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FUTURE DIRECTION OF AIDS WATCH AFRICA (AWA) 2012-2015

AWA Revitalized as an African High Level Advocacy & Accountability Platform to Combat HIV/AIDS, TB, and Malaria

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I. INTRODUCTION AND BACKGROUND

AU Commitments to Combat HIV/AIDS, TB and Malaria are adopted

In 2000, 44 African Heads of State and Government assembled at Abuja and adopted the Declaration and Framework for Action on Roll Back Malaria in Africa, with targets to be met by 2005, 2010 and 2015 respectively. A year later, AU Heads of State and Government also adopted the Abuja Declaration on HIV/AIDS, Tuberculosis (TB) and Other Infectious Diseases. They collectively committed themselves to taking personal leadership in the fight against these diseases, and stated that: "*We are fully convinced that the epidemics of HIV/AIDs, Tuberculosis and other infectious diseases should constitute our top priority for the 1st quarter of the 21st Century".*

In 2006, African leaders reaffirmed previous commitments and adopted the Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, TB and Malaria Services. At their July 201 Kampala Summit, they extended the 'Abuja Call' mandate to 2015, to coincide with the Millennium Development Goal (MDG) targets. Note should be made that these commitments and strategies are linked to relevant regional and international commitments and partnerships, all geared towards promotion universal access to health, and bringing Africa nearer to attaining the targets of the MDGs by 2015.

It is encouraging to note that through the political will and commitment of African Leaders, these commitments were turned into concrete action and partnerships at national and regional levels, resulting in significant achievements in many African countries. For more than a decade, therefore, African Heads of State and Government have led by example, and expressed their commitment through building and sustaining the political will in the fight against these diseases. At National level, these have resulted in varying but significant levels of success.

AIDS Watch Africa (AWA) is created

At the Abuja 2001 Special Summit, and as a show of leadership and commitment to meeting the crisis of HIV/AIDS head on, eight African leaders joined hands to create AIDS Watch Africa (AWA) as an advocacy platform to mobilize action and resources. It was also as a show of commitment to monitor progress on implementation of the Abuja Declarations. Note should be made that the 2006 Special Summit on HIV/AIDS, TB, and Malaria (ATM) was organized under the initiative, leadership and guidance of the then AWA Chairperson and came up with a defined and forward-looking agenda for action.

Achievements and Partnerships

Since the creation of AWA and under its leadership, many achievements have been made though concerted efforts by African and international partners to combat HIV/AIDS, TB and Malaria. These include: Unprecedented community mobilization for better access to prevention, treatment, care and support; progressive increases in national budget allocation to the health sector, even if some are yet to meet the 15% Abuja target; the creation of the Global Fund for HIV/AIDS, TB and Malaria of which Africa has been the

Other related commitments of Heads of State and Governments have been turned into strategies for implementation: Pharmaceutical Manufacturing Plan; Framework on Sexual and Reproductive Health and Rights; Africa Health Strategy; Africa Fit for Children. They were aimed at promoting access to medicines and commodities, improve maternal and child health and strengthen health systems. Campaigns have been launched to accelerate action: in 2007, Campaign on Malaria Elimination in Africa, and Campaign on "*Stepping up the Pace for HIV prevention*"; and in 2009 Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA). Mobilization for external resources was undertaken by African leaders through bilateral and multilateral dialogue with donors, or at international forums such as the G8, G20, EU Summits and Africa/EU Summits.

Burden and Progress in the Response to HIV/AIDS, TB and Malaria in Africa

Estimates by UNAIDS in 2011 indicate that of the 34 million people currently living with HIV in the world, 22.7 million are from Africa South of the Sahara, although some countries show decline. In spite of successes in prevention, there 1.9 million new infections in Africa (including 390,000 are children). About 1.2 million Africans died from AIDS in 2010. However, access to therapy has improved and averted 2.5 million deaths globally: antiretroviral coverage was 2.95 million in 2008 and increased to 3.9 million in 2009! But, 37% of those eligible for treatment still cannot access it. Of the children globally orphaned by AIDS, 90% are from Africa. Girls and women are still disproportionately affected by HIV/AIDS in Africa (57%).

Member States of the WHO Africa Region account for 85% of malaria cases and 90% of deaths worldwide; and 85% of these deaths are among children under 5 years (with a child dies every 30 seconds). Pregnant women are also at high risk of malaria. During the last decade, improved malaria control efforts (use of insecticide treated nets, indoor residual spray, intermittent preventive treatment and prompt treatment with artemisinin-based combination therapy) have borne encouraging results. Between 2000 and 2008, 10 African countries had reduced malaria cases by 30%, and a few are actually moving towards malaria elimination. Of the WHO Eastern Mediterranean African Member States, the main challenge of Malaria is in only two countries.

