

Closing the Data Gap:

Transparent Health R&D Financing in South Africa

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Executive Summary

South Africa carries one of Africa's most complex disease burdens. The South African Medical Research Council describes it as a '**quadruple burden**' comprising four colliding epidemics: HIV and TB, non-communicable diseases (NCDs), maternal and child mortality, and violence and injuries.^{1,2} With the world's largest HIV epidemic — approximately 8 million people living with the virus^{3,4} — South Africa remains on all three of WHO's lists of 30 high-burden countries for TB, HIV-associated TB, and drug-resistant TB.⁵

Yet despite this burden, South Africa cannot readily answer: how much of its public investment goes to health research and development (R&D), where the money goes, and what it produces? For more than two decades, the Department of Health (NDoH) and the Ministry of Health have committed to allocate 2% of the national health budget to health R&D.⁶ A peer-reviewed analysis published in the *South African Medical Journal* confirmed this commitment has not yet been met. Total Gross Expenditure on R&D (GERD) as a share of GDP has oscillated between 0.60% and 0.62% across every year since 2019/20,^{7,8,9,10} less than half the National Development Plan target of a 1.5% GERD-to-GDP investment ratio by 2030.¹¹

The data systems to track progress toward these commitments are inadequate. Disease-specific breakdowns of health R&D spending are not publicly available. Private-sector contributions are largely undisclosed. International donor flows are not centrally recorded. This policy brief sets out a six-point policy agenda to be championed by the SAHTAC coalition, AVoS health champions, and parliamentarians committed to health accountability.

¹South African Medical Research Council (SAMRC). 'The State of Health in South Africa: Reflections and Future Directions', 2023

²SAMRC Parliamentary Briefing: 'Burden of Health and Disease in South Africa.' Parliamentary Monitoring Group, 2016.

³UNAIDS. 'South Africa charts a new frontier by rolling out lenacapavir', October 2025 (confirms ~8 million people living with HIV in South Africa).

⁴Spotlight. '8 million people living with HIV in SA, according to latest estimates.' Based on Thembisa v4.8 modelling, March 2025.

⁵National Department of Health. TB Recovery Plan 4.0, April 2025 – March 2026. South Africa remains on all three WHO high-burden country lists for TB, TB/HIV, and DR-TB.

⁶Paruk F et al. 'Health and finance: National expenditure on health research in South Africa: What is the benchmark?' *South African Medical Journal*, 2014; 104(7). doi:10.7196/SAMJ.8371.

⁷HSRC/DSTI. South African National Survey of Research and Experimental Development, 2023/24. HSRC CeSTII for DSTI, October 2025.

⁸HSRC/DSTI. South African National Survey of Research and Experimental Development, 2022/23. HSRC CeSTII for DSTI, November 2024.

⁹HSRC/DSTI. South African National Survey of Research and Experimental Development, 2021/22. HSRC CeSTII for DSTI, February 2024.

¹⁰HSRC CeSTII. 'Main Trends in South African R&D 2022/23: Recovering from COVID-19.' Human Sciences Research Council, September 2025.

¹¹AUDA-NEPAD. Health Research and Innovation Strategy for Africa (HRISA) 2018–2030. African Union Development Agency, 2018.

South Africa must establish a National Health R&D Observatory, ring-fence at least 2% of the national health budget for R&D with binding annual reporting to Parliament, mandate standardised disclosure from all public, private, and donor funding actors, and link investment systematically to measurable health outcomes.

1. South Africa's Disease Burden and Research Imperative

South Africa's health research environment is among the strongest on the African continent. The country leads in HIV/AIDS science, has contributed landmark clinical research on tuberculosis diagnostics and treatment, and is ranked as among the most innovative countries in Africa in the 2022 Global Innovation Index. Yet this scientific capacity sits in direct tension with the opacity of its health R&D financing architecture.

