Unbound* and Mode 4: "Unbound, except for specialist doctors only". There is also a limitation on Mode 1 for the supply of hospital services.

Lesotho's Mode 1 entry is "unbound". For services by physiotherapists and paramedical personnel medical, Lesotho's commitments are unbound in relation to Modes 1 and 2, meaning the requiremennts are not guaranteed for the future.

South Africa has similar limitations to Lesotho on services by physiotherapists and paramedical personnel medical. South Africa also has a limitation on Mode 1 for the supply of services by midwives and nurses.



There is sufficient room for all the SADC MSs to achieve "GATS Plus" commitments. This is because the existing GATS offers could be improved by providing more predictable conditions for Mode 1 and 2 supply, especially given the technological changes which enable the supply of healthcare services through these modes of supply. For the MSs that have no GATS commitments, their existing regimes as shown in sections 6 and 7.4 of this report suggest an open market with no trade barriers; but also the demand for additional healthcare services seems to make a case for commitments under the SADC second round of negotiations.

7.5 Issues for negotiations

Key respondents from MSs' trade and labour ministries reported some major challenges for trade in health services. The establishment of healthcare facilities by foreign entities was subject to existing business and investment regulations in each MS including a miriad of regulations such as:

- In Mauritius establishment of such business is guided by the requirements of the Economic Development Board.
- In Botswana establishment is subject to the Citizens Empowerment Act where the majority shareholder should be a citizen.
- In Seychelles, applications for establishment are processed through the Seychelles Investment Bureau.
- The South African National Health Act provides that a Certificate of Need must be obtained before the establishment, construction, modification or acquisition of a private health establishment in the country.

While regulation was required to enable MSs to exercise due diligence on permit and licence applications, application processing times were sometimes unduly lengthy. However, the regulatory bodies seemed to exercise such regulatory controls without regard for the impact on trade in health services, which was often seen to relate more to medical tourism.

Some MSs cautioned that trade liberalisation may lead to unregulated markets and have a negative influence on health services. This mirrors the SADC Health Sector Policy Framework Document 2000⁴⁷ which provides for the need to engage with appropriate national representatives and international organisations to ensure that trade liberalisation does not affect the health services in the region. Also, it highlights the need to advocate and develop mechanisms to minimise the negative impact of unregulated market approaches in the health sector.

However, it is important to recall that unregulated markets are unlikely to result from trade in health services liberalisation given the fact the SADC PTIS (a) excludes "services supplied in the exercise of governmental authority" from the scope of the PTIS; and (b) enshrines the right to regulate their services sectors as long as regulations are administered in an impartial and objective manner and not as a disguised barrier to trade. In addition, as the study argues in section 3.3, there are some positive relationship between the public and private sectors in terms of collaboration and capacity support, and hence the need to establish an effective private-public mix strategy taking into account movement of both domestic and foreign professionals.

7.6 Conclusion

There is some scope for expansion trade in services in all the four modes of supply in the sector. It Is interesting that despite HRH shortages and the limited statistics on cross-border trade in health services, there is evidence of intra-regional movement of professionals and inflow of private investment in the sector. However, it is noted movement of foreign professionals is largely through government support schemes. Patient outward movement to other MSs for treatment (mode of supply Mode 2) mostly caters for diseases that cannot be treated within existing domestic health care packages. Most MSs have liberal regimes allowing inbound foreign practice and private investment (both for profit and not-for-profit). Existing GATS commitments are largely consistent to the governing regimes of the respective MSs. There are no common barriers to trade in services, except where foreign ownership under Mode 3 is limited or subject to joint venture requirements. This presents enough room for "GATS Plus" commitments by all SADC MSs, which would largely



lock-in the existing liberal regimes. Otherwise, it appears that the challenges limiting effective market access for health professionals in the regions are mostly related to recognition of foreign qualifications and streamlining or simplification of admission processes.

8 ACCESS TO SPECIALISED PERSONNEL AND SERVICES FOR THE PHARMACEUTICAL INDUSTRY

8.1 Overview of the SADC Pharmaceutical Manufacturing Sector

The pharmaceutical manufacturing sector varies significantly between SADC MSs. South Africa has a relatively well-developed industry while other MSs have an emerging sector with companies at different stages of development or no local pharmaceutical manufacturing at all. South Africa produces a wide range of products, while the majority of manufacturers in other MSs mainly produce simple oral liquid and solid dosage formulations. The pharmaceutical market in SADC is estimated at over \$6 billion with more than 50% of this being in South Africa.¹⁸ The region predominantly relies on imports, with local production accounting for only 15% of antiretrovirals (ARVs) and 24% of other generic drugs. In 2019, the region imported a total of \$5 billion of pharmaceuticals, of which South Africa's share was \$2.4 billion while total exports stood at \$485 million, of which South Africa accounted for \$434 million¹⁹. Several MSs import medicines from within the SADC region, the majority from South Africa.

In addition, the region imports most of the production inputs including active pharmaceutical ingredients (APIs), equipment and machinery, excipients and pharmaceutical grade primary packaging materials²⁰. The pharmaceutical companies in the region can be categorised into four distinct groups:

- 1. Subsidiaries of large transnational companies such as Pfizer and GSK which manufacture branded products for regional markets;
- 2. Global generic manufacturers such as Cipla, Ranbaxy and Sandoz with global value chains which they use to channel raw materials and infrastructure to compete at the local and regional scale;
- 3. Manufacturers of generics with predominantly national operations such as Varichem and Adcock in Zimbabwe and South Africa respectively. They are dominant players in their home markets and are beginning to export into the region;
- 4. Small-scale local manufacturers with modest portfolios and struggle to meet GMP standards serving only local markets.

The mismatch between the Essential Medicines List (EML) and actual product portfolios supplied by local manufacturers represents a significant potential market for locally manufactured products. The SADC region remains the area most affected by the HIV epidemic. Based on the UNAIDS 2019 Global Report data, 44.7% of the total number of people living with HIV worldwide in 2018 were from the Southern Africa region, while the three highest HIV prevalence rates in the world are in SADC countries, with 67% of adults with HIV in the region on ARV treatment. Therefore, a major market segment relates to ARVs. However, the ARV market is controlled by international donors and NGOs, where 84% of expenditures for ARV therapy come from international sources. To date,

¹⁸ Author projections from 2017 market data

¹⁹ ITC calculations based on UN COMTRADE and ITC statistics

²⁰ Draft SADC Pharma Prefeasibility Study, February, 2021



only a few SADC companies have supplied international donor markets but several manufacturers in South Africa supply ARVs to the national government-funded market ²¹

A feasibility study on local manufacturing undertaken in 2015 indicated that most companies were willing to upgrade and modernise their production capacities on condition of improved access to the regional market and support to their investments. They all suggested that governments and SADC should work towards coherent policies in areas such as tariffs on APIs and supporting materials, but no tariffs on finished dosages forms; domestic preference rather than regional preference; improved enabling environment, and provide incentives or specific support. In South Africa, the manufacturer can supply the regional market with national Medicines Control Council (MCC) registration and do not see much benefit in upgrading to WHO prequalification due to higher costs and cannot compete with Indian prequalified manufacturers in other SADC markets²².

8.2 Availability of appropriate skills

Pharmaceutical manufacturing skills requirements range from biological, physical, life and to engineering sciences. Generally, the core technical personnel in a pharmaceutical manufacturing company require chemistry, biological sciences, pharmacy and engineering background but business development and sales skills are critical. Skill set requirements varies across the various functions in pharmaceutical production. Broadly, the key skill sets for each process are outlined in Table 8 below;

	Process	Skills set	
i)	Research and Development	 a) Chemists (medicinal, synthetic, analytical and organic) b) Biologists (microbiologists, molecular biologists) c) Pharmaceutical Sciences (Pharmacology, pharmaceutics, pharmacognosy & pharmaceutical chemistry. 	
ii)	Manufacturing/GMP	Plant engineers (chemical, process, mechanical and artisans)	
iii)	Regulatory	Production and regulatory pharmacists	
iv)	Quality Assurance	QC personnel – pharmacists, chemists and microbiologists	
v)	Data management	Data managers and IT personnel	

 Table 9:
 Mapping of skill sets for specific processes in pharmaceutical manufacturing

In analysing the availability of specialised pharmaceutical skills in SADC, it is, therefore, necessary to examine whether institutions of higher learning are offering training or producing graduates in biological sciences, physical sciences, life sciences, engineering and business. In addition, the study assesses whether graduates are appropriately trained to match industry needs. The findings are informed by interviews with representatives of industry, policymakers and higher education institutions and existing sector reports.

8.2.1 Training institutions

The institutions of higher learning across the region provide basic training in biological sciences, physical sciences, life sciences and engineering. According to the study responses by industry stakeholders, these trainings are not necessarily aligned to the needs of the pharmaceutical industry. Fresh graduates recruited by the industry have to undergo rigorous on the job training

²¹ Feasibility study on regional manufacturing of medicines and health commodities, 2015

²² Feasibility study on Regional Manufacturing of Medicines and Health Commodities, 2015



before they can competently assume their prospective roles in the manufacturing process. The CEO of Plus Five Pharmaceuticals, Zimbabwe, indicated that it takes between two to five years to train graduate employees. Pharmacy schools normally produce graduates that are better prepared to work in retail and community pharmacies. The industry representatives stated that pharmacy and engineering graduates tend not to be fully conversant with the Good Manufacturing Practice (GMP) requirements such as qualification, validation and documentation.

The CEO of Chemical Process Technologies, South Africa, indicated that chemistry graduates from the local universities are not conversant with API manufacturing and lack practical skills in chemical synthesis; similar sentiments were shared by Stride Pharma, Mozambique and Aspen Pharma, Tanzania. Overall, the industry in the region is nascent and small, therefore students and training institutions do not see a significant demand for pharmaceutical personnel. Further, the regulatory authorities indicate that graduates from local universities would require further on the job training to be fully conversant with their roles. These findings are in line with a report by the Department of Trade and Industry, South Africa, which indicated that university graduates are inadequately equipped to work in industry, and the existing science, engineering and technology, and pharmaceutical curricula do not adequately respond to industry needs.²³ The Pharmaceutical Manufacturing Plan for Africa (PMPA) also cited this problem as being continent-wide and a likely barrier to the development of the pharmaceutical industry if not urgently addressed.²⁴

Only a few higher learning institutions have made efforts to offer training courses tailored to the needs of the industry. These are in South Africa and Tanzania, with the former being driven by an existing demand owing to the relatively well-developed industry in the country. A look at the International Pharmaceutical Federation (FIP) database on schools of pharmacy²⁵ and a list compiled by the South Africa Generic Manufacturers' Association (SAGMA) report²⁶ indicates the following key Higher Education Institutions (HEIs) offering industry-relevant basic training in the region and summarised in Table 9 below.

