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FIVE-YEAR REVIEW OF THE ABUJA CALL FOR ACCELERATED ACTION TOWARDS UNIVERSAL ACCESS TO HIV/AIDS, TUBERCULOSIS, AND MALARIA SERVICES BY 2010

PROGRESS REPORT (2006-2010)

TABLE OF CONTENTS

ABBREVIATIONS

ACT	Artemisinin-based combination therapy
AFRO	WHO Regional Office for Africa
AIDS	Acquired Immune Deficiency (or Immunodeficiency) Syndrome
ART	Antiretroviral therapy
ARVs	Antiretroviral drugs
AU	African Union
CAR	Central African Republic
CEMAC	Communauté Economique et Monétaire de l'Afrique Centrale
CPT	Cotrimoxazole preventive therapy
CSWs	Commercial sex workers
CTX	Cotrimoxazole
DOT	Directly observed treatment
DOTS	Directly observed treatment strategy
DRC	Democratic Republic of Congo
DST	Drug susceptibility testing
ECOWAS	Economic Community of West African States
GDF	Global drug facility for tuberculosis
GFATM	Global Fund to fight AIDS, Tuberculosis, and Malaria
GLC	WHO's green light committee
HHA	Harmonization in Health for Africa initiative
HIS	Health information systems
HIV	Human Immune-deficiency Virus
HIVDR	HIV drug resistance
HSSP	Health sector strategic plan
HTC	HIV Testing and Counseling
IDB	Islamic Development Bank
IPT_p	Intermittent preventive treatment during pregnancy
ITNs	Insecticide treated nets
LLINs	Long-lasting insecticidal nets
MDGs	Millennium Development Goals
MDR-TB	Multi-drug resistant tuberculosis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PITC	Provider initiated HIV testing and counseling
PMI	United States President’s Malaria initiative
PMTCT	Prevention of mother to child HIV transmission
RBM	Roll Back Malaria
RDTs	Regional directors' teams
SADC	Southern Africa Development Community
SME	Surveillance monitoring and evaluation systems
TB	Tuberculosis
TSS	Task shifting strategy
UA	Universal access
UNAIDS	United Nations Joint Program for AIDS
UNGASS	United Nations General Assembly's special session on HIV/AIDS
UNICEF	United Nations Children’s' Fund
UNITAID	International facility for purchase of drugs for HIV/AIDS, tuberculosis,
VCT	Voluntary counseling and testing
WBB	World Bank booster program
WHO	World Health Organization
XDR-TB	Extremely drug resistant tuberculosis

EXECUTIVE SUMMARY

The primary objective of the 2000 and 2001 Abuja Declarations and Frameworks for Action adopted by AU Heads of State and Government on Malaria, and on HIV and AIDS, TB and Other Related Infectious Diseases respectively was to urge Member States to undertake action to arrest and reverse the staggering rate at which these diseases were eroding progress in socio-economic development in Africa at the turn of the century. The Abuja Declarations and subsequent commitments stimulated sharp increase in resource mobilization and the scale up of programs to fight these diseases in Africa. In early 2006, additional momentum was provided by the emerging international consensus on Universal Access as a means to attain Millennium Development Goal 6 and other health-related Millennium Development Goals (MDGs).

This culminated in the adoption of the "Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services in Africa" and related commitments at the Special Summit which was held in Abuja in May 2006 under the theme: "*Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by 2010*". The main objective of the Special Summit was to review the status of implementation of the Declarations and Plans of Action on the 2000 Abuja Summit on Roll Back Malaria (RBM) and the 2001 Abuja Summit on HIV/AIDS, TB and Other Related Infectious Diseases (ORID).

The combined burden and socio-economic impact of the HIV/AIDS, tuberculosis, and malaria epidemics in Africa has been massive. Tuberculosis (TB) is the leading cause of death in people living with HIV, due to the high HIV/TB co-infection. Malaria threatens a disproportionately high percentage of the population in Africa, with about 350 million episodes annually.

HIV/AIDS, tuberculosis and malaria undermine productive capacities of populations, perpetuate poverty, exacerbate social problems and overwhelm health services and contribute to a reversal in the health status of Africans, and threaten the development gains made in previous years.

Since 2006, significant progress has been made by Member States towards universal access to health services in general and HIV/AIDS, tuberculosis, and malaria in particular. There is clear continental and international political will and commitment to achieve universal access and the health-related Millennium Development Goals by 2015.