The SAMRC defines South Africa's health challenge as a **'quadruple burden' — four colliding epidemics**: HIV/AIDS and tuberculosis; non-communicable diseases; maternal, newborn and child health challenges; and violence and injuries. Quantified mortality data confirms the weight of each component: NCDs account for 43% of deaths; HIV/AIDS and TB together account for 34%; other communicable diseases, maternal and perinatal causes, and nutritional deficiencies account for 14%; and injuries for 10%.¹²

The value of sustained health R&D investment is visible across this burden. South Africa has achieved a 57% decline in TB incidence since 2015, making it one of a small number of high-burden countries globally to meet the WHO End TB Strategy's 2025 milestone. The country's HIV treatment programme — the largest in the world, reaching approximately 6.2 million people — is equally a product of decades of clinical trials, implementation science, and health systems research. A third imperative is antimicrobial resistance (AMR), a national priority whose R&D investment remains invisible in national data, making it impossible to know whether the research response matches the threat. Despite South Africa carrying one of the world's highest TB burdens, many patients in under-resourced communities still face delayed diagnosis, interrupted treatment, long travel distances to care, and preventable deaths, particularly from drug-resistant TB. While the country has contributed significantly to global TB research, gaps in transparent and sustained domestic R&D financing, procurement planning, and implementation investment continue to delay equitable access to life-saving innovations. These financing and accountability gaps directly determine whether vulnerable patients receive timely diagnosis, effective treatment, and a fair chance at survival.

Across all three, the evidence is that the gap is not investment in scientific capacity — it is the absence of accountability systems needed to sustain, scale, and direct that investment where it is most needed, demonstrating the link between R&D capacity and lives saved.

1.2 Continental and Global Context

Africa CDC, in its April 2025 Health Financing Strategy, documented that official development assistance (ODA) to Africa has fallen by 70% between 2021 and 2025, while disease outbreaks surged 41% over the same period. Africa CDC explicitly identifies inadequate data and weak financing tracking as core vulnerabilities.^{13,14} African Union Development Agency (AUDA-NEPAD) Health Research and Innovation Strategy for Africa (HRISA) 2018–2030 identified gaps in financing health research, weak data systems, and inadequate coordination as central structural obstacles — calling explicitly for sustained investments and financing mechanisms in health R&D.¹⁵ A 2025

¹²Jansen van Vuren E et al. 'Inequity in the Distribution of Non-Communicable Disease Multimorbidity in Adults in South Africa: An Analysis of Prevalence and Patterns.' *International Journal of Public Health*, 2022.

¹³Africa Centres for Disease Control and Prevention (Africa CDC). 'Africa CDC Unveils Strategic Plan to Transform Health Financing and Advance Self-Reliance'. April 2025.

¹⁴Africa CDC. 'Africa's Health Financing in a New Era'. April 2025. [Official Development Assistance to Africa fell 70% between 2021 and 2025; disease outbreaks surged 41% from 2022 to 2024.](#)

¹⁵AUDA-NEPAD. [Health Research and Innovation Strategy for Africa \(HRISA\) 2018–2030. A situational analysis identified gaps in financing health research, data systems, and coordination as central structural obstacles.](#)

Lancet analysis reinforced the stakes for investment in R&D: Africa accounts for only 3% of global medicine production, with more than 90% of drugs and 99% of vaccines consumed on the continent imported. It attributed this directly to the absence of a well-defined continental health research governance framework and scarce sustainable financing for R&D.¹⁶

2. The Commitment Gap: A 25-Year Broken Promise

The South African government has formally recognised the case for investing in health R&D for over two decades, yet financing commitments remain unmet and, critically, unmeasured.

The National Health Research Policy (2001) proposed raising the health research budget to at least 2% of total public sector health expenditure (roughly USD 360 million). The Ministry of Health subsequently committed to the same 2% target through the Mexico (2004), Bamako (2008), and Algiers (2008) ministerial declarations on health research. The 2011 National Health Research Summit further recommended that the NDoH increase its health research funding to that level.¹⁷

A 2014 National Health Research Committee (NHRC) review, using data up to 2009/10, found that public-sector health research funding remained below the 2% commitment.¹⁸ A peer-reviewed analysis in the South African Medical Journal (2020) found the government's own health research commitment targets had not been met more than 18 years after they were made. The authors noted that the majority of funders approached during their research 'were not able to break down expenditure by disease area'¹⁹ — a finding that cuts to the heart of the data gap problem.

The South African Medical Journal (SAMJ) 2020 analysis also found that in 2016/17, an estimated 75% of South Africa's health research funding originated from foreign sources.²⁰ In the absence of robust domestic tracking systems, the PEPFAR and USAID funding disruptions of 2025 exposed the country's acute vulnerability: no government system was available to provide a comprehensive baseline of what had been lost or forecast a credible financing transition.