There is a close link between HIV and TB: two thirds of those infected by HIV will die of TB; and 25% of TB deaths occur in HIV positive persons. Globally, 5,000 people die daily from TB. While 29% of the global TB infections are in Africa, death rate from TB is highest in Africa – 74/100,000 population (2010 World Health Sciences Report). WHO (March 2012 Fact Sheet) reported that 8.8 million people fell ill and 1.4 million died from TB in 2010. However, due to improved efforts in diagnosis and treatment, TB deaths dropped by 40% between 1990-2010. The added challenge is multi-drug resistant TB (MDR-TB) which is present in all countries and is much more expensive to diagnose and treat.

Challenges to the Response to HIV/AIDS, TB and Malaria in Africa

The successes registered thus far, and the progress made to date is extremely fragile, and should be sustained as complacency can have dire results. There are also many competing challenges and emergencies in Africa which must also be addressed: food shortages, widespread poverty and hunger, shortages of human resources and medicines/ commodities, conflicts, democratic transitions and climate change. Furthermore, the recent global financial and economic crisis poses an added challenge as two thirds of the funding for HIV/AIDS, TB and Malaria control is external. Since 2010, international investment for

much more than the current expenditures.[1] Investment needs for the Roll Back Malaria[2] (RBM) Global Malaria Action Programme (GMAP) are estimated at US$26.9 billion for 2012-2015, but the funding gap is estimated at US$9.7 billion or US$2.4 billion per year. WHO[3] reports that funding for Tuberculosis from domestic and donor sources is expected to amount to $4.4 billion in 2012, but countries are reporting funding gaps of close to $1 billion in 2012. Cancellation of Round 11 grants by the Global Fund to fight AIDS, TB and Malaria due to lack of funding is a threat to the gains made by the continent in the past decade.

II. REVITALISATION OF AWA

In July 2010, the mandate of the Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, TB and Malaria Services was extended from 2010 to 2015, coinciding with the MDGs target. Recognizing that the successes of the last decade depended, among others, on political will and commitment of Africa's top leadership, a decision was taken by the 18th Session of the AU assembly to revitalize AWA in January 2012 (Decision No: Assembly/AU/Dec.395(XVIII).

By Decision No: Assembly/AU/Dec.413(XVIII), the AU Commission, NEPAD Planning and Coordination Agency (NPCA), in collaboration with UNAIDS were also requested to work out a roadmap of shared responsibility for a viable response including Health Financing for AIDS (paragraph 21). This is prudent, in view of the global economic and financial crisis and its consequences on financial aid to Africa, especially for HIV/AIDS, TB and Malaria. Urgent action has to be taken therefore, towards better partnerships for a sustainable response to these diseases, including domestic resource mobilization. The "Roadmap" has been developed and is presented separately. It is based on three action pillars which are among the priority areas of the "Abuja Declarations and Abuja Call":

i. Ensure country leadership for an orderly and strategic translation to more diversified, balanced and sustainable financing models for AIDS, TB and Malaria;
ii. Ensure accelerated access to affordable and quality-assured medicines and health-related commodities within the framework of the Pharmaceutical Manufacturing Plan for Africa (PMPA);
iii. Enhance leadership, governance and oversight to implement African solutions for AIDS, TB and Malaria in a sustainable manner with emphasis on results, transparency and equity.

III. JUSTIFICATION FOR AWA REVITALIZATION

As the target year for the MDGs approaches, there is need to re-activate Africa's leadership to avoid reversing the gains made in HIV/AIDS, TB, and Malaria control. AWA is therefore envisioned as an African-led advocacy and accountability to accelerate continental action to combat the triple scourges during 2012-2015 and beyond; and to ensure that important political commitments made to date are immediately turned into visible action. Therefore, it was deemed necessary to revitalize AWA because:

i. There is proof that top political leadership and commitment are paramount in building and sustaining action to defeat HIV/AIDS, TB, and Malaria in Africa;
ii. AWA has the ability to directly leverage all African Heads of State and Government;
iii. AWA Action Committee potentially has the power to build viable and fruitful partnerships, and to mobilize resources at national and international levels;

iv. Different partners have always been and are still ready to support and collaborate with AWA. Full advantage should be taken of this goodwill and solidarity spirit.