Co	untry	University	Description of Courses
1.	Angola	 i. Jean Piajet University ii. Jean Piajet de Benguela Higher Polytechnic Institute iii. Atlântida Higher Polytechnic Institute iv. Agostinho Neto University v. University of Angola vi. Malanje Higher Polytechnic Institute vii. Ekuki II Humanities and Technology Higher Polytechnic Institute 	Pharmacy, Engineering and Chemistry
2.	Botswana	University of Botswana	Chemistry, Pharmacy and Engineering
3.	DRC	i. University of Kinshasaii. University of Lubumbashi	Pharmaceutical sciences, Chemistry and Engineering
4.	Lesotho	National University of Lesotho	Chemistry, Pharmacy
5.	Madagascar	i. Ecole de Med. Et de Pharmacieii. Université d'Antananarivo	Pharmacy, Chemistry, Masters in Pharmacology, Physical Chemistry and Natural Products Chemistry
6.	Malawi	i. University of Malawi ii. Mzuzu University	Chemistry, pharmaceutical sciences
7.	Mauritius	University of Mauritius	Chemistry, pharmaceutical sciences

Table 10	List of calcoted UEIs Institutions in SADC offering relevant training for the phormacoutical industry
Table IV.	LIST OF SELECTED LETS HISTITUTIONS IN SADE OHENNU LETEVANT RAMINU TOT THE DUALINGCENTICAL INDUSTRY

²³ Department of Trade and Industry (DTI). Human Capital Outlook Implications for Skills Development in the Pharmaceutical Sector: The Adequacy of Higher Education and Training Provision for API and Biotechnology Manufacturing Skills Requirements.

²⁴ AUC – UNIDO. Pharmaceutical Manufacturing Plan for Africa. Addis Ababa. November 2012

²⁵ Available on https://www.fip.org/world-list-of-pharmacy-schools

²⁶ Analysis of Training Needs in the Generic Medicines Sector in the South African Development Community, SAGMA, 2014



Country	University	Description of Courses		
8. Mozambique	 i. Instituto Superior de Ciencias e Tecnologia de Mocambiqu ii. Universidade Lurio iii. Universidade Eduardo iv. Mondlane v. Universidade Pedagogica 	Chemistry, pharmaceutical sciences		
9. Namibia	University of Namibia	Chemistry, Pharmacy		
10. South Africa	 i. Nelson Mandela Metropolitan University ii. North-West University iii. Rhodes University iv. Tshwane University of Technology v. University of KwaZulu-Natal vi. University of Limpopo Turfloop Campus vii. University of Limpopo (Medunsa Campus) viii. University of Pretoria ix. University of the Western Cape x. University of Witwatersrand xi. Stellenbosch University 	 a. Pharmacy, Masters and PHD in pharmaceutics, pharmaceutical chemistry b. Masters in Regulatory Sciences c. Engineering – Bachelors, masters and PHD d. Industrial Engineering e. Chemistry – Bachelors, Masters and PHD f. Short learning programmes for industry personnel g. Short courses on Clinical trials h. Short courses on Engineering Sciences 		
11. Tanzania	 i. Muhimbili University of Health and Allied Sciences ii. St. John's University of Tanzania iii. Weill Bugando University College of Health Sciences iv. University of Dar es Salaam 	 a. Pharmacy, Masters in Industrial Pharmacy, QC/QA, Pharmacognosy, Medicinal Chemistry, Biotechnology and Regulatory Sciences b. Chemistry – Bachelors and postgraduate c. Engineering – Bachelors and Postgraduate d. Short courses tailored to the needs of the industry 		
12. Zambia	i. University of Zambia ii. Texila American University	Pharmacy, Chemistry and Engineering		
13. Zimbabwe	 i. University of Zimbabwe ii. Harare Institute of iii. Technology (Zimbabwe) iv. National University of v. Science and Technology vi. Medicines Control vii. Authority of Zimbabwe 	 a. Pharmacy, Pharmaceutical Technology, Chemistry and Engineering b. MCAZ's laboratory is used to offer training/short courses for the pharmaceutical industry on topics including analysis and quality control of samples 		

Source: FIP world list of pharmacy schools (April 2021) and SAGMA study report (2015)

The list above indicate that most of the MSs have some HEIs that offer basic courses relevant to the industry such as Pharmacy, Chemistry and Engineering. However, South Africa offers more diverse industry-relevant courses than the other MS and this has been driven by an existing demand for specialised pharmaceutical personnel in the country.

A SADC health workforce stock and densities for 2018 indicates a total of 30,550 pharmacists, technicians and associates, out of which 16,195 were to be found in South Africa (more than 50%)²⁷. Only six countries in the region had more than 1,000 of these personnel, namely Angola, the DRC, Mozambique, South Africa, Tanzania and Zambia. The report did not indicate the number of pharmacists or technicians engaged by the pharmaceutical manufacturing sector.

 $^{^{\}rm 27}$ SADC Health Worjforce Strategic Plan : 2020 -2030



8.2.2 Case study 1 - Tanzania

Kilimanjaro School of Pharmacy (KSP) and Pharmaceutical R & D Laboratory, the Muhimbili University of Health and Allied Sciences (MUHAS), Tanzania

The Kilimanjaro School of Pharmacy (KSP), offered an advanced training programme in an industrial pharmacy under its Industrial Pharmacy Teaching Unit (IPTU) in collaboration with Purdue University and Howard University, the USA between 2014 and 2019. The Industrial Pharmacy Advanced Training Program (IPAT) consisted of four courses; Drug Development, Drug Manufacturing, Regulatory Affairs, and Quality Compliance. Each course had 45 contact hours as well as associated homework assignments and examinations. The course included practical assignments to be carried out at the student's workplace. A total of 108 participants from seven African countries; DRC, Ghana, Kenya, Lesotho, Nigeria, Tanzania and Uganda completed the programme. The IPTU has a fully equipped pilot production facility for training students that was constructed with the support of GIZ through an \$ 800,000 grant. The students were drawn from both public and private sectors (regulators, manufacturers and lecturers) with the former receiving full scholarships from the UN Industrial Development Organisation (UNIDO) and private sector participants receiving partial support. In addition, the school offers diploma level training on pharmaceutical sciences and its pilot production plant is available to students from other institutions in the country for practical sessions. The Director indicated KSP's openingness to collaborate with the industry from SADC and other partners to provide relevant short course training.

The Pharmaceutical Research and Development (R&D) Laboratory at MUHAS in Tanzania has bench-top equipment for formulation development and offers short courses in qualification and validation in Pharmaceutical Manufacturing, Pharmaceutical Analysis (method development and validation), Pharmaceutics (fluid bed drying, granulating and coating, granulation and tabletting), Quality Assurance and Quality Control. The laboratory was established in 2009 with the support of GIZ and technical assistance from ActionMedeor. The short-course programmes cover several aspects of pharmaceutical production, from drug discovery to quality assurance and regulatory affairs. They also occasionally run short courses in specialized areas; one example of this was a three-day course in tablet coating run by the pharmaceutical company, BASF. Apart from offering training, the laboratory is also used for generic formulation development.

According to the Head of the laboratory, they have previously collaborated with KSP on the development of ARV formulations as a technology transfer initiative to the industry. The unit is currently collaborating with Physikalisch-Technische Bundesanstalt (PTB) on proficiency testing (PT) schemes and currently organizing round 10 of the PT schemes. Since the launch of the programme, they have seen improvement in personnel competence from 57% to over 90% reporting acceptable results. The trainees are from public and private sector pharmaceutical laboratories with the majority from the industry. He also indicated that they are involved in analytical testing services, for the PEPFAR programme and as well as collaborating with USP PQM plus on a landscape analysis for manufacturers within Africa.

Further, he indicated that even though they offer a Masters in industrial pharmacy, the graduates are not absorbed in the industry but rather by regulatory agencies and training institutions. The industry is instead looking for hands-on skills in formulation, documentation, tabletting, stability testing and quality management systems (QMS). The laboratory has also collaborated with IPAT and TMDA under the umbrella of NEPAD Centre of Excellence to offer short courses in medicines assessment and Bioequivalence studies. The combination of facilitators from the industry, regulators and academia proved to be very beneficial to the trainees.

8.2.3 Case study 2 - South Africa

The Tshwane University of Technology and North-West University, South Africa

Tshwane University of Technology (TUT) in Pretoria, South Africa has a Department of Pharmaceutical Science which trains pharmacists through a joint programme with the University of Limpopo MEDUNSA Campus. In addition, they offer B. Tech. (Pharmaceutical Science) the programme which is available at the postgraduate level and is aimed at entrants into the industry. The programme runs for the whole year with Saturday lessons. It consists of six modules covering clinical trial management, Good Clinical Practice (GCP), Good Manufacturing Practice (cGMP),



biopharmaceutics, registration of medicines and formulation. The programme is popular with persons already employed in the pharmaceutical industry, particularly clinical research associates and medicine registration personnel. TUT has a well-equipped laboratory with tabletting, dissolution and other pharmaceutical production apparatuses as well as a sterile manufacturing facility for undergraduate teaching. The North-West University, Short learning programmes (SLP) is aimed at persons with industry experience (B. Pharm. degree is a requirement). The SLP courses include Tablet and Capsule Manufacturing and Quality Assurance in the Pharmaceutical Manufacturing Industry. Duration varies from 3 months to 1 year. The short courses are given as distance learning and consist mostly of module work. The primary method of course delivery and communication is online through the university's educational platform, eFundi.

8.2.4 On-the-job trainings

Owing to the mismatch of the HEI graduates with the industry requirements, local manufacturers have resorted to developing in-house training programmes. Some companies indicated that they are collaborating with local universities to train their personnel and by providing internship opportunities. Chemo Processing Technologies, South Africa, for example, is collaborating with a local university and an American technology company. According to the company, this has helped to quickly build capacity on chemical synthesis and API manufacturing. Shelys Aspen, Tanzania, apart from conducting in-house training has also benefited from short courses offered by the School of Pharmacy at MUHAS to the industry. However, the disadvantage cited by local companies in their collaboration with local universities is that the short courses are offered randomly and therefore they are unable to adopt them fully as part of their capacity-building strategies.