The NDoH's Integrated National Strategic Framework for Health Research (2017–2022) set explicit progressive targets: health research investment of 0.18% of GDP by 2021, rising to 0.4% of GDP by 2030; and NDoH spending of 1.1% of consolidated government health expenditure by 2021, rising to 2% by 2030.²¹ No publicly available report tracks performance against these targets.

3. Data Gaps Undermining Health R&D Accountability

Strengthening Africa's Health Technologies Advocacy's national data gap mapping exercise²² — informed by DSI/HSRC survey reports, SAMRC financial data, institutional reporting analysis, and peer-reviewed literature — identified six structural gaps. Each represents a concrete target for reform.

Gap 1: No Disaggregated National Accounting for Health R&D

The DSI's National Survey of Research and Experimental Development — published annually — provides aggregate figures on medical and health sciences R&D expenditure. However, publicly available summaries do not provide breakdowns by specific disease area, institution, province, or subnational geography.

¹⁶ [A call for health R&D prioritisation and governance mechanisms in Africa.' The Lancet, March 2025](#)

¹⁷ [Paruk F et al. 'Health and finance: National expenditure on health research in South Africa: What is the benchmark?' South African Medical Journal, 2014; 104\(7\).](#)

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²⁰ Barnabé E et al., SAMJ, 2020 (op. cit.). Three-quarters of South Africa's health research funding in 2016/17 originated from foreign sources.

²¹ [National Department of Health. Integrated National Strategic Framework for Health Research in South Africa, 2017–2022.](#)

Gap 2: Private-Sector Health R&D Spending Is Not Publicly Disclosed

There is no legal requirement in South Africa compelling private entities to disclose health R&D expenditure. The Companies Act and Johannesburg Stock Exchange listing rules require financial reporting, but do not mandate health R&D-specific breakdowns.

Gap 3: International Donor Funding Is Not Centrally Tracked

International donors — including the NIH, PEPFAR, CDC, USAID, and philanthropic foundations — have historically contributed a substantial share of South Africa's health research funding. However, there is no centralised government system tracking these flows by donor, disease area, institution, or research output.

Gap 4: No Integrated, Publicly Accessible Health R&D Data Platform

No centralised, publicly accessible platform exists where researchers, civil society, parliamentarians, or policymakers can view health R&D financing data across public, private, and donor sources. The National Research Fund (NRF) offers some data on funded research, but it is neither health-specific nor updated in real time.

Gap 5: Inconsistent Institutional Reporting

South Africa's universities and public research institutions report research funding in ways that are inconsistent, fragmented across departmental reports, and not standardised for cross-institutional comparison. This fragmentation means that the national landscape of research capacity cannot be mapped from publicly available data, nor can duplication of efforts or investment gaps be identified.

Gap 6: No Systematic Link Between Investment and Outcomes

Even where expenditure data exists, there is a dearth of publicly accessible information linking R&D spending to outputs. A systematic analysis of COVID-19 research funding data found that funding acknowledgements were frequently missing or inconsistent across major academic databases, making it impossible to trace funders to published research outputs or applied outcomes.²³

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Without outcome data, health R&D investment cannot be evaluated for efficiency or return on public funds. Parliament cannot hold the NDoH accountable to research outcomes. Civil society cannot assess whether investment is aligned with public health need.

4. Why This Matters: Costs of the Data Gap

Data gaps are not an administrative inconvenience. In the context of South Africa's disease burden and its stated ambitions for health sovereignty, they carry measurable costs across governance, public health, innovation, and the economy.

Impact Area	Consequence of Data Gaps
Disease priority alignment	Absence of disease-specific data hampers verification of proportionate funding for research of priority conditions (TB, HIV, AMR, NCDs).
Parliamentary accountability	Absence of a public tracking of the 2% commitment embedded in policy instruments means that Parliament has no basis to hold the NDoH accountable.

