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AFRICA'S COMMON POSITION TO THE UN GENERAL ASSEMBLY SPECIAL SESSION HIGH-LEVEL MEETING ON AIDS (JUNE 2016)

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We, African Ministers of Health, meeting on sidelines of the World Health Assembly ……., under the theme "…", and considered …Continental policy guidance for AIDS and health;

RECALLING AND EMPHASIZING the highest level commitment shown by Africa's Heads of State and Government to fight the AIDS Epidemic including the following:

- the Decision **Assembly/AU/Dec.395(XVIII)** on the Revitalisation of AIDS Watch Africa as the highest continental-level advocacy, resource mobilisation and accountability platform for AIDS, TB and Malaria (Jan 2012);

- the Decision **Assembly/AU/Decl.2. (XIX),** that endorsed the African Union Roadmap for Shared Responsibility and Global Solidarity for AIDS, Tuberculosis (TB) and Malaria Response (2012-2015) which was extended to 2020 by **Decision Assembly/Au/14(XXV);**

- the Declaration of the 2013 Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria, aptly titled **"*Abuja Actions Toward the Elimination of HIV and AIDS, Tuberculosis and Malaria in Africa by 2030*";**

- the Decision **Assembly/AU/Dec.503(XXII)** adopting the Common African Position (CAP) on the Post-2015 Development Agenda (Jan 2014) which includes 'Ending the epidemics of AIDS, TB and Malaria' by 2030 under the Pillar III on People-Centred Development; the 50th Anniversary Solemn Declaration that requested the development of Africa's Agenda 2063 (2013) as the overarching vision for the continent, and its subsequent adoption (June 2015);

- the Decision **Ex.CL/Dec. 883(XXVII)** on the Report of the Commission on the development of the first ten-year implementation plan for Agenda 2063; read with Decision **Assembly/AU/4(XXV)Rev.1** of the Sandton Ministerial retreat of the Executive Council on the First 10-year implementation plan of Agenda 2063 adopted in June 2015;

- the Decision on the Report of the AIDS Watch Africa (AWA) **Assembly/Au/14(XXV)** of Heads of State and Government that requested "the Commission working with NEPAD Agency in consultation with Member States and development partners to develop a "Catalytic Framework" detailing milestones towards ending the epidemics of AIDS, TB and malaria in line with the Abuja +12, 2030 target";

- consequently through a consultative process the African Union Commission and partners developed the Catalytic Framework to end AIDS, TB and Malaria by

2030 with a business model, strategic approaches and implementation plan with key targets and milestones;

- This joint Ministerial Meeting to consider and adopt the 'Catalytic Framework' together with the Africa Health Strategy and other continental health policy instruments.

ACKNOWLEDGING that Africa has made remarkable progress in the AIDS response:

- The world achieved the UNGA Political Declaration Target of having 15 million people on treatment by 2015, nine months ahead of schedule, with **10.7 million people on ART** in Africa, up from fewer than 100,000 in 2002. As a result, AIDS-related deaths **decreased by 48%** between 2005 and 2014;

- New HIV infections in Africa **declined by 39%** between 2000 and 2014, and since 2009, there has been a **48% decline** in new HIV infections among children in the 21[1] Africa priority countries of the Global Plan;

- TB-related deaths in people living with HIV have **fallen by 36%** since 2004.

- Political will, leadership, ownership and accountability, evident in the National Strategic Plans (NSPs) in Africa has led to significant sustainability.

CONCERNED that despite the progress, the AIDS epidemic is ***NOT OVER YET*** *and that:*

- At the end of 2014, there were **25.8 million** people living with HIV in Africa South of the Sahara. Approximately **800,000** people died of AIDS-related causes in Africa south of the Sahara in 2014. TB remains the leading cause of death among people living with HIV;

- In 2014, there were an estimated **1.4 million** new infections, approximately **70%** of the global total of new infections. New infections have not declined fast enough in recent years, facilitated by the insufficient scale of prevention programmes and inadequate investments;

- **Young people, women and girls on the continent are disproportionately infected** with and affected by HIV, and violence against women and girls, especially in conflict and post conflict situations, has led to the feminisation of the HIV epidemic in Africa;

[1] Angola, Botswana, Burundi, Cameroon, Chad, Côte d'Ivoire, the Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Uganda, the United Republic of Tanzania, Swaziland, Zambia and Zimbabwe.