The following specialised skills were identified by the industry as most in need; GMP & QA specialists, formulation experts and common technical document (CTD) experts. Further, a survey conducted to identify training and research needs for pharmaceutical training show that industry-related training in SADC is largely focused on regulatory affairs and quality matters, neglecting other operational issues such as formulation development, plant engineering and supply chain management. The findings of the assessment confirmed major gaps in the capacity of pharmaceutical managers and regulators to carry out their regulatory tasks, research/research oversight and management in the SADC region. They provide a potential starting point, however, in strengthening regional pharmaceutical training and research programmes²⁸.

The local industry and regulators also indicated that development partners have played a significant role in providing on-job training. The GIZ and UNIDO pharmaceutical sector programmes were mentioned as having provided training on various aspects of GMP to the local manufacturers. The UNIDO project supported SAGMA in 2015 to conduct a training needs assessment for the industry and the report was able to map out the gaps and providers of relevant courses. The national regulatory agencies through the ZAZIBONA initiative indicated that WHO and other partners including the African Union New Partnership fof Africa's Development (NEPAD) were able to run series of training on regulatory affairs on areas of product evaluation, audits and inspections.

The local industry and regulatory authorities struggle to retain highly trained and experienced personnel. Shelys Aspen, Tanzania reported personnel attrition despite their best efforts to provide competitive packages and other incentives. They lose personnel to the national regulatory authority and competitor companies. The national regulators on the other hand lose their personnel to international agencies such as the WHO. Tanzania and Zimbabwe were in particular given as examples where the national regulators have seen their staff being recruited by the WHO. The staff move due to better pay and benefits.

²⁸ Prof Henry Fomundam. Identifying Training and Research Needs and Facilitating the Selection of Centres of Excellence and Centres of Specialisation in Pharmaceutical Training. SADC, August 2015



Box 3: ZAZIBONA Initiative

The ZAZIBONA is a regional collaborative Initiative on assessment and inspections for medicines registrations with objectives to; reduce workload; reduce timelines to registrations; develop mutual trust and confidence in regulatory collaboration and a platform for training. The four founding countries are ZAmbia, ZImbabwe, BOtswana and ZAmbia and the first assessment session was held in October 2013 at Windhoek, Namibia. The initiative was endorsed by SADC Ministers of Health & Ministers Responsible for HIV & AIDS in January 2015 with 16 SADC member states now involved in various capacities. There are nine active members (Botswana, DRC, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia, Zimbabwe), five non-active (Angola, Eswatini, Seychelles, Madagascar) and two with observer status (Lesotho, Mauritius).

The initiative has been a good platform for building capacity with up to 40 assessors having been trained. The countries with relatively weak regulatory capacity have been able to benefit from the assessment work done by the more well-developed regulatory authorities in the region. Interviews with the industry indicated that the initiative has been useful but it needs to be scaled up and needs to be more responsive to the local manufacturer needs. The representatives of the national regulatory authorities though acknowledging the importance of ZAZIBONA indicated the need for a full endorsement and support by the SADC secretariat. The key successes of ZAZIBONA include; 32 joint assessment sessions; 44 manufacturing sites jointly inspected by the NMRas; 22 manufacturing sites approved through desk review; and 9 NMRAs participating in at least one regional joint inspection. Number of products registered at country level; Botswana (80), Malawi (2), Mozambique (1), Namibia (83), South Africa (8), Zambia (80) and Zimbabwe (74).

Source: Sakhile Dube-Mwedzi, ZAZIBONA Coordinator

8.3 Movement of pharmaceutical personnel and services in the region

The study also assessed the movement of pharmaceutical personnel in the SADC region. A particular effort was made to determine the main source countries and if indeed there was movement from one SADC country to the other. Interviews with representatives of the pharmaceutical industry provided the following key highlights:

- Local companies prefer to source specialised pharmaceutical experts from India. According to one manufacturer, Indian professionals are better skilled and experienced than from other sources. In addition, compared to South Africa they will demand low salaries by up to 40 %, an example was given that the Indian professional would be paid \$ 3,000 while a South African would be paid \$ 5,000.
- The high salaries demanded by foreign professionals discourage most companies from engaging them even in circumstances when local talent is unavailable. This ultimately tends to impact the company's overall performance and compliance with GMP requirements.
- None of the companies interviewed indicated having sourced from any of the SADC countries. One manufacturer mentioned that they do not have a full understanding or procedure for sourcing personnel from the other SADC countries.
- The companies indicated that they are required to justify the recruitment of a foreign professional to the Ministry of Labour/Immigration services before being granted the relevant work permits. For some countries like Mozambique, the recruitment is subject to a quota system of one foreigner for every 14 locals. This tends to limit companies on the number of foreigners which they can hire.
- Service and preventative maintenance engineers were not available in the country in most of the SADC countries. Instead, the manufacturers had equipment supplier agreements that included servicing and repair as necessary. Most companies, source equipment from India and the service engineers predominantly come from India. They indicated that the service engineers based in South Africa tend to support equipment providers from Europe and they will tend to charge higher fees.

Discussions with regulatory agencies and the Department of Pharmaceutical Services at the Ministries of Health from the MSs indicated employing nationals from other SADC countries. For example, the BOMRA in Botswana confirmed having engaged Zimbabwean nationals. Lesotho indicated their pharmacists are employed in Namibia and Botswana, especially when the two countries were yet to establish their schools of pharmacy. The two countries are now producing pharmacy graduates and the Lesotho nationals are not getting their work permits renewed. The



country has also a unique memorandum of understanding (MoU) with South Africa, where the latter has made an obligation not to engage Lesotho pharmacists to prevent brain drain. The Lesotho pharmacists' association raised this as being discriminatory to their members who are seeking better terms outside the country. A WHO baseline assessment (2010) in SADC put the median total number of pharmaceutical personnel (defined as pharmacists, pharmaceutical assistants, pharmaceutical technicians and related occupations) in the MSs at 0.7 (range 0.3 to 7) per 10,000 inhabitants. Although there is no internationally recommended ratio for pharmaceutical human resources, these figures suggest that there are serious shortages of qualified personnel in several SADC countries²⁹.

8.4 Conclusion

Across the region, there are HEIs that offer foundational courses in chemistry, engineering and pharmacy. However, the graduates from these institutions are not adequately prepared to take up their roles in the pharmaceutical industry. As a result, fresh graduates have to undergo on the job training for between two to five years to deliver optimally. The National Medicines Regulatory Authorities recruit fresh graduates and provide on-job training to address the skills gaps. The North West and TUT universities in South Africa have adjusted their programmes to address the industry needs. They offer short courses and have set up pilot production plants for practical training. The KSP and MUHAS R &D laboratory in Tanzania, with the support of partners, were able to offer industry-relevant training addressing key topical issues on GMP and Quality Assurance. The pharmaceutical industry in the region is still nascent and the students and the training institutions do not see obvious career prospects. In South Africa, however, the relatively well-developed local manufacturing industry has created a demand for relevant training.

Pharmaceutical companies in the region source foreign experts mainly from India and there doesn't seem to be recruitment from the other SADC countries. This is because experts from India are better skilled and cheaper compared to sourcing from South Africa, for example. In general, local companies prefer to develop local talent rather than hiring expatriates as they are much more expensive. Some regulatory authorities such as BOMRA have recruited personnel from other SADC countries with Zimbabwe being given as an example. Pharmacists from Lesotho have been recruited in Botswana and Namibia but as the local capacity in these countries grows, nationals from the former are not having their work permits renewed. In conclusion, while a shortage of pharmacists and other technical staff with pharmaceutical skills is often mentioned as a key challenge in sub-Saharan African countries, respondents in the SADC MSs stated that there are sufficient human resources to run at least one GMP compliant manufacturing plant per country or play a significant role in the process of establishing a GMP compliant plant.

²⁹ WHO Baseline assessment of the Pharmaceutical situation in Southern African Development Community Countries Fact Book 2009 (WHO/EMP/MPC/2010.3). 2010



9 RECOMMENDATIONS

The study used a health systems approach to analysing the environment and market for foreign health services and professionals across the SADC region. Also, it specifically looked at the impact of COVID-19 pandemic on the MSs abilities to respond and continue to provide routine health services. The study analyses the challenges and opportunities relating to the availability of the essential workforce for the pharmaceutical manufacturing industry within the larger health sector. It explores the issues inherent in the MSs' health systems related to policy, planning, implementation, healthcare financing and HRH for provision of health services.

Generally, HRH shortages are one of the biggest challenges that threaten the type and quality as well as the efficiency and effectiveness of healthcare services in the MSs. The role of the SADC Secretariat has also been reviewed with respect to these challenges. Additionally, the study critically appraised the private health sector, the various challenges it poses and opportunities it carries.

The recommendations presented hereunder follow the analytical framework structure referred to above and are aimed at enabling national and regional health systems in their ability to respond to ongoing health needs and emergencies including and similar to COVID-19 and to facilitate trade liberalisation within the health services and pharmaceutical areas.

9.1 Health systems

9.1.1 Develop resilient health systems

The study identified the need for resilient health systems across the SADC region. There is a clear need for urgently developing strategies and ramping up the process for developing resilient health systems and communities in the region. The concept of resilience is not new but, against the background of the present COVID-19 pandemic, resilience needs to be viewed as a priority and as an urgent reform agenda. It must be remembered that resilient (health) systems are strong health systems. Therefore, aspiring to build resilience in health systems is in itself an agenda for health systems strengthening.

It is therefore recommended that the SADC Secretariat initiates a process of developing a regional strategy for health systems strengthening for resilience and the MSs to engage in this process in a coordinated manner. Individual and more specific responses need to be developed by the MSs for achieving this target in the shape of health sector reform agendas to be achieved in the next four to five years. It is recommended that the SADC health sector provides the leadership as well as technical resources to initiate and coordinate this process.

It is recommended that sufficient time (e.g. a period of six months), human and financial resources be dedicated to the development of *SADC regional strategy for health systems strengthening for resilience* and health sector reform agendas for MSs within the framework of this strategy. MSs need to make sincere efforts to contribute to the development of this regional strategy and then use it as a framework for developing their own country-specific health sector reform agendas. It is ambitious but is a necessity and time should be used wisely to take these steps as urgently as possible as the need has been identified and the time is right.