IV. OBJECTIVES OF AWA

The main objectives of AWA include the following:

i. To re-mobilize and sustain high level leadership and commitment in the fight against HIV/AIDS, TB and Malaria;
ii. To promote national level ownership (by governments, the private sector, and civil society) and ensure self-sufficiency by African countries in efforts to combat HIV/AIDS, TB, and Malaria;
iii. To mobilize resources, both domestic and international to implement HIV/AIDS, TB, and Malaria commitments; as well as resources for AWA programme and activities;
iv. To facilitate accountability by member states for measurable results to ensure that people-level impact is achieved;
v. To keep HIV/AIDS, TB and Malaria high on Agendas at all levels, facilitate continental and country decision-making process and disseminate information widely to galvanize action to achieve the MDGs by 2015.

V. FUTURE STRATEGIC DIRECTION OF AWA

To reflect the changing environment in which AWA revitalization will operate, the following future strategic directions were approved:

i. Institutionalization of AWA: this will be consolidated within the AUC through the annual Meeting of the Action Committee of Heads of State and Government (HS. AWA is linked to the AU Conference of Ministers of Health, and other African mechanisms for follow upon the implementation of MDGs.

ii. Integration of HIV/AIDS, TB, and Malaria Efforts: AWA's mandate was broadened to include HIV/AIDS, Tuberculosis, and Malaria, in order to seek synergies between the combined efforts which are underway, in line with the *2006 Abuja Call for Accelerated Action towards universal Access to HIV/AIDS, TB and Malaria Services*.

iii. AWA Continent-wide Representation: AWA membership has been extended from 08 to 21 members comprising the Action Committee. However, it is proposed that all AU Heads of State and Government join AWA, and each AU Region to have one champion to spearhead action in the region.

iv. Establishing Strategic partnerships: Strong partnerships have been the cornerstone of the achievements of the response to HIV/AIDS, TB and Malaria. Therefore, AWA will expand and further develop partnerships with Member States, Regional Economic Communities (RECs) and Regional Health Organizations (RHOs), the UN family and other international organizations, donors, private sector and civil society.

v. **Strategic Initiatives to Accelerate the Implementation of Continental Commitments on HIV/AIDS, TB and Malaria:** AWA will contribute to the follow up and reporting on the implementation of "Abuja Call" and other commitments on health and development in Africa, including development of the 2nd issue of the Progress Report, *"Scoring Africa's Leadership for Better Health"*. AWA also will lead in Africa's response to global commitments on HIV/AIDS, TB and Malaria: Declaration of Commitment on AIDS, Global Action Plan on Roll Back Malaria 2010-2015, and Global Action Plan to

VI. AWA IMPLEMENTATION STRUCTURE

The approved AWA Structures is as follows:

i. AWA Heads of State and Government Action Committee comprises 21 members (full list in AWA Revitalization Concept Document), plus the AU Commission Chairperson. It is chaired by the current AU Chairperson, and is open to more membership. Its roles include:
   - To consider annual progress on action plans, and approve prioritized action agenda(s) for AWA at its annual Meeting; and
   - To report and recommendations to regular AU Assembly of Heads of State and Government on progress in control of AIDS, TB and Malaria in Africa;
   - Sustain high level advocacy at any available opportunity at national, regional and international level, to keep HIV/AIDS, TB and Malaria high on National and International Agendas
   - To mobilize local and international resources.

As for other high level meetings of AU organs, executives heads of partner agencies will be invited to attend Action Committee Meetings as observers.

ii. The AWA Consultative Experts Committee comprising at least 25 Member State senior experts (*21 AWA member states + current chair of AU which is also AWA chair + country hosting summit or particular AWA meeting + current chair of the AU Conference of Ministers of Health*) will serve a 3-year term or as applicable, then rotate. The Committee will be chaired by the representative of the member State chairing the AWA. Member States should nominate one or more representative(s) conversant with and experienced in the response to the AIDS, TB and Malaria. The roles of this Committee include:
   - To generate an action agenda and documentation for consideration by the AWA Heads of State and Government Action Committee.
   - To conduct advocacy and network partners in and outside Africa, and
   - To follow up on the recommendations of the AWA Action Committee, including advocacy.

Representatives of AU organs, regional and international as well as civil society organisations and the private sector will be invited to all AWA meetings as Observers.

iii. AWA Secretariat as established in the AUC Department of Social Affairs will coordinate the activities of AWA and advocacy by the Action Committee. It will also work in close collaboration with member States, other AUC Departments and organs, as well as regional and international partners.

Phases for Future Direction AWA 2012-2015 (Activities in Implementation Plan)

- The Secretariat will develop an AWA Action Plan annually.

Phase I: 2012 – Initial Phase (Revitalization: Setting Up Structures and Sensitization)
Phase II: 2013 – Consolidation (sensitization and advocacy for action and resources)
Phase III: 2014 – Advocacy and Accountability (review of status of implementation of MDG 6 and continental commitments)