²³[Systematic review of COVID-19 research funding data across Crossref, Scopus, and Web of Science databases. Found funding acknowledgements frequently missing or inconsistent. Cited in: SAHTAC Data Gap Mapping Report, 2025; original analysis at PMC.](#)

Impact Area	Consequence of Data Gaps
Domestic financing transition	Africa CDC estimates ODA to Africa fell 70% between 2021 and 2025. With 75% of South Africa's health research historically funded from foreign sources, the absence of donor-flow tracking leaves the country without a baseline for transition planning.
Private sector engagement	Without disclosure requirements, private-sector health R&D contributions are invisible, creating the risk of duplication and missed co-investment opportunities.
Innovation and economic value	Closing data gaps will unlock the economic value of evidence-based local manufacturing for the continent that currently produces just 3% of global medicines.
Continental leadership	Transparent health R&D funding is key to strengthening pharma policy, boosting local manufacturing, improving pandemic readiness, and attracting biotech investment. It helps identify funding gaps, guide priorities, ensure accountability, and build investor confidence in South Africa's health innovation system. It also supports alignment with African initiatives like the African Medicines Agency and African Continental Free Trade Area (AfCFTA) to enhance regulation, manufacturing, and market integration
Community and equity impact	When health R&D investment is invisible, it cannot be tested against burden, directed toward neglected populations, or prioritised for translation into care. Communities cannot trust what they cannot see.

5. Policy Recommendations: A Six-Point Agenda to Close South Africa's Health R&D Data Gap

The following recommendations are sequenced to address structural roots and not the symptoms.

#	Key Actions	Lead Actors and Mechanism
1 National Health R&D Observatory	- Establish a centralised, publicly accessible platform tracking allocations, disbursements, and expenditures across public, private, and donor sources, and updated annually. - Disaggregate data by disease area, institution, province, and research type. - Build on existing infrastructure: SAMRC's Strategic Health Innovation Partnerships (SHIP) initiative and the national Funders Forum. - Institute a multi-stakeholder governance board. - Table an annual 'State of South African Health R&D' report before Parliament. - Position within Africa CDC's continental Health Financing Scorecard and AUDA-NEPAD HRISA transparency architecture.	Lead: Department of Science, Technology and Innovation (DSTI) + SAMRC Co-owners: NDoH, NRF, NHRC Mechanism: Parliamentary mandate — amendment to the National Health Act or a dedicated Health R&D Financing Transparency Act Oversight: Portfolio Committees on Health and Science & Technology
2 Ring-Fence 2% of the Health Budget for R&D	- Ring-fence at least 2% of the consolidated national health budget for health R&D in MTEF allocations from the 2027/28 financial year. - Mandate annual Parliament reporting on performance against this target: auditable figures, disaggregated by disease priority and institution type. - Adopt the NDoH Strategic Framework's GDP-based milestones — 0.18% of GDP by 2026 (revised) and 0.4% of GDP by 2030 — as formal National Treasury benchmarks. - Require NHRC independent verification of all reported figures.	Lead: National Treasury (MTEF embedding) and NDoH (target-setting) Mechanism: Annual Estimates of National Expenditure (ENE) reporting requirement Verification: NHRC Oversight: Parliament Portfolio Committees on Health and Science & Technology
3 Standardise & Mandate Institutional Reporting	- DSTI to develop and publish a mandatory reporting framework for all research, policy, and implementation bodies— requiring disease-area disaggregation aligned with the DSI's annual R&D Survey. - Amend the Companies Act to require pharmaceutical, biotech, and medical device companies to separately disclose health R&D expenditure in annual financial statements, categorised by disease area and research type. - All institutions to report to the Observatory using common templates, enabling national aggregation and cross-sector comparison. - SAMRC and NHRC to provide technical support to smaller institutions to prevent disproportionate compliance burden.	Lead: DSTI (reporting framework) Co-leads: National Treasury and Department of Justice (Companies Act amendment) Technical support: SAMRC and NHRC Legislation: Parliament to enact mandatory disclosure requirements