There would be need for the use of formal approaches³⁰ to analyse and develop strategies to build *adaptive resilience* across national and sub-national health systems in the SADC MSs, grounded in the health system strengthening agendas. The agendas should be designed to ensure:

³⁰ Formal approaches would mean purposively analysing the situation with a view to identify systemic weaknesses and aiming to strengthen systems for resilience. It means using the lens of resilience to review and plan and remaining contextually relevant and appropriate.



- Approaches are context specific to the MSs;
- Health systems become risk-aware;
- Health systems' capacity is enhanced to address a broad range of health challenges by strengthening governance functions at both national and decentralised levels and targeting enhanced coverage of poor with adequate scope of quality health services that do not require catastrophic and impoverishing expenses;
- Core health services provision continues despite emergencies. Enabling health systems to be able to contain and isolate health threats while delivering core health services and avoiding propagating instability throughout the system;
- Functioning coordination is established among diverse actors, ideas, and groups to formulate solutions and initiate action;
- The systems become adaptive i.e., develops the ability to transform in ways that improve function in the face of highly adverse conditions and the system is able to *build back better*,
- There is clear interconnectedness among the MSs' agendas to ensure regionality of approach and support can and should be provided through regional platforms of SADC.

It is recommended that the Secretariat should consider initiating a study on developing resilient health systems in the region.

9.1.1.1 Adaptive Resilience

Switching between development and humanitarian modes is disruptive, inefficient and wasteful for health and social gains. A hybrid model allowing for adaptive resilience needs to be developed as depicted in Figure 13.



Figure 13: Proposed Adaptive-Resilient healthcare model

Unless there is a major/complete physical destruction, for example, in severe calamities in which case the provision of emergency services may not be possible, the system continues to provide the least essential health services while, at the same time, has the ability to provide emergency services to address the crisis. As shown in Figure 13, an adaptive-resilient system is able to predict and respond to emergencies and adapting a reduced set of priority (essential) healthcare services at the same time. These essential services are continuously provided unless there is complete physical obstruction to the health workforce and/or infrastructure due to the severity of calamity.

9.1.2 Develop local solutions to HRH shortages at the primary level

The analysis in section 3 indicates that the largest HRH shortages exist at the level of primary healthcare in the MSs. These shortages negatively affect the provision of essential healthcare to the wider population and especially the poor. Hence, there is a need for MSs to develop local solutions to address these primary level HRH gaps as they cannot be filled by foreign health professionals. Several approaches can be considered with the selection of the more appropriate and feasible for the MSs, for example:



- Engaging with private (both for-profit and not-for-profit) to source out the provision of essential healthcare at the primary level. Several MSs already have service level agreements and MoUs in place with faith-based networks. Similar arrangements can be sought by other MSs and/or expanded in MSs already using these approaches.
- Exploring entrepreneurial approaches, which may include privatisation of service provision and therefore shifting the burden of HRH maintenance to the entrepreneur. Policy shifts will be needed to allow levying of controlled user charges and selling of commodities and allowable medicines by the primary healthcare worker.
- Considering task-shifting and multi-skilled workers. A thorough review would help to identify
 underutilised cadres to allow task shifting and cadre mergers. This will allow a smaller number
 of staff to provide services to a larger range of the population. However, there will be a need
 for investing more resources in the short term to compensate readjusted etc. This approach
 may, in the long term, be an answer to the HRH shortage and coverage at the primary
 healthcare level.
- Supporting implementation of SADC HWSP 2020-2030 through a participatory approach or mobilisation of resources to support the implementation activities and explore entrepreneurial approaches to innovative healthcare financing and HRH availability.
- Developing contextually relevant innovative approaches for engaging with the private sector and creating entrepreneurial innovative healthcare financing solutions that offer enhanced HRH at the primary healthcare level, sustainability and market growth through private sector development;

As referred to in section 2.6, Riggirozi⁴⁸ notes that UNASUR mediates relationships between relevant actors and stakeholders which enhances the probability of collaborative achievements within the agreed scope of work. On the same lines, the SADC Secretariat could explore the possibility of engaging with the private sector in the region and broker relationships between MSs' health sectors and private sector actors to enable access to non-state HRH and to produce improved health outcomes within the region.

9.1.3 Develop public-private mix strategy

MSs should analyse the current roles played by the public and private sectors in the national health systems and develop a strategy for an appropriate public-private mix. The strategy is key and will ensure that the strengths of both sectors can be consciously and strategically combined and managed to produce larger health benefits. A Public-Private Mix strategy would be useful to developing mechanisms for better regulation and facilitation of the private health sector as well as to enhance governments' leverage in investing resources in places where the private sector may not be able to step in. It will help MSs to adopt better mechanisms for coordination, pricing, reporting, role distribution, expectation management, taxation, support and performance assessment of the private sector.

There is no prescription for a perfect mix of public and private healthcare provision. Governments should adopt policies governing the development of standards and guidelines that cover the performance of the whole sector for both the education and practice of health professionals.

The Secretariat could develop an analytical framework that enables assessment of the roles of public and private (both local and foreign) sectors in healthcare provision needs and how to address the identified gaps by modifying their roles and scope of services. Such an analytical framework can be very useful in determining the right and contextually relevant public-private mix in MSs. Also, the framework should be sensitive to any perverse effects of private practice by government-employed health professionals in perpetuating and deepening poverty.


9.2 Foreign health professionals

9.2.1 Establish the need for foreign health professionals

Lack of analysis of HRH needs that can be met by foreign health professionals creates inconsistencies in the way MSs approach seeking and managing foreign health professionals. This gap is related to and affects strategic purchasing in healthcare. It was noticeable in relation to the COVID-19 pandemic as well as in "normal times".

MSs should therefore adopt a formal engagement in recognition, identification and analysis of HRH needs that can be addressed by sourcing foreign health professionals. This exercise will help cost the requirements, rationalise strategies to source foreign health professionals and build a deeper understanding of alternatives that may be more cost-effective and sustainable. The investments in sourcing foreign health professionals need to be based on decisions grounded in analysis and evidence.

It is also recommended that a regional database of health professionals be developed that includes information on various types and levels of health professionals in the MSs. The SADC Health Workforce Resource Pool, as proposed in the SADC HWSP 2020-2030, will benefit from developing a health professionals database. Such a database would be a very useful tool in analysing how much of the HRH need within the region can be met by local professionals *vs.*, foreign health professionals and can help strategise ways to fill the gap. The database will require extracting and importing data from various registers that the MSs maintain for example with the professional councils and will need both automated and deliberate data collection actions. However such registers will need to be updated for the database to be effective.

To remain relevant and effective a regional resource pool will need to take into consideration factors such as epidemiological transition, initiatives such as task shifting and job enrichment, innovative health financing, and addressing HRH shortages and the role of non-state actors as these can impact on the HRH need and therefore the utilisation of professionals registered in the resource pool.

9.2.2 Health planning to include foreign health professionals

It is recognised that the process of health planning undertaken by Ministries of Health is routinely done based on resources available and in reach within the country. From the interviews it was clear that most MSs' national health strategic plans do not necessarily show the needs and plan for recruitment of foreign health professionals. However, it was reported that, at the institutional level, MSs are sourcing health specialists from other countries e.g. India, Brazil, China, Cuba, etc.. This makes it more difficult to ascertain the unmet HRH need that could potentially be sourced within the region. It creates a missed opportunity to plan more comprehensively and at the same time does not allow for proper financial analysis of the health plans.

MSs should integrate foreign health professionals formally into national health planning and develop foreign HRH plans to chart out support and guidance pathways that will not only facilitate foreign health professionals to come and work in their countries but will also allow the government of recipient governments to manage their resources strategically by making the best and need-responsive use of foreign health providers. The planning process should include health systems specialists (health planners, managers, epidemiologists) in the plan for sourcing foreign health professionals, in addition to the core technical HRH categories that are service providers.



9.2.3 Formalise coordination among ministries

The analysis in section 6.3 suggests that there is limited cooperation and joint planning between the ministries that deal with the requirements that foreign health professionals have to meet as a pre-condition to be able to practise. A lack of proper coordination impacts on the effectiveness of MSs' policy approaches related to foreign health professionals.

It is recommended that formal annual consultations between ministries of health, trade and labour are held to review and establish mechanisms to respond to the need for foreign health professionals and to take steps to meet the need.

To establish the need for foreign health professionals it is recommended that, based on joint reviews, three-year rolling plans are developed as instruments of inter-ministerial engagement and action, so that the MSs have a strategic steer on the need, utilisation, facilitation and movement of foreign health professionals. The main areas to be covered in the proposed three-year rolling plans are:

- Steering the recruitment of foreign health professionals;
- Providing guidelines and relevant exemptions/waivers depending on the urgency;
- Detailed planning each year with one year added on a rolling strategic basis.

Formal inter-ministerial (trade, labour/immigration and health) coordination mechanisms would link facilitate the actual movement of health professionals as part of the implementation of the rolling plans. Initially, the concept of such coordination and rolling plan development could be initiated at a regional level following which MSs could contextualise and embed in their systems, breaking down the silos.

9.2.4 Enhance attractiveness

With the difficult environments in most SADC MSs, it is important to explore what benefits SADC can offer for health professionals to choose SADC MSs preferentially as work destinations rather than aspire to go to western countries.

While it is recognised that due to lack of resources SADC MSs may not be able to match compensations given by richer countries, SADC can consider adopting approaches that can enhance the attractiveness factor for health professionals such as:

- Personal development and professional growth opportunities, for example by creating and linking professionals with regional bodies and communities of practice that can help people grow in their relative fields and contribute to the enrichment of other professionals;
- Rotation for experience in various countries. Developing programmes that can rotate professionals to obtain experience in various environments and countries can enhance their exposure and seniority. Such opportunities can be attractive to some who are driven by professional experience and excellence.
- Offering professionals to engage in research and learning. SADC could consider initiating region-level health research and engage health professionals to play a role in the research. Recognition, learning and becoming associated with research can be positive factors for many.
- Conferring certifications or awards based on professional achievements. This will require developing regional programmes that can enrol and track professionals in various forms of interventions and professional accomplishment for recognition at a regional level.