- **Stigma and discrimination remain key barriers to access to services** in Africa, and addressing HIV and human rights is critical in ensuring that no one is left behind in accessing HIV services;

- Progress continues to be undermined by various factors such as **weak health systems** including inadequate human resources for health, weak drug and commodity supply chains, insufficient quality control, inadequate integration of HIV services with tuberculosis, MNCH, Hepatitis C, Cervical Cancer and other health and development services;

- With **11.5 million** people on the continent receiving ART as of June 2015, the number of people receiving ART will need to roughly double to at least 21.1 million to reach the 90-90-90 target, and reach 25.8 million to treat everyone living with HIV as recommended by the 2015 WHO guidelines;

- While much progress has been made in financing the AIDS response, the resources required for the AIDS response all African countries will need to increase to a projected **US$12.2 billion** by 2020, then gradually decrease to **US$10.8 billion** by 2030 if Fast-Track targets are met;

- **FURTHER CONCERNED** that the progress achieved is very fragile and complacency will lead to backtracking on many of the gains made over the last decade:

- The next five years provide a fragile window of opportunity to Fast-Track the AIDS response and empower people to lead dignified and rewarding lives;

- That not rapidly implementing a Fast-Track Strategy to End the AIDS Epidemic will result in increasing number of new infections and deaths, and the resources needed to ultimately end the epidemic will escalate drastically;

- That many national responses remain highly dependent on external support, and are very vulnerable given the competition for resources from other global emergencies; and that predictable and sustainable health financing is a shared responsibility which cannot be achieved without global solidarity and collective effort;

- That if donors shift focus from the AIDS response at this critical juncture, and a transition between external and domestic funding is not managed well, this will result in programmes collapsing, patients being taken off treatment, and a bigger rebound of AIDS-related deaths and new HIV infections;

- That while the SDGs are broad and comprehensive, without spreading resources to high impact areas will reverse the gains achieved in the AIDS response. Ending AIDS will be a shared triumph for several SDGs, including but not limited to SDG 1 on ending poverty; SDG 3 on good health and well-being; SDG 5 on gender equality and women's empowerment; SDG 8 on economic growth; SDG

10 on reduced inequalities; SDG 16 on just, peaceful and inclusive societies and SDG 17 on global partnerships.

WELCOMING AND ACKNOWLEDGING *that* the United Nations General Assembly High-Level Meeting on AIDS to be held from 8 to 10 June 2016:

- Provides the platform to develop a Global Compact on Ending AIDS by 2030, including the Fast-Track actions required to succeed, measurable targets and milestones, and the requisite financial commitments;

- Is a critical moment to shape and catalyse the final race to end AIDS as a public health threat by 2030; that the HLM is an opportunity to define not just responsibilities of countries but of donors, civil society, the private sector as well as other stakeholders;

- That the new UNAIDS Strategy "On the Fast-Track to End AIDS" endorsed by all, including Africa, can serve as the basis of the High Level Meeting Political Declaration;

- Mindful that Africa still shoulders the biggest AIDS burden, the Catalytic Framework alongside disease specific global strategies places Africa on a distinct pathway towards ending AIDS by 2030.

FURTHER WELCOMING that Africa has played its part in shaping global declarations:

- That as the continent most affected by the AIDS epidemic, Africa led the mobilisation for, and the Outcomes of the prior HLMs though the Abuja Declaration in 2001, the Abuja Call in 2006, and in 2011, a highly consultative process converged in Windhoek, Namibia, where the 5th Conference of African Ministers of Health agreed on the Africa's Common Position to the HLM whose targets shaped the 2011 UNGA Political Declaration; and

- That the Common African Position for the Post-2015 Development Agenda (2014) was an impactful contribution to the Sustainable Development Goals and Targets adopted by the UNGA in 2015.