#	Key Actions	Lead Actors and Mechanism
4 Incentivise Private-Sector Disclosure & Co-Investment	- Introduce enhanced tax incentives (building on Section 11D) conditional on health R&D investment in priority disease areas — with public disclosure as a mandatory condition of the incentive. - Make health R&D transparency a condition of eligibility for preferential procurement, DTIC incentives, and inclusion in the Strategic Integrated Projects (SIP) framework for health manufacturing. - Establish a public–private Health R&D Co-Investment Fund — government-seeded, with matched private-sector contributions — conditioned on full disclosure. - Facilitate pre-competitive data-sharing between private companies and public research institutions, particularly in disease areas where South Africa is building local manufacturing capacity.	Lead: National Treasury (tax incentives) Co-lead: Department of Trade, Industry and Competition — procurement conditions and Co-Investment Fund design Co-lead: DSTI — pre-competitive collaboration frameworks <i>*The DSTI's Vaccine Manufacturing Strategy provides an existing government framework for co-investment and transparency.</i>
5 Open-Access Reporting from International Donors	- Require registration of donor-funded projects and their annual expenditure and output data to the Observatory. - Establish a Donor Coordination Mechanism, ensuring alignment with national health R&D priorities as set by the NHRC. - Require open-access publication of all research outputs from donor-funded health R&D projects. - Design a Health R&D Transition Fund to progressively substitute donor-funded research with domestic financing over a defined multi-year horizon, informed by data mapping through the Observatory.	Lead: NDoH (donor coordination) Lead: DSTI (Observatory registration and data integration) Lead: National Treasury (Transition Fund design) Supporting: DIRCO — to negotiate open-access and disclosure requirements in future donor agreements
6 Link Investment to Outcomes & Accountability	- Link public and donor health R&D grants in the Observatory to standardised outcomes indicators (peer-reviewed publications, patent applications, clinical trial registrations, regulatory approvals, technology transfers, and documented policy impacts.) - Require all grant recipients to submit outcome reports 24 months post-grant completion, enabling retrospective assessment of research investment value. - SAMRC to publish an annual 'State of South African Health R&D' report synthesising investment and outcomes data, tabled before Parliament. - SAHTAC and AVoS champions to systematically translate Observatory data into policy briefs, Parliamentary submissions, budget advocacy, and public media engagement.	Lead: SAMRC — outcome reporting frameworks and annual State of Health R&D report Lead: DSTI — Observatory architecture and data infrastructure Lead: NDoH — Parliamentary tabling of annual report Civil society: SAHTAC coalition and AVoS champions — accountability, advocacy, and public communications

6. Advocacy Entry Points for SAHTAC and African Voices of Science (AVoS) Champions

The following near-term opportunities should anchor SAHTAC's and AVoS champions' advocacy agenda in the period May–December 2026:

Opportunity	Specific Ask	SAHTAC / AVoS Actor
MTEF Budget Submissions (Mid-2026)	Formal representation to National Treasury calling for ring-fencing of 2% of consolidated government health expenditure for R&D in the 2027/28 MTEF, with mandatory ENE reporting.	SAHTAC coalition; SAMRC civil society engagement
Parliament — Portfolio Committee on Health	Formal committee briefing on the NDoH's 2% health R&D commitment and NHRC progressive targets. Table SAHTAC's data gap mapping findings as evidence.	SAHTAC members; AVoS health policy champions
Parliament — Portfolio Committee on Science & Technology	Advocate for legislative mandate for the National Health R&D Observatory and mandatory private-sector health R&D disclosure under the Companies Act.	AVoS champions with science policy expertise (e.g. Glaudina Loots)
DSI Annual R&D Survey Engagement	Formally engage DSTI/HSRC to redesign the annual R&D survey to require disease-specific, institutional, and subnational breakdowns published in the main report.	SAHTAC; academic partners; SAMRC
SAMRC SHIP Initiative and Funders Forum	Use SAMRC's SHIP programme and the national Funders Forum as institutional anchors for the proposed National Health R&D Observatory.	SAHTAC coalition; Ncengani Mthethwa (SAMRC)
Africa CDC Health Financing Scorecard (2025–2026)	Advocate for South Africa's active participation in Africa CDC's Scorecard and transparency dashboard processes, using them to anchor Observatory design.	AVoS champions in health systems and financing
AU Summit on Health Financing (2026)	Champion South Africa's domestic transparency reforms as a model contribution to AUDA-NEPAD HRISA implementation — positioning data accountability as a prerequisite for Africa's health self-reliance agenda.	AVoS — Ntobeko Ntusi, Glaudina Loots, Lisa Micheni
Media and public accountability	Continue and deepen op-ed and media engagement in national (Daily Maverick, Mail & Guardian) and continental (Devex, The East African) outlets to sustain pressure for Parliamentary action.	SAHTAC authors: Khaweka, Mthethwa, Dube; AVoS champions

7. Conclusion: What Gets Measured Gets Funded

South Africa has the scientific institutions, the disease burden context, and the continental standing to set the standard for health R&D financing transparency in Africa. What it has lacked — for more than two decades — is the political will to convert its own commitments into binding accountability systems. The SAHTAC coalition and AVoS champions are asking for the transparency infrastructure,

without which money cannot be directed effectively. If we ring-fence, report, align, and review the funding properly, the 2% conversation will become a reality.

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