In spite of the commendable progress made, this is still insufficient to attain the Abuja target of universal access to HIV/AIDS, Tuberculosis and Malaria services by 2010. The '*final push'* towards universal access should be advanced through intensified implementation of national programmes with the support of the UN

system and international partners, further mobilization with more rational use of resources, and better harmonization and coordination of partnerships at national, regional and continental levels.

Reducing the impact of the three diseases would significantly propel efforts to achieve, not only MDG 6 and other health related MDGs, but also development goals related to women's and children's rights to health, education, nutrition and equality, as well as the reduction of extreme poverty.

This Report therefore represents a summary of the progress made by Member States since 2006 towards the implementation of the “Abuja Call”, under its priority areas. (Moved from Para 2)

INTRODUCTION

Background

1. In the wake of the September 2000 Millennium Summit, the leaders of African Union Member States assembled in Abuja, Nigeria in 2000 and 2001, and adopted the Abuja Declarations and Frameworks for Action on Roll Back Malaria, and on HIV and AIDS, tuberculosis and other related infectious diseases. The primary objective of the Abuja Declarations and Frameworks was for Africa to collectively and individually work towards arresting and reversing the staggering rate at which these diseases were eroding prior progress made in socio-economic development. This high-level commitment marked a turning point in the continental response to these three diseases. The 2001 Declaration and Framework for Action also comprised Africa's Common Position to the 2001 United Nations General Assembly Special Session (UNGASS) on HIV and AIDS, which resulted in the landmark UN Declaration of Commitment on HIV and AIDS and also led to the establishment of the Global Fund to fight AIDS, Tuberculosis, and Malaria.

2. This commitment was reinforced on multiple occasions at the continental level:

- The AU Conference of Ministers of Health adopted the Gaborone Declaration on Sustainable Access to Treatment and Care for the Achievement of the Millennium Development Goals (Gaborone, October 2005);

- Ministers of Health of the WHO Regional Committee for Africa declared tuberculosis an emergency, and called upon Member States to implement *"urgent and extraordinary actions"* to bring tuberculosis under control (Maputo, August 2005);

- AU Member States adopted the Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS prevention, treatment, care and support in Africa by 2010 (March 2006)
- The AU, WHO, UNAIDS, UNICEF, ECA and other partners launched the campaign on: 2006 as the year for accelerating HIV prevention under the theme: "*Step Up the Pace for HIV Prevention in Africa*".
- The AU Conference of Ministers of Health adopted the Johannesburg Declaration on Strengthening of Health Systems for Equity and Development in Africa" April 2006.

3. These commitments stimulated a sharp increase in resources and the scale up of programs to fight these diseases in Africa. However, it quickly became clear that much more needed to be done to achieve Millennium Development Goal 6. Momentum gathered towards an ambitious new target – universal access – that would pave the way to achieving Millennium Development Goal. In May 2006, the Special Summit on HIV and AIDS, Tuberculosis and Malaria in Abuja, reviewed continental progress towards the commitments made in the 2000 and 2001 Abuja Declarations and African leaders made a new collective commitment under the "*Abuja Call for Accelerated Action towards Universal Access to HIV and AIDS,*

Tuberculosis and Malaria Services in Africa". Other commitments included Africa's Common Position to the UN General Assembly High Level Meeting on HIV and AIDS, which endorsed the target of universal access to HIV prevention, treatment, care and support services for all who need it by 2010.

4. The main objective of the 2006 Special Summit was to review the status of implementation of the Declarations and Plans of Action on the 2000 Abuja Summit on Roll Back Malaria (RBM) and the 2001 Abuja Summit on HIV/AIDS, TB and Other Related Infectious Diseases (ORID). The Abuja Call has the following priority areas to guide related action: Practical Leadership at National, Regional and Continental levels; Resource mobilization; Protection of Human Rights; Poverty Reduction, Health and Development; Strengthening Health Systems; Prevention, Treatment, Care and Support; Access to Affordable Medicine and Technologies; Research and Development; Implementation; Partnerships whereby the roles of each stakeholder were clearly spelt out; and Monitoring Evaluation and Reporting.

5. In accordance with the Abuja Call, regular progress reports on implementation are prepared and reviewed by the African Union policy organs. As requested the AU Commission, with the support of the United Nations, developed this five-year Progress Report on the Abuja Call for Accelerated Action towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa by 2010.