To this end, ***WE RECOMMEND***:

To African Union Member States

I. Political Declaration Negotiations and Africa Specific Targets

a) Negotiate as an undivided block, highly impacted by HIV and AIDS, and demand a Political Declaration that commits to bold strategies that aim to End the AIDS Epidemic as a Public Health Threat by 2030;

b) Commit to a Political Declaration that has global targets and strategies, as well as Africa-specific targets;

c) *Propose that these overall Targets for Africa, in alignment with the AU Catalytic Framework, are to:*

- *Reduce AIDS-related deaths to less than 375,000 per year by 2020, and less than 150,000 per year by 2030;*
- *Reduce new HIV infections to less than 375,000 per year by 2020, and less than 150,000 per year by 2030[2];*
- *End HIV-related Discrimination by 2020.*

II. Maximising the Impact of Treatment and Fast Track Strategy

a) *Advocate for and implement programmes to achieve 90-90-90 by 2020 i.e. 90% of PLHIV know their status; 90% of PLHIV who know their status are on ART; 90% of PLHIV on ART have suppressed viral load, all by 2020. Advocate for 95-95-95 by 2030;*

b) *Commit to have, by 2020, at least one million[3] children living with HIV on treatment and virally suppressed, through integrating HIV and MNCH services, increasing point of care diagnostics, expanding case-finding outside PMTCT settings, adopting innovative systems to track mother-baby pairs through the continuum of care, increasing and improving adherence counseling for children, mothers and caregivers, scaling up of viral load testing, and disaggregating treatment data by age.*

III. Stopping new HIV infections

a) *Commit to achieve and sustain, by 2020, a final mother-to-child HIV transmission rate of under 5%, leading to under 40,000 new HIV infections among children, and take steps towards achieving WHO certification of elimination of mother-to-child HIV transmission, while keeping mothers alive and healthy;*

b) *Target to have 90% of men and women accessing HIV combination prevention and SRH services, including access to 8 billion condoms annually and Pre-Exposure Prophylaxis (PrEP) as needed,[4] and voluntarily medically circumcising 25-27 million additional men in high prevalence settings;*

c) *Strive to achieve 90% of young people empowered with skills to protect themselves from HIV, including through youth-driven interventions, and 90% of key populations accessing HIV combination prevention services;*

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[2] There were approximately 1.5 million new HIV infections in 2010 in Africa, and approximately 1.5 million deaths as well. 2020 Target calculated as Reducing AIDS-related deaths and new HIV infections to less than 25% of 2010 baseline levels, and 2030 Target as less than 10% of baseline levels.

[3] Based on reaching 95% coverage of antiretroviral treatment for pregnant women, and 90*90*90 targets for children's treatment, by 2020.

[4] Estimates suggest Africa will about 2 million people to be on Pre-Exposure Prophylaxis each year

d) *Innovate in the use and scale-up of testing initiatives such as home testing and rapid point-of-care diagnostics, and use social media and mobile technologies to reach populations left behind; work with partners to scale up and accelerate the development and testing of vaccines, female-controlled methods with male involvement, microbicides and other prevention tools such as post exposure prophylaxis.*

IV. Leave No-one Behind – Human Rights, Gender and Social Protection

a) *Establish legal, political and social environments that enable effective HIV responses — including through protective laws, supportive law enforcement and access to justice- — to end all discrimination towards people living with HIV and other key populations, including in health, education and workplace settings.*

b) *Resource interventions that empower women and girls and engage communities to reverse harmful gender norms, ensure universal access to sexual and reproductive health and reproductive rights,[5] address violence against women and girls, and ensure 90% of women and girls live free from gender inequality and gender-based violence to mitigate risk and impact of HIV.*

c) *Ensure PLHIV and households affected by HIV are addressed in social protection strategies so that 75% of PLHIV and at risk or affected by HIV, who are in need, benefit from HIV-sensitive social protection.*

d) *Provide services to the people affected by conflict and humanitarian emergencies to help guarantee that no one is left behind, including addressing the vulnerability of women in conflict and post-conflict situations.*

e) *Take urgent steps to improve the quality, coverage and availability of disaggregated data and use new innovative tools such as location risk analysis to identify underserved and overburdened populations, gaps in community and health systems and areas needing service saturation, to ensure that no one is left behind.*

V. Sustainable Financing for the HIV Response

a) *Drawing on principles of Shared Responsibility and Global Solidarity, significantly increase domestic resources for the AIDS response including but not limited to meeting the Abuja Declaration target of allocating at least 15% of national budget for health, and exploring and implementing innovative financing mechanisms in partnership with the Private Sector and other stakeholders;*

[5] Language used in June 2015 Declaration **Assembly/AU/Decl.1(XXV)** Declaration on 2015 year of women's empowerment and development towards Africa's agenda 2063.