9.2.5 Reduce barriers and attract foreign investment

In addition to adopting strategies to enhance attractiveness for foreign health professionals, it is equally important to address the barriers that deter foreign health services and professionals to work in SADC MSs. MSs are encouraged to undertake binding commitments under the PTIS negotiations, locking in the existing liberal market regimes as means to create legal certainty and protection of foreign (SADC citizen) investment or practice in their countries. While the interviews with Ministries of Health and the analysis of existing GATS commitments show enough room for



"GATS Plus" commitments, individual MSs should undertake institutional and regulatory reviews to identify any barriers that could be removed within the health sector or in the cross-cutting measures to enhance trade in health services.

The reviews should be accompanied by targeted actions to reduce the trade barriers, for example:

- Where applicable, amend laws to allow majority equity ownership by foreign entities, an incentive to see that their investments are safe and that they can exercise more control.
- As a matter of policy, visa and immigration processes should be streamlined so that foreign health professionals have to go through fewer hoops to be able to travel to another MS to work. MSs could develop an integrated one-stop-shop online portal that provides information on all possible requirements and processes for admission to allow health professionals to complete all requirements in one portal. Whereas the backend may be connected to various government departments, the user would not be required to liaise and work with a multitude of stakeholders. This simplification would ease the process of application and approvals and add to the comfort and peace of mind of foreign health professionals.
- Guidelines to facilitate cross-border movement of health professionals during the interviews, some MSs indicated the need for Regional Guidelines to facilitate orderly and managed movement of the health workforce in the region. Such Guidelines should build on the WHO Codes on International Recruitment of Health Workforce but also cater for emergency and non-emergency conditions. Also, they would be useful in ensuring effective market access where MSs undertake to liberalise Mode 4 trade in the health sector. Annex 3 sets out a first draft which could be used as a basis for such guidelines. They have been drafted with the COVID-19 pandemic in mind as exceptions to the rules that would apply in non-emergency situations, but could be developed to cover both.

9.2.6 Harmonise compensation across the region

Due to the differential in compensation packages offered by richer countries, there is always a pull factor for foreign health professionals to gravitate towards higher income opportunities. This tendency undermines countries that do not have adequate resources to compete and thus perpetuates need. MSs should consider if a regional harmonisation of compensation packages for health professionals adjusted by cost of living can be developed. This will ensure that there is not much difference between what foreign health professionals may earn in one SADC MS compared to another. Consequently, it will facilitate more equitable distribution of HRH across the region if such disparities are reduced and thus complement SADC HWSP 2020-2030 objectives.

9.2.7 Invest to improve health providers' management

In view of the identified issues related to foreign health professionals, it is recommended to the SADC health sector to invest in:

- Development of a regional database of available/eligible professionals and continually update it so that all MSs can have access to quality real-time information on available HRH in the region. This will help MSs in developing strategies for accessing foreign HRH and manage them better. The system can also offer to track foreign health providers in MSs.
- Streamlining regulatory mechanisms and mutual recognition of degrees as in the short term this set of issues remain as barriers to the movement of health professionals across the region.



9.3 Pharmaceutical industry

9.3.1 Support development of favourable framework for the pharmaceutical industry

The SADC pharmaceutical manufacturing industry is nascent with the region relying predominantly on imports. Local companies are disadvantaged against imports due to lack of policy coherence where tariffs are applied on inputs such as APIs and other materials but no tariffs on finished dosages forms. In addition, domestic preference is only accorded at national level and not regional, this does not allow companies to leverage on the regional market and economies of scale. There is need therefore to put in place measures at regional and national level that are supportive of the local industry. These include promoting policy coherence across trade, health and industry as well as implementing an industry incentive framework (fiscal and non-fiscal). These initiatives will allow the existing players to thrive and encourage new investments to the sector. SADC should develop a model package of pharmaceutical incentives to be adopted at regional and MS state level. Further, the COVID-19 pandemic has demonstrated the risk of overdependence on imports for essential medicines and other health technologies. Therefore, strengthening local pharmaceutical production will contribute to overall effort of building health systems resilience in the region.

9.3.2 Facilitate movement of pharmaceutical personnel in the region

The interviewed pharmaceutical industry stakeholders were not aware of any preferences given to SADC nationals in the context of free trade area agreements, i.e. SADC Protocol on Trade or the PTIS negotiations. They were also not conversant with the opportunities provided by the PTIS with regards to the movement of services and service providers. The SADC Secretariat and MSs should promote the movement of pharmaceutical personnel as part of the wider strategy to address skills gap shortages in the health sector, optimal use of human resources and grow the local pharmaceutical industry in the region. Pharmacists and other licensable pharmaceutical personnel should be prioritised among the list of professionals for consideration in PTIS negotiations. In addition, a mutual recognition mechanism should be established to ensure harmonised and effective recognition of pharmaceutical qualifications by MSs' professional/regulatory bodies.

9.3.3 Establish a regional database of pharmaceutical training institutions and personnel

It became apparent in the course of this study that the MSs and the region do not have an up to date and easily accessible database of all institutions offering industry-relevant training. In most MSs there is a record of registered pharmacists licensed to practise. However, a record of other pharmaceutical industry personnel such as analytical chemists, biochemists, microbiologists and pharmacologists among others is not available. The SADC Secretariat, in partnership with the MSs, should establish an up-to-date online database of institutions in the region offering industry-relevant training. This could include diploma, undergraduate and postgraduate degrees and short-term courses being offered. In addition, the database should contain an inventory of all pharmaceutical industry personnel in the region along with their expertise and years of experience. The database could provide a platform for linking job seekers, consultancies, employers and service providers across the region.

9.4 Other regional initiatives

9.4.1 A case for a framework on mutual recognition

Protracted or bureaucratic processes in recognition of qualifications, licensing and approvals from foreign health professionals may constitute barriers to the movement of health professionals across the region. In line with the objectives of establishing the MDRA (see section 6.2), it is suggested that SADC MSs support and accelerate proper functioning of the MDRA as regional platform for addressing issues of non-recognition of health qualifications obtained in one MS for the purpose of



practice in another MS. However, there will be need for the MRDA to work together with private and public sector stakeholders as well as Universities offering health academic qualifications to ensure the proper alignment and regional-wide recognition of educational and professional qualifications.

Such an institutional arrangement would facilitate a sectoral approach to issues related to mutual recognition of professional qualifications and could help streamline issues and barriers to the movement of health professionals across the SADC region. It is noted that the HWSP 2020-2030 provides for the mutual recognition of titles and health worker categories in the SADC region by 2027. Also, since the PTIS (Article 7) provides for the development of a negotiating mechanism for mutual recognition agreements in professional services, there will be need to ensure that the negotiations under the SPH and PTIS are coordinated to enhance and ensure that the framework addresses both the health sector and trade-related concerns in mutual recognition of professional health qualifications, obtained or achieved in one country for practice in another MS.

Such an approach could:

- Address HRH shortages in the MSs
- Standardise training across the region
- Reduce costs by not requiring travel and living in another country
- Extend teaching and training to the remote rural areas of MSs and can directly contribute to HRH development even at the primary healthcare level
- Improve training impact by enabling comfort of trainees in their environment
- Arrange for internships locally which can still be supervised remotely
- Enable movement across borders with a standard degree/certification not needing licensing
- Remove the need for exams and background academic verifications
- Conduct standard exams for those already working and reducing the time and effort required for each country to undertake background checks, establish equivalence etc for registration and issuing work permits

This could start with development of a concept for the establishment of such a regional health university or council/network and linking with universities in some development countries for example in Germany. Also, assistance could be extended to develop qualifying examinations for existing health professionals to enable them to achieve region-wide recognition using the examples of the US Medical Licensing Examination or the UK's Professional and Linguistic Assessments Board. The SADC Secretariat would logically be the host institution and custodian of the health university or council/network development.

9.4.2 Establish a regional accreditation mechanism for HEI offering health and pharmaceutical training

To address the existing mismatch between training offered by universities and the industry needs, it is necessary to strengthen linkages between the two. As suggested in SHSP 2020-2030, SADC should establish a platform for exchange between the industry, academia and other stakeholders which will among other interventions support a review of curriculum, design of short courses and sustainability of the same. The platform should promote the exchange of staff between the industry and academia.

The SADC Secretariat and MS should also establish a mechanism for assessing and accrediting as appropriate all institutions offering pharmaceutical industry-related training as well as training in the medical field. This will set the standards for training and recognition in the region. Such accredited institutions will offer training targeting participants from all SADC MSs and the potential trainees will have the comfort that the course is approved and recognised in the region.



9.5 Trade in services negotiations

9.5.1 Improve market access and national treatment commitments

Given the liberal regulatory regimes governing trade in health services across in the region, the negotiations on liberalisation commitments should seek to lock in existing levels of market opening and national treatment. The commitments should include a reduction of limitations on foreign capital participation to promote intra-regional trade and investment in health services. There would be need for trade and health ministries to engage in dialogue on a cross-border (Mode 1) framework that could allow multi-country (regional) professional practice in specialised health services as a possible means of address the HRH shortage.

In the area of social services, there would be scope for commitments on residential care or rehabilitation homes or rehabilitation facilities, for example, since this could be a growth area for the future.

9.5.2 Fast-track mutual recognition of qualifications

Also, there would be need to fast track the trade negotiations on mutual recognition of qualifications in order to facilitate effective market access for health professionals. It is important for MRA negotiations to be prioritised especially, with development of a framework that allows for sectoral MRA negotiations. This will complement the objective of the SHP and facilitate the implementation of the SADC HWSP 2020-2030, which *inter alia* indicates that by 2027 the SADC Secretariat should have developed strict compliance criteria for mutual and reciprocal recognition of health education and professional qualifications.



10 ANNEX 1: REVIEW QUESTIONS

MSs' Health Systems

- How is the national health system structured within your country?
- What healthcare services are being provided by the public health sector and the private health sector?
- What is the total health expenditure of the country? {Annual for last 5 years}
- What do you consider as the major gaps in the public healthcare system?
- What are the major constraints that the public health system faces in addressing the needs of the community?
- What is the role of private health sector in the country with respect to the scope of services and affordability of private healthcare?
- How do public and private health sectors cooperate? Main examples
- Is there adequate supply/production of healthcare professionals in the country with respect to need? What are the major health human resource gaps if any?
- How does planning, production, placement and management of Health Human Resources (HRH) take place in the country?
- Who are the main HRH producers and where does the HRH supply usually go?
- Is health insurance available in the country? Any details...?
- How are the poor provided healthcare? *Especially with reference to* access, scope, equity in healthcare.

COVID-19 related issues

- What has been the impact of COVID-19 on the country's population: morbidity, mortality and other associated factors?
- What have been the major issues faced by the country's health system and services due to COVID-19?
- Has there been a regional response at SADC level for COVID-19? What are the key features of this response?
- How has the country responded to the COVID-19 pandemic in terms of providing services?
- Did any foreign health provider extend support for COVID-19 response within the country? How?
- What lessons can be drawn from the regional response, if any, to the pandemic with regards to leveraging on movement of healthcare professionals and services?

Market segmentation

- What is the market for private healthcare in the country and what segments of community/users access private healthcare?
- Do people from this country travel to other MSs to obtain health and medical services?
- Has telemedicine played any role in the health systems and services in the country? Please explain

Pharmaceutical Industry related issues

- What are the major skills gaps that are faced by pharmaceutical manufacturers in the Country? For the identified skills gaps what are the major constraints encountered in filling the positions from within the country, regionally and from outside SADC?
- How has the skills shortage affected the competitiveness of the pharmaceutical manufacturing industry in the country? Has it been a major obstacle in greater product diversification and movement up the value chain?
- How accessible are support services such as equipment maintenance and repair, laboratory analysis in the Country?
- To what extent has the COVID-19 disrupted the supply chain in the regional pharmaceutical industry with regards to accessing inputs and movement of finished products?
- During the pandemic, has there been a spike/ increased demand for some life saving products? How has the local industry responded to the demand? Has the response been hampered by skills shortage or delay in accessing and licensing of foreign workers?

Benchmarking



 Are there any international best practices and examples with regards to facilitating movement of health professionals and services across borders that the country looks at as examples or lessons?

Regulation

- What are the regulations and regulatory frameworks in place related to foreign healthcare providers, professionals and services and their movement to and from the country?
- Which types of medical professions and degrees from other countries of the region are accepted, if any, in this country?
- Are there any qualifying requirements and/or exams and/or exemptions for foreign health professionals to allow them to work in the country?
- Are there any training or skill upgrading courses/requirements available in the country to enable foreign healthcare professionals wishing to work in your country?
- Are there any differences in regulation of national and foreign healthcare professionals and services in your country? Explain
- What are the existing institutional and regulatory structures that govern healthcare practice and service delivery in the region? Do these structures take into consideration the movement of health professionals and services within an integrating SADC?
- What are the key drivers and challenges on movement of health professionals and services across the borders of your country?
- Can you please provide information on how many foreign born/trained doctors/nurses/pharmaceutical experts are present in the country? (for instance, compare two years: 2010, 2020)

Environment

- What is the current policy regarding foreign health providers to operate and provide health services in your country? Main policy references and key features
- What are the views of health sector regulators in the country related to foreign health providers presence: present and potential? Issues, benefits, influence, economy, health needs, other factors
- Is there a difference in cost of health services provided by foreign health providers and comparable national healthcare providers in this country?
- What are the various types and levels of health services that foreign health providing entities including businesses, investors and providers are currently engaged in providing in your country including within all four modes?
- · What are the barriers to movement of health professionals across borders in SADC?

Strategic issues

- Are there any issues or problems that originate from the health services of foreign entities in your country?
 - How does trade in health services affect the quality of health services in your country?
- What is the aspired mix of local and foreign health providers for your country?
 - Thinking in terms of proportionality within major types and reasons why this should be so?
- Is there adequate capacity in the country's health sector to manage and regulate the aspired mix of local-foreign health provision?
- Are there any legal restrictions to reach this aspired mix?
- Are there any economic and/or other benefits or losses established or anticipated with foreign health providers in the country?
 - What are they and how are they estimated?
- What does trade liberalisation in health services mean in the context of your country's health sector?
- What is the position of national labour, health and trade ministries on provision of health services by foreign entities in your country? Opportunities, constraints, concerns, possibilities.
- What are the main legalistic constraints or grey areas impacting the ability of foreign entities to provide cross-border healthcare or establish practice in your country?
- How can these legalistic constraints be addressed?
- How does health sector accommodate and adjust to foreign health providers?



What are the advantages and disadvantages of HWF mobility: both sides - sourcing member • state and receiving member state?

List of relevant national policies, strategies & datasets sought from key informants

- No. of registered healthcare workers
 No. of healthcare facilities public & private
 No. of Training Institutions for healthcare workers
 No. of foreign health workers & service providers Pharmaceutical Industry personnel Industrial pharmacists, GMP specialists, Pharmacologists, Clinical Trial Specialists
- 5. Relevant national laws regulating health workers and services
- 6. National policies and strategies for development of HRH



11 ANNEX 2: DRAFT GUIDELINES FOR THE MOVEMENT OF HEALTH PROFESSIONALS IN A HEALTH EMERGENCY

1. Background

The COVID-19 pandemic has highlighted the shortages of human resources in the health systems of most SADC Member States to treat patients infected with COVID-19. Although the impact of the first wave of the pandemic was not as great as expected, Member States are now experiencing second and, in some cases, third waves of the pandemic with greater impact due to the higher transmissibility of new variants such as the Beta variant (B.1.351) (first identified in South Africa) present in most SADC Member States and the Delta variant (B.1.617.2) (first identified in India), of which the first cases have been identified in South Africa.

Given this understandable demand for additional human resources in Member States most affected by shortages, there is justification at the regional level for Member States to cooperate in facilitating the movement of health professionals between them during health emergencies. Measures such as visas, work permits and qualification requirements act as restraints on the movement of health professionals. In times of health emergencies, maintenance of such measures would be counterproductive to addressing the needs of Member States to facilitate movements quickly.

These guidelines have been developed to encourage Member States to co-operate in addressing human resource shortages by promoting temporary relaxation of normal procedures and requirements in order to fast-track the movement of health professionals that are desperately needed to assist Member States in coping with health emergencies such as the current pandemic. They should also apply not just from other SADC Member States but from other countries with an ability to supply at short notice.

While COVID-19 is a challenge on human resources for health, any temporary relaxation of requirements applied in normal times for the movement of health personnel should still ensure the bona fides of such personnel. Cooperation between Member States under these guidelines should be based on patient care support and ensure that any abuses of the flexibility afforded by these guidelines are prevented.

2. Objectives

The objectives of these guidelines are to:

- a. Complement the SADC Health and Human Resources Strategy;
- Facilitate the ability of Member States to obtain additional human resources to address national and regional shortages of health professionals in health emergencies;
- c. Make it more attractive for health professionals to come to the SADC region to support the region's efforts to address health emergencies.



3. Guidelines

These guidelines assume that Member States are implementing the policies and measures to combat COVID-19 recommended by the World Health Organization (WHO), in particular the WHO Global Code of Practice on the International Recruitment of Health Personnel, and the SADC Health Workforce Strategic Plan 2020-2030.

a) Managing demand

Addressing shortages of health professionals must begin with Member States' requesting assistance. Member States' Health Ministries inevitably monitor the impact of health emergencies through national data as well as sources such as the WHO, which also maintains data on health resource density, while the Worldometers website also maintains up-to-theminute data on infection rates, drawing from national reports. At present, however, there is no regional co-ordination mechanism to assist Member States that have a shortage of health professionals to register their needs and match such data with demand.

Member States are encouraged to develop such a mechanism, based on the following principles:

- i. Transparency: Recruiting Member States should be encouraged to register their urgent needs for health professionals, as soon as a health emergency is identified;
- ii. Data: Registrations should be accompanied by such data as is available to support the urgent requirement;
- iii. Recruitment: Recruiting Member States should set out their requirements and indicate the temporary conditions and flexibilities such as those set out in section 3.1 below that will be applied to fast-track the supply of health professionals;
- iv. Contact points: Member States should register with the mechanism a national contact point to whom demands can be registered.

b) Managing supply

From the perspective of supplying Member States, there is a need for a regional mechanism to manage a pool of available, qualified professionals.

At the heart of the SADC Health Workforce Strategic Plan is an objective to develop, manage, and monitor a SADC regional health workforce recruitment pool, guided by the following principles.

- i. The SADC Secretariat is the custodian of the recruitment pool;
- ii. In operationalising the recruitment pool, consideration is given to the WHO Code international labour standards and similar policy instruments that impact on SADC;
- iii. The pool is established based on voluntary structured cooperation between two or more countries;
- iv. The recruitment pool is developed and organised based on the underlying SADC and national legal frameworks, diplomatic and policy instruments;
- v. It allows for wide participation by various stakeholders e.g. health agencies, health care providers, education institutions, research institutions, regulatory / statutory bodies, or other relevant health sector actors;
- vi. Each Member State must establish / strengthen and maintain an updated database of laws and regulations relating to the recruitment of health personnel including migration;



vii. Each SADC Member State must submit to the SADC Secretariat data relating to its health needs that justify the need to recruit from other Member States

While the objective of developing a SADC regional health workforce recruitment pool is a medium-term strategy, the COVID-19 pandemic has demonstrated the need for a more urgent response.

Commitments relating to measures affecting the movement of health professionals as service suppliers that are applicable in normal times are negotiated under the Protocol on Trade in Services. This Protocol recognises (in Article 10) that "subject to the requirement that such measures are not applied in a manner which would constitute a means of arbitrary or unjustifiable discrimination between countries where like conditions prevail, or a disguised restriction on trade in services, nothing in this Protocol shall be construed to prevent the adoption or enforcement by any State Party of measures ... necessary to protect human life or health."

These guidelines encourage Member States to disapply temporarily requirements and procedures that are not necessary in a health emergency in a way that ensures that genuine health professionals can be operational effectively in the shortest possible time.

3.1 Entry requirements

Maintaining restrictive visa and other entry formalities act as disincentives when countries are sourcing scarce human resources in a health emergency. To reduce barriers to the entry of foreign health professionals that are needed to in the case of health emergencies, Member States are encouraged <u>temporarily</u> to:

- a. Relax entry requirements for key health professionals such as doctors, nurses, physiotherapists, pharmacists, as well as technicians that are required to train local medical staff in the operation of health equipment such as ventilators, etc.;
- b. Increase length of stay periods for migrant health professionals and their dependents to remain in the country for as long as may be necessary for them to assist in dealing with patients affected by the health emergency;
- c. Fast-track entry procedures for visas and residency permits;
- d. Waive visa requirements such as travel restrictions for applicants with job offers.

3.2 Work permits

To reduce labour market barriers to the employment of foreign health professionals that are needed to treat patients in the case of a health emergency, Member States are encouraged <u>temporarily</u> to:

a. Relax work permit requirements for key health professionals such as doctors, nurses, physiotherapists, pharmacists, etc, or those who could be recruited as healthcare assistants or assistant practitioners;



b. Facilitate and prioritise the processing of work permit and other related applications in order to fast-track the ability of foreign health professionals to commence legal employment.

3.3 Recognition of qualifications

To reduce recognition of qualification barriers to the entry of health professionals that are needed to treat patients in the case of a health emergency, Member States are encouraged <u>temporarily</u> to:

- a. Fast-track recognition of qualifications of health professionals that are required to treat patients affected by the health emergency;
- b. Recognise the qualifications of health professionals where they have been qualified in their own countries to work in related treatment areas even though their qualifications have not been formally recognised;
- c. Flexibly apply recognition of the training of health professionals qualified to work in related activities even if they have not fully completed their medical training in non-relevant areas;
- d. If necessary, facilitate the admission of health professionals as healthcare assistants or assistant practitioners, as necessary under appropriate local or foreign medical supervision.

This shall not affect the negotiation of mutual recognition of qualifications under the Protocol on Trade in Services.

4. Safeguards against abuses

Member States may maintain measures and/or procedures to ensure the bona fides of health professionals afforded flexibility under these guidelines, and to protect against abuses. Letters of good standing from relevant regulatory bodies may be required, but procedures for issuing them should be fast-tracked and should not be used to delay movements of critical health personnel resources that are necessary in a health emergency.



References

SADC Health Workforce Strategic Plan, 2020-2030, November 2020.

SADC Protocol on Trade in Services, 2012.

- AU Protocol to the Treaty Establishing the African Economic Community Relating to Free Movement of Persons, Right of Residence and Right of Residence, 2018.
- WHO (2010a). "User's Guide to the WHO Global Code of Practice on the International Recruitment of Health Personnel". Geneva, World Health Organization, 2010. Accessed at <u>https://apps.who.int/iris/bitstream/han-</u> <u>dle/10665/70525/WHO HSS HRH HMR 2010.2 eng.pdf;jses-</u> sionid=0C7B7C2A439914EAF54B30A654127352?sequence=1
- WHO (2010b). "Global policy recommendations on increasing access to health workers in remote and rural areas through improved retention". Geneva, WHO, 2010. Accessed at <u>https://apps.who.int/iris/bitstream/han-</u> dle/10665/44369/9789241564014_eng.pdf?sequence=1
- OECD (2020). "Contribution of migrant doctors and nurses to tackling COVID-19 crisis in OECD countries." May 2020. Accessed at <u>https://read.oecd-ili-brary.org/view/?ref=132_132856-kmg6jh3kvd&title=Contribution-of-migrant-doctors-and-nurses-to-tackling-COVID-19-crisis-in-OECD-countries</u>



12 ANNEX 3: CLASSIFICATION OF MEDICAL, HEALTH AND RELATED SOCIAL SERVICES

Table 11: Classification of medical, health and related social services

W/120				CPC Provision	al	CPC Version	2.1	Comments	
1	BUSINESS SERVICES			1					
	Α	Profes	sional services						
		h.	Medical and dental services	9312	Medical and dental services	9312	Medical and dental services		
				93121	General medical services	93121	General medical services		
				93122	Specialised medical services	93122	Specialised medical services		
				93123	Dental services	93123	Dental services		
		j.	Services provided by midwives, nurses, physiotherapists and para-	93191	Deliveries and related services, nursing services, physiotherapeutic	93191	Childbirth and related services	Para-medical services not separately listed	
			medical personnel		and para-medical services	93192	Nursing services		
						93193	Physiotherapeutic services		
				93192	Ambulance services	93194	Ambulance services		
8	HEAL	TH AND RELATED SOCIAL SERVICES (other than those listed under 1.A.h-j.)							
	Α.	Hospital services		9311	Hospital services	9311	Human inpatient services	Note: Hospital outpatient services covered by 93121 and 93122; Dental ser- vices by 93123; Ambu- lance services by 93192	
						93111	Surgical services for inpatients		



W/120				CPC Provision	al	CPC Version	2.1	Comments
						93112	Gynaecological and obstetrical services for inpatients	
						93113	Psychiatric services for inpatients	
						93119	Other services for inpatients	
		В.	Other human health services (other than 93191)	9319	Other human health services	9319	Other human health services	
				93193	Residential health facilities services other than hospital services	9321	Residential health-care services other than by hospitals	Covered by separate cate- gory "Residential care ser- vices for the elderly and disabled"
						93221	Residential care services for the elderly	
						93222	Residential care services for young disabled persons	
						93223	Residential care services for disabled adults	
				93199	Other human health services	93195	Medical laboratory services	"Other human health ser- vices" split out into new separately identified ser- vices
						93196	Diagnostic-imaging services	
						93197	Blood, sperm and organ bank services	
						93199	Other human health services	



W/120				CPC Provision	al	CPC Version 2	.1	Comments
		C.	Social services	9331	Social services with accommoda- tion	9330	Other social services with accommoda- tion	Classification revised sep- arating out services relat- ing to persons suffering from mental retardation, mental health illnesses or substance abuse; and other social services
				93311	delivered to old persons and the handicapped			
				93312	delivered to children and other clients			
				93313	Other social services with accom- modation			
						93301	Residential care services for children suffering from mental retardation, mental health illnesses or substance abuse	
						93302	Other social services with accommoda- tion for children	
						93303	Residential care services for adults suf- fering from mental retardation, mental health illnesses or substance abuse	
						93304	Other social services with accommoda- tion for adults	
				9332	Social services without accommo- dation	934	Social services without accommodation for the elderly and disabled	Split between services for the elderly and disabled; and other services (e.g. for children)



W/120			CPC Provision	al	CPC Version 2	2.1	Comments
					935	Other social services without accommo- dation	
			93324	Vocational rehabilitation services	9341	Vocational rehabilitation services	
					93411	Vocational rehabilitation services for per- sons with disabilities	
					93412	Vocational rehabilitation services for un- employed persons	
					9349	Other social services without accommo- dation for the	Services for elderly and those for disabled sepa- rated out
					93491	Other social services without accommo- dation for the elderly	
					93492	Other social services without accommo- dation for disabled children	
					93493	Other social services without accommo- dation for disabled adult	
					935	Other social services without accommo- dation	
			93321	Child day-care services (including day-care services for the handi-capped)	9351	Child day-care services	Handicapped moved to disabled children 93492
			93322	Guidance and counselling services n.e.c. related to children	9352	Guidance and counselling services n.e.c. related to children	
			93323	Welfare services not delivered through residential facilities	9353	Welfare services without accommoda- tion	
			93329	Other social services without ac- commodation	9359	Other social services without accommo- dation, n.e.c.	

Source: McKinnon, 2019



13 ANNEX 4: GATS COMMITMENTS IN MEDICAL, HEALTH AND RELATED SOCIAL SERVICES

Table 12: Summary of SADC MS' GATS Commitments in Medical, Health and related Social Services

Country	Subsector	Market Access	National treatment	Additional commitments
Botswana	1.A.h Medical and dental services	M1 & 4: Unbound, M2:None and M3: Foreign-owned hospitals or clinics are encouraged to enter into joint ventures with local hospitals and clinics. The service should only be supplied by natural persons.	M1: unbound, M2: None, M3: The hospitals and clinics should employ Botswana nationals as doctors, medical personnel and supporting staff. The qualifications of foreign natural persons employed by the hospitals or clinics should be recognized by the Botswana Medical Council in the Ministry of Health.	
			M4: All medical and dental practitioners should be registered with the Botswana Medical Council.	
	1.A.k Other: specialised medical services	M1& 4: Unbound, M4: None, M3: Only natural persons can supply specialized medical services.	M1 &4: Unbound, M2: None, M3: The qualifications of suppliers of specialized medical services should be recognized by the Botswana Medical Council.	
DRC	1.A.h Medical and dental services	M1 - 3: None, and M4: Unbound, except as indicated in the horizontal section.	M1 - 3: None, and M4: Unbound, except as indicated in the horizontal section.	
Eswatini	1.A.h Medical and dental services	M1: Unbound, except for specialist doctors, M2 & 3: None and M4: Unbound, except for specialist doctors	M1- 4: None	
	8.A Hospital services	M1: Unbound*, M2-3:None, M4: Unbound except for specialist doctors	M1- 4: None	
Lesotho	1.A.h Medical and dental services	M1: Unbound, Mode 2 & 3: None, and M4: Unbound, except as indicated in the horizontal section	M1: Unbound, Mode 2 & 3: None, and M4: Unbound except as indicated in the horizontal section	
	1.A.j Services by midwives and nurses (CPC 93191)	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	
	1.A.j Services by Physiotherapists and Paramedical Personnel (CPC 93191)	M 1 – 2: Unbound*, M3: None, and M4: Unbound, except as indicated in the horizontal section	M1 – 2: Unbound*, M3: None, and M4: Unbound, except as indicated in the horizontal section	
Malawi	1.A.h Medical and dental services	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	



Country	Subsector	Market Access	National treatment	Additional commitments
	1.A.j Services provided by midwives, nurses, physiotherapists and paramedical personnel(CPC 9312)	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	
	8.A Hospital services			
Seychelles	1.A.hMedicalanddentalservices- Specializedmedicalservices(CPC 93122)- Dental services(CPC 93123)	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	
	1.A.j Services provided by midwives, nurses, physiotherapists and Para-medical personnel (CPC 93191)	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	
	8.A Hospital services, including hospital management services (CPC 93110)	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	
	- Ambulance services (CPC 93192) - Residential health facilities services other than hospital services (CPC 93193) - Other human health services, including services in the field of morphological or chemical pathology, bacteriological, virology, immunology (CPC 93199**)			
	 8.B Other human health services Welfare services delivered through residential institutions to children and other clients (CPC 93312) 	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	
	8.C Other social services with accommodation (CPC 93319)	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	M1-3: None, M4: Unbound, except as indicated in the horizontal section	
South Africa	1.A. h Medical and dental services (CPC 9312)	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	
	1.A j)Services provided by: (i) Midwives and nurses (CPC 93191)	M1: Unbound*, M 2 & 3: None, and M4: Unbound, except as indicated in the horizontal section	M1: Unbound*, M2 & 3: None, and M4: Unbound, except as indicated in the horizontal section	
	(ii) Physiotherapists and paramedical personnel	M1 – 2: Unbound*, M3: None, and M4: Unbound, except as indicated in the horizontal section	M1 – 2: Unbound*, M3: None, and M4: Unbound, except as indicated in the horizontal section	



Country	Subsector	Market Access	National treatment	Additional commitments
Zambia	h) Medical and dental services (CPC 9312)	M1 – 3: None, M4: Unbound except as indicated in the horizontal section	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	
	 j) Services provided by midwives, nurses, physiotherapists and para-medical personnel (93191) 	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	
	A. Hospital Services (9311)	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	
	B. Other Human Health Services (9319) (other than 93191)	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	M1 – 3: None, M4: Unbound, except as indicated in the horizontal section	

Source: I-TIP Services database

Literature

USAID TECHNICAL BRIEF – AFRICA: Health, Economic Development and Trade. The African Strategies for Health Project.



14 REFERENCES

- ¹ SADC FACTS & FIGURES. <u>https://www.sadc.int/about-sadc/overview/sadc-facts-figures/#LifeExpec-tancy</u>. Accessed 03 Jun 2021
- ² Human Development Report 2020 The Next Frontier: Human Development and the Anthropocene (PDF). United Nations Development Programme. 15 December 2020. pp. 343–346. ISBN 978-92-1-126442-5. Retrieved 15 December 2020.

³ Ibid

- ⁴ <u>https://sadc.int/news-events/news/get-know-more-about-sadc-protocol-trade-services/</u>
- ⁵ The Health Sector Policy Framework Document, SADC Health Ministers. Approved by the SADC Council of Ministers. September 2000. SADC Health Sector Coordinating Unit
- ⁶ SADC (Nov 2020) Health Workforce Strategic Plan, 2020-2030
- ⁷ 4.2 By 2027 SADC Secretariat will have developed a framework with strict compliance criteria for mutual and reciprocal recognition of health professions education and qualifications
 - 4.3 By 2026 Member States will be promoting exchange programmes between the Member States especially for skills transfer
 - 4.4 By 2026 Member States will have created multi-sectoral collaboration/partnerships (PPP) to facilitate sharing of HRH resources
- ⁸ P Riggirozi (undated). COMPARING SADC AND UNASUR REGIONAL HEALTH
- GOVERNANCE AND POLICY. PRARI Working Paper 15-2. Poverty Reduction And Regional Integration.
- ⁹ Mahlati P, Dlamini J. Minimum data sets for human resources for health and the surgical workforce in South Africa's health system. A rapid analysis of stock and migration: Africa Institute for Health and Leadership Development; 2015. https://www.who.int/workforcealliance/031616south_africa_case_studiesweb.pdf. Accessed 10 April 2021.
- ¹⁰ Malakoane et al. Public health system challenges in the Free State, South Africa: a situation appraisal to inform health system strengthening BMC Health Services Research (2020). https://doi.org/10.1186/s12913-019-4862-y
- ¹¹ WHO Country Cooperation Strategy 2016 2020, Zimbabwe. WHO 2016.
- ¹² WHO Country Cooperation Strategy 2016 2020, Zimbabwe. WHO 2016.
- ¹³ Ntembwa H K and Lerberghe W V (2015) Improving Health System Efficiency: DEMOCRATIC RE-PUBLIC OF THE CONGO; Improving aid coordination in the health sector. WHO.
- ¹⁴ Ntembwa H K and Lerberghe W V (2015) Improving Health System Efficiency: DEMOCRATIC RE-PUBLIC OF THE CONGO; Improving aid coordination in the health sector. WHO.
- ¹⁵ WHO Country Cooperation Strategy 2016 2020, Zimbabwe. WHO 2016.
- ¹⁶ Data extracted from WHO website: GHO | By category | Health workforce (who.int). https://apps.who.int/gho/data/node.main.HWFGRP?lang=en . Accessed 28 May 2021
- ¹⁷ Data extracted from WHO website: <u>GHO | By category | Health workforce (who.int)</u>. https://apps.who.int/gho/data/node.main.HWFGRP?lang=en . Accessed 28 May 2021
- ¹⁸ <u>https://www.who.int/health-topics/health-workforce#tab=tab_1</u>
- ¹⁹ Paper for World Economic Forum. Accessed at https://www.weforum.org/agenda/2020/04/africacannot-lose-doctors-covid-19/
- ²⁰ Agnes Gatome-Munyua and Nkechi Olalere (Oct 2020). Public financing for health in Africa: 15% of an elephant is not 15% of a chicken. Africa Renewal. <u>Public financing for health in Africa: 15% of</u> <u>an elephant is not 15% of a chicken | Africa Renewal (un.org)</u>
- ²¹ Global Burden of Disease Health Financing Collaborator Network. (2019). Past, present, and future



of global health financing : a review of development assistance , government , out-of-pocket , and other private spending on health for 195 countries, 1995-2050. Lancet, April 25, 28.

https://doi.org/10.1016/S0140-6736(19)30841-4

²² Barros AJD, Wehrmeister FC, Ferreira LZ, Vidaletti LP, Hosseinpoor AR, Victora CG. Are the poorest poor being left behind? Estimating global inequalities in reproductive, maternal, newborn and child health. BMJ Glob Health. 2020;5(1):e002229. Published 2020 Jan 26. doi:10.1136/bmjgh-2019-002229

²³ Public Financing for Health in Africa: from Abuja to the SDGs.

https://apps.who.int/iris/bitstream/handle/10665/249527/WHO-HIS-HGF-Tech.Report-16.2-

eng.pdf?sequence=1

²⁴ Wagstaff A, Flores G, Hsu J, et al. Progress on catastrophic health spending in 133 countries: a

retrospective observational study. Lancet Glob Health. 2018;6(2):e169-e179. doi:10.1016/S2214-

109X(17)30429-1

²⁵ Kleinhert S, Horton R. South Africa's health: departing for a better future? Lancet. 2009;374(9692):759–60.

- ²⁶ Ntembwa H K and Lerberghe W V (2015) Improving Health System Efficiency: DEMOCRATIC RE-PUBLIC OF THE CONGO; Improving aid coordination in the health sector. WHO.
- ²⁷. Countries with the Highest Rates of HIV/AIDS Joyce Chepkemoi on January 21 2019 in Society. https://www.worldatlas.com/articles/countries-with-the-highest-rates-of-hiv-aids.html
- ²⁸ Malakoane et al. Public health system challenges in the Free State, South Africa: a situation appraisal to inform health system strengthening BMC Health Services Research (2020). https://doi.org/10.1186/s12913-019-4862-y
- ²⁹ WHO Country Cooperation Strategy 2016 2020, Zimbabwe. WHO 2016.
- ³⁰ Ntembwa H K and Lerberghe W V (2015) Improving Health System Efficiency: DEMOCRATIC RE-PUBLIC OF THE CONGO; Improving aid coordination in the health sector. WHO.
- ³¹ Health in 2015: from MDGs to SDGs. Geneva: World Health Organization; 2015 (http://apps.who.int/iris/bitstream/10665/200009/1/9789241565110_eng.pdf?ua=1, accessed 23 Jan 2021).
- ³² Working for health and growth: investing in the health workforce. Report of the High-Level Commission on Health Employment and Economic Growth. WHO 2016
- ³³ Universal health coverage (UHC). WHO. 21 April 2021. https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)#:~:text=UHC%20means%20that%20all%20individu-als%20and%20communities%20receive,rehabilitation%2C%20and%20pallia-tive%20care%20across%20the%20life%20course.
- ³⁴ Chopra, M., Lawn, J., Sanders, D. et al.; Achieving the Health Millennium Development Goals for South Africa: challenges and priorities; 2009, The Lancet, 374; 9694; 1023-1031
- ³⁵ Kleinhert S, Horton R. South Africa's health: departing for a better future? Lancet. 2009;374(9692):759–60.
- ³⁶ Malakoane et al. Public health system challenges in the Free State, South Africa: a situation appraisal to inform health system strengthening BMC Health Services Research (2020). https://doi.org/10.1186/s12913-019-4862-y
- ³⁷ SADC MSs take action on Covid-19. The Herald. 04 APR, 2020. <u>https://www.herald.co.zw/sadc-member-states-take-action-on-covid-19/</u>
- ³⁸ COVID-19, Statistics, and Africa. Council on Foreign Relations 100. Blog Post by John Campbell. January 7, 2021. <u>COVID-19, Statistics, and Africa | Council on Foreign Relations (cfr.org)</u>



³⁹ SADC contributes half Covid-19 numbers in Africa. African News Agency (ANA), IOL. 2 Feb 2021.

- https://www.iol.co.za/news/africa/sadc-contributes-half-covid-19-numbers-in-africa-3d5c9508-a255-52d0-a8fe-dac34b0353b1
- ⁴⁰ SADC moves towards establishing disaster and emergency operations centre. News; SADC. 31 Mar, 2021. <u>https://www.sadc.int/news-events/news/sadc-moves-towards-establishing-disaster-and-emergency-operations-centre/</u>
- ⁴¹ Impacts of the COVID-19 Pandemic in SADC. PESA. Aug 2020
- ⁴² WHO 2020c. 10th Ebola Outbreak in the Democratic Republic of Congo Declare Over; Vigilance Against Flare-Ups and Support for Survivors Must Continue, World Health Organisation: Geneva. Available At: https://who.int/ [Last Accessed: 13 July 2020].
- ⁴³ Impacts of the COVID-19 Pandemic in SADC. PESA. Aug 2020
- ⁴⁴ Building Resilient Health Systems: Policies for Inclusive Health in Post-COVID-19
- Africa A Brainstorming E-Policy Seminar. African Development Institute, African Development Bank Group. 22 Jun 2020. https://www.afdb.org/sites/default/files/2020/06/15/concept_note_-g-cop_seminar_on_inclusive_health_policy_in_a_post-covid-19_africa.pdf
- ⁴⁵ OECD, 2020. The Contribution of Migrant Doctors and Nurses to Tackling Covid-19 Crisis in OECD Countries <u>https://www.oecd.org/coronavirus/policy-responses/contribution-of-migrant-doctors-andnurses-to-tackling-covid-19-crisis-in-oecd-countries-2f7bace2/</u> [accessed on 04/09/2020]
- ⁴⁶ Interview and correspondence with Department of Trade, South Africa
- ⁴⁷ Health Sector Policy Framework Document (September 2000). SADC Council of Ministers. SADC Health Sector Coordinating Unit.
- ⁴⁸ P Riggirozi (undated). COMPARING SADC AND UNASUR REGIONAL HEALTH