Mandate

6. In the "Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa" the African Union Commission was mandated in collaboration with Development Partners to:

- Prepare a biennial Progress Report for consideration by Inter-Ministerial Committee Members of AU Member States;
- Submit a biennial Progress Report on the status of implementation to the AU Executive Council and Assembly of Heads of State and Government.
- Undertake consultative review at five years (2010) on the status of the implementation of the 2006 Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services by 2010; and of the MDGs.

Purpose

7. The purpose of this report is to present progress made by Member States since 2006 towards the implementation of the "Abuja Call". The report covers the progress for HIV and AIDS, Tuberculosis, and Malaria programs under the priority areas as identified in the Abuja Call. The report once adopted by the AU Ministers of Health, and endorsed by the Executive Council and the Assembly of Heads of State and Government, will be a framework for further continental efforts in the fight against these diseases. It will also contribute to Africa's Common Position to the United Nations Summit on the Millennium Development Goals in September 2010, review of the end-of-decade of Roll Back Malaria and other forums.

Methods

8. The primary sources of data for this report include:

- ✓ 2008 and 2009 Progress Reports on the status of implementation on the Abuja Call to the AU organs, which were based on annual country reports on the three diseases.
- ✓ Biennial country progress reports for the United Nations Declaration of Commitment on HIV and AIDS and annual country reports for monitoring the health sector response towards Universal Access for HIV prevention, care, and treatment from 52 African Union Member States. This data has been validated and reconciled with other global reporting mechanisms, such as PEPFAR, UNAIDS, and UNICEF databases.
- ✓ For tuberculosis, WHO collects information on tuberculosis control program performance indicators from member countries using a standard tuberculosis data collection form on which countries voluntarily specify control policies and implementation of strategies, case finding activities, population coverage and access to services, and treatment outcomes for various forms and types of tuberculosis.
- ✓ Apart from reporting on tuberculosis case details for the year under review, Member States also updated information for specified previous years where possible, which was used to produce this status report.
- ✓ For malaria, the main sources of data are questionnaires received from 43 malaria-endemic countries whose data have contributed to the 2009 World Malaria Report, other published and unpublished reports as well as data that has been reviewed, summarized and synthesized to give an overall picture of the malaria situation in Africa, and that allows for comparison across AU Member States.
- ✓ Global and regional reports on HIV and AIDS, tuberculosis, and malaria received from UNAIDS, WHO, the AFRO Region, the Stop TB Partnership, Rollback Malaria, and other partners, which are again based on country reports.

SITUATIONAL ANALYSIS

9. The combined burden and socio-economic impact of the HIV and AIDS, tuberculosis, and malaria epidemics in Africa has been massive. Tuberculosis is the leading cause of death in people living with HIV, due to the high HIV co-infection. Malaria threatens a disproportionately high percentage of the population in Africa, with about 350 million episodes annually.

10. HIV and AIDS reduce GDP growth in Africa by an estimated 0.5% and 2.6% annually. In countries with a high prevalence of tuberculosis, economic loss is estimated at between 4% and 7% of GDP annually. Due to the high prevalence of malaria in the past 30 years, Africa's GDP lost as much as USD 100 billion. HIV and AIDS, tuberculosis and malaria undermine countries' productive capacities, perpetuate poverty, exacerbate social problems and overwhelm health services. Together, they account for 75% of Disability Adjusted Life Years (DALYS) lost on the

continent, contributing to a reversal in the health status of Africans and threatening to undermine the development gains made in previous years.[1]

HIV and AIDS

11. Africa is the continent worst affected by HIV and AIDS, with the highest HIV prevalence concentrated in five countries in Southern Africa. In 2008, more than two million people in Africa became newly infected with HIV, bringing the total number of people living with HIV to over 22 million. While the rate of new HIV infections in most of Africa has slowly declined—with the number of new infections in 2008 approximately 25% lower than at the epidemic's peak in 1995—the number of people living with HIV in Africa increased slightly in 2008, in part due to increased longevity stemming from improved access to HIV treatment. North and West Africa have been least affected by HIV to date, although some countries in West Africa are experiencing rising HIV prevalence to as much as 5%. In 2008, an estimated 1.4 million AIDS-related deaths occurred in sub-Saharan, representing an 18% decline in annual HIV-related mortality since 2004. AIDS-related deaths in North Africa were estimated to be less than 20,000 in 2008. Since the epidemic began, more than 14 million children have lost one or both parents to AIDS. [2] HIV and AIDS is the leading cause of maternal mortality in high prevalence countries.[3] The epidemic has an enormous impact on households, communities, businesses, public services and national economies. Africa faces a triple challenge of scaling up prevention activities to reduce the number of new infections, providing adequate care and support to the growing population of people living with HIV, and ensuring adequate care for the millions of orphans and people affected by HIV.

Tuberculosis

12. In 2005, tuberculosis was declared an emergency across Africa in response to the rapid increase in new cases in recent years. Since 1990, the annual number of new cases has more than quadrupled in most African countries and continues to rise. Tuberculosis is the leading killer of people living with HIV in Africa. Although it has only 11% of the world's population, Africa accounts today for more than 25% of the global tuberculosis burden with an estimated 2.4 million tuberculosis cases and 540,000 tuberculosis deaths annually.[4]

13. In Southern Africa in particular, weak health systems and poor tuberculosis control, compounded by a spiralling HIV epidemic and endemic poverty, has resulted in multi-drug resistant tuberculosis, which dramatically increases treatment costs, duration of treatment, and lowers the chances of treatment success. Tuberculosis is estimated to deprive the world's poorest countries of an estimated $1 to $3 trillion over the next 10 years. In some countries, loss of productivity attributable to tuberculosis has been estimated to be as high as 7% of GDP.[5]

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[1] "The Impact of HIV/AIDS, Tuberculosis, and Malaria on the World of Work in Africa". African Union Commission, 2009.
[2] www.avert.org
[3] Lancet, April 2010.
[4] www.who.int
[5] www.who.int

Malaria

14. The vast majority of global malaria deaths – around 767 or 89% of malaria mortality globally - occur in African countries south of the Sahara, and mostly in young children. Malaria is Africa's leading cause of under-five mortality (20%) and constitutes 10% of the continent's overall disease burden. Malaria accounts for 40% of public health expenditure, 30-50% of inpatient admissions, and up to 50% of outpatient visits in areas with high malaria transmission and is estimated to cost Africa more than USD 12 billion every year in lost GDP, although the disease could be controlled for a fraction of this amount.[6] Despite commitments to eradicate malaria, most African nations lack the infrastructures and resources necessary to mount sustainable, effective campaigns.

15. One of the greatest challenges, in reaching RBM 2010 malaria control targets and MDGs faced by Member States today, is the effective containment of the spread of drug and insecticide resistance. Resistance to chloroquine, the cheapest and most widely used anti-malarial, is common throughout Africa. As a result, all malaria endemic many countries have changed their first line treatment policies to artemisinin-based combination therapies (ACTs). ACTs availability at no cost in public sector providers is increasing with funding from GFATM, UNITAID, World Bank Booster and the President's Malaria Initiative, albeit slowly; the Affordable Medicines Facility for malaria (AMFm) attempts to ensure availability of ACTs in private sector outlets at the price of chloroquine, a still widely available and consumed drug. But the appearance of artemisinin resistance, as has been already documented in South-East Asia, could become a real threat to malaria treatment in Africa. The greatest threat to the development and spread of resistance to artemisinin is the use of oral artemisinin-based monotherapies for the treatment of malaria. Despite a World Health Assembly resolution in 2007 calling for halting the marketing and use of these medicines, 16 countries in Africa still provide marketing authorization for them.

16. Modern malaria vector control is thoroughly dependent on pyrethroids. They are the only class of insecticides currently available to treat nets. Pyrethroids are also used in large quantities for the indoor residual spraying of houses. However, various pyrethroid resistance mechanisms are now evolving in African malaria vectors. The impact of these on the effectiveness of vector control is not yet well understood, but the threat of resistance is real and threatens to cancel vector control gains made to-date as no new classes of insecticide currently exist for the treatment of bed nets.

FINDINGS

LEADERSHIP AT NATIONAL, REGIONAL AND CONTINENTAL LEVEL

The primacy of national leadership and ownership as well as the alignment of development efforts around national priorities is enshrined in the provisions in the "Three ones Principles for Coordination and Harmonization of Programmes"; recommendations of the Global Task Team on Improving Coordination Among

[6] www.rollbackmalaria.org

Multilateral Institutions and International Donors, and the 2005 Paris Declaration and Accra Plan of Action on Aid Effectiveness. This reaffirms the central role of sovereign nations in their development efforts and the primary responsibility of national governments for the welfare of their citizens. These national efforts are supported through sub-regional, regional and global forums, which act as catalysts for collective action.

17. The African Union Commission (AUC) and Regional Economic Communities (RECs), with support from national and international partner agencies and organizations, have led these catalytic efforts since the Abuja Call was adopted in 2006.

CONTINENTAL LEADERSHIP

18. To better harmonize the continent's intensified efforts to combat HIV and AIDS, the African Union developed an HIV and AIDS Strategic Plan for 2005 – 2007, and the AIDS Watch Africa Strategic Framework, with four key objectives:

- ✓ Building the African Union (AU) leadership, accountability and advocacy,
- ✓ Promoting African and external stakeholder accountability to mitigate HIV/AIDS,
- ✓ Facilitating the harmonization of HIV and AIDS policies at the continental, regional, and national levels, and
- ✓ Mobilizing sustainable human and financial resources for a long-term AU response.

19. In 2007, the AU developed an implementation plan entitled "Accelerating Action and Responding to a Continental Emergency" for 2008 – 2010, in which the AUC committed to eight deliverables, including the development of a monitoring, evaluation and reporting framework, a process for coordinating and harmonizing efforts by RECs, Member States and partners, a campaign to address gender, youth, violence, and HIV, advocacy tools to improve access to services for vulnerable populations, the creation of an African Research Network for HIV and AIDS, tuberculosis and malaria, policy for regional cooperation on HIV and AIDS and conflict situations, a HIV and AIDS information and media strategy and an AU workplace program for mainstreaming of HIV and AIDS within the AUC.

20. In a further effort to assist Member States to harmonize their responses to combating diseases across the continent, the AU Conference of Ministers of Health adopted the Africa Health Strategy for 2007–2015, a framework whose goal is "to contribute to Africa's socio-economic development by improving the health of its people and by ensuring access to essential health care for all Africans, especially the poorest and most marginalized, by 2015."[7] The overall objective of this strategy is to strengthen health systems in order to reduce morbidity and accelerate progress towards attainment of the Millennium Development Goals in Africa. More specifically, it aims to assist in the strengthening of national health systems in Member States, to build stronger collaboration between health and other sectors to improve the socio-

[7] Africa Health Strategy: 2007 – 2015. African Union Commission, Addis Ababa, 2007.

economic and political environment for improving health and to facilitate the scaling up of health interventions by Member States and through regional and intergovernmental bodies.

21. In April 2007 in Johannesburg, at the 3rd Session of the AU Conference of Ministers of Health, the Campaign for Malaria Elimination in Africa was launched to supplement the acceleration of Malaria control efforts. Furthermore, the MDG Malaria Summit was held in New York under the theme: "World Leaders Unite" and participants announced new funding in excess of USD 3 billion committed to eliminating malaria mortality by 2015.

22. In October 2008, the Department of Social Affairs of the African Union Commission held the 1st Session of the AU Conference of the Ministers in charge of Social Development in Windhoek, Namibia with the theme: "Towards a Sustainable Development Agenda for Africa". At this conference, the AU's Social Policy Framework for Africa was adopted aimed at providing an overarching policy structure to assist African Union Member states in the development of integrated national social policies to promote human empowerment and development and serving as a coordination tool.

23. At the 64th United Nations General Assembly in September 2009, the African Leaders Malaria Alliance (ALMA) was adopted by all African Heads of State and Government. Dedicated to ending malaria deaths in Africa, the purpose of the Alliance is not only to provide a forum for high level, collective advocacy to ensure: efficient procurement, distribution, and utilization of malaria control interventions; the sharing of most effective malaria control practices and ensuring that malaria remains high on the global policy agenda, but also seeks to help coordinate issues of joint importance, such as procurement to better leverage the collective buying power of ALMA members. In addition, the "United Against Malaria" campaign was launched in Addis Ababa in November 2009, with the slogan, "United, We Can Beat Malaria", to ensure that no one suffers from Malaria during the July 2010 Football World Cup in South Africa.

24. To improve coordination and harmonisation of partnerships at regional and continental levels, Inter-Agency Meetings on HIV/AIDS, TB and Malaria Strategies were held in 2006 (Addis Ababa), 2008 (Abuja) and 2009 (Addis Ababa), bringing together the AU, Regional Economic Communities (RECs), Regional Health Organisations (RHOs), UN Agencies, CSOs and other international partners. This operates under the AU/UN Regional Coordination Mechanism (RCM). The 2009 Inter-Agency Meeting was held under the theme - *"Progress Towards Achievement of Abuja Call for Universal Access to HIV/AIDS, TB and Malaria Services by 2010: The Final Push for Action".* Important recommendations to guide partnerships and follow-up action were adopted.

REGIONAL AND NATIONAL LEADERSHIP

25. The East, Central, and Southern African Health Community (ECSA-HC) has contributed to the coordination and harmonization of policy, advocacy and program implementation to control HIV and AIDS, tuberculosis, and malaria among its Member States. Activities undertaken between 2005 and 2009 included

strengthening policies, strategies and protocols across all countries, technical assistance for expansion of prevention and treatment services, advocacy for an integrated approach to HIV and tuberculosis, HIV and reproductive health, development of a regional pharmaceutical strategy and harmonized standardized treatment guidelines for all three diseases.[8]

26. The Member States of the East African Community (EAC) are currently involved in coordinating drug regulatory and purchasing activities to resolve the challenges of high medicines prices, poor quality and other bottlenecks generally associated with the procurement and supply chains of essential medicines. The EAC Secretariat is building its capacity to support pooled regional procurement[9]. In addition, countries within the EAC are also finalizing a common HIV Prevention and Management Bill to establish minimum standards for HIV and AIDS services. This is particularly significant in that it takes into consideration cross border movement and the need for a uniform response to the HIV epidemic. The legislation is intended to provide a basic legal framework in countries where no HIV laws exist and to address disparities in HIV and AIDS responses across this region. Under the EAC Treaty, regional law supersedes national law.[10]

27. The Inter-Governmental Authority on Development (IGAD) Ministerial Committee on HIV and AIDS created the IGAD Regional HIV and AIDS Partnership Program (IRAPP) in 2007. Supported by the Africa Catalytic Growth Fund administered through the World Bank, with technical assistance from numerous UN agencies, this four year program aims to improve access to HIV and AIDS services for cross border and mobile populations and surrounding host communities, as well as to establish a common approach for scaling up of services and support to these populations amongst IGAD Member States. Preparatory activities took place in 2008, and activities to reach populations in need commenced in 2009.[11] IGAD has added this year malaria to their agenda.

28. Heads of State of the Southern African Development Community (SADC) signed the Maseru Declaration on HIV and AIDS in July 2003, in which they reaffirmed the need to address HIV and AIDS as an urgent priority and committed to collective action through the multisectoral strategies reflected in the SADC HIV and AIDS Strategic Framework and Programme of Action. Progress has been regularly reviewed at subsequent summits, the latest being in Kinshasa, DRC in September 2009. The SADC Secretariat is now a Principal Recipient of a Round 9 Global Fund grant focused on HIV prevention and treatment services for mobile populations in the region.

29. SADC has also undertaken initiatives to combat the considerable burden placed on its Member States from endemic malaria and tuberculosis, including some of the first MDR-TB to be identified on the continent. The Directorate of Social and Human Development and Special Programs support the provision of essential,

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[8] "Progress Report of the Implementation of Abuja Call for Action on HIV/AIDS, TB, and Malaria Activities in East, Central, and Southern African Region from 2005 to 2009", ECSA-HC; 2009.

[9] http://www.eac.int/health/index.php?option=com_content&view=article&id=52&Itemid=117

[10] "EAC Development Strategy 2006 - 2010", East African Community, 2006.

[11] "IRAPP Annual Report for 2009", IGAD Regional HIV/AIDS Partnership Program; January 2010.

affordable, good quality and safe medicines for all three diseases, for urban and rural communities. The Directorate further seeks to promote and increase the coordinated and sustainable participation of all stakeholders, including the private sector, in the provision of services.[12] In addition, SADC created a specific SADC malaria week.

30. In 2008, the Economic Community of West African States (ECOWAS),working jointly with UNAIDS and with funding from the Embassy of Norway, conducted an epidemiological analysis of its Member States to better understand the dynamics of and each country's governance of response to the HIV epidemic. Findings from this drove the development of a bold strategic plan on HIV to assist member States to improve their policies and strategies. ECOWAS also includes a support program on HIV and AIDS as one of its five priority programs in education. The program aims to foster sharing of experiences for those working in HIV and AIDS, promote learning at all levels of the educational system on life skills for HIV and AIDS, and to provide care for those affected by HIV and AIDS within the educational system. This initiative has received considerable political support from Member States as well as financial and technical support from the UN and other international partners. ECOWAS issued a resolution on malaria in 2009.

31. The Community of Central African States (ECCAS) formed an HIV and AIDS and Health Committee to increase understanding of the growing HIV and AIDS problem in this region, as well as to accelerate a coordinated response to this situation. With technical assistance from a number of international agencies, 28 representatives of the nine Member States in Central Africa convened to determine the feasibility of implementing a regional surveillance and monitoring system to better