b) *Call on international partners to sustain global solidarity and continue to support international funding mechanisms such as the Global Fund to Fight AIDS, TB and Malaria, PEPFAR and others; with the target of a total investment of US$20 billion[6] for the AIDS response in Africa by 2020;*

c) *Improve use of strategic information for enhancing efficiency and effectiveness of health and AIDS interventions, accountability and maximise impact.*

VI. Strengthening Health Systems to achieve treatment and prevention targets

a) *Reinvigorate efforts to address the health workforce crisis and build sustainable health systems, through implementing existing commitments and strategies regarding human resources for health towards the global mobilisation to end the AIDS epidemic and achieve the broader health-related ambitions enshrined in Sustainable Development Goal 3 and Agenda 2063 Aspiration 1, Goal 3;*

b) *Rapidly scale up efforts to build a robust and expanded community health workforce, fully integrated into comprehensive inter-disciplinary service delivery teams and financially compensated, trained, equipped with mobile technologies, supported and supervised. Volunteerism should also be welcomed, where appropriate, as an additional element of efforts to strengthen community systems;*

c) *Identify multi-disease strategies and chronic care models applicable to other chronic conditions, including prevalent non-communicable diseases, and exploit synergies between the HIV response and efforts to achieve the Sustainable Development Goals, including scaling up efforts to address HIV and TB co-infection, leveraging the AIDS response to improve maternal, child and sexual and reproductive health outcomes, and integrating HIV-related services into the broader health and development agenda.*

VII. Access to affordable and quality assured medicines, commodities and technologies

a) *Continue advocating for more affordable, quality assured, more resilient, less toxic, longer-acting and easier-to-use drug regimens, including timely development and availability of the most efficacious and ARV formulations suitable for children as well as more effective treatment for common co-infections such as TB, STIs and Hepatitis;*

b) *Make full use of the provisions and flexibilities in the Agreement on the Trade Related Aspects of Intellectual Property Rights (TRIPS) and Public Health, and enhance access to all essential medicines at affordable prices.*

[6] Figure includes both domestic and international financing

c) *Commit to bolster the pharmaceutical industry in African countries by harmonising highly heterogeneous and wide ranging quality standards and regulations to which firms adhere;*

d) *Prioritise building in-country essential skills in manufacturing and management through technology transfers and south-south and north-south cooperation;*

e) *Significantly strengthen involvement of the Regional Economic Communities (RECs) as regional platforms for information sharing and for implementing the AU Model Law[7]. This includes enforcement of standards and capacity and promoting greater regional legislative harmonisation and implementation of common registration systems.*

VIII. Leadership and Mutual Accountability

a) *Commit to an all-inclusive and accountable leadership that ensures integration of HIV into national development instruments and create space for national debate on priorities, strategic investments, social protection and legal measures;*

b) *Focus and re-energise commitment to ending AIDS at all levels of leadership and strengthen mechanisms for coordination, decentralisation, setting or revising HIV-targets and further improving monitoring, evaluation and reporting;*

c) *Actively support and strengthen the capacity of national institutions and community systems to mount multi-sectoral, evidence-informed and rights-based responses.*

AU Commission, Regional Economic Communities and Regional Health Organisations

a) *Proactively advocate for accelerated implementation of the Business Plan for the Pharmaceutical Manufacturing Plan for Africa to advance local production of medicines and other commodities, bulk purchasing, transfer of technologies and development of traditional medicine;*

b) *Continue processes for the establishment of the Africa CDC, and monitor progress towards ending AIDS as one of the core achievements.*

International Development Partners

a) *Meet fair-share commitments to reach investment needs through long-term, predictable financing commitments;*

[7] African Union Model Law on medical Products Regulation and Harmonisation in Africa

b) *Enhance the implementation of the Paris Declaration on Aid Effectiveness and the Accra Agenda, and align to national priorities, policies, plans, frameworks and reporting systems while sustaining commitments to reach investment needs through long-term, predictable financing.*

We hereby mandate the Chair of the 1st Working Group of the Specialised Technical Committee on Health, Population and Drug Control and the Chairperson of the African Union Commission to:

- Transmit this Common Africa Position to the President of the General Assembly and Co-Chairs of the United Nations General Assembly High-Level Meeting on AIDS in June 2016 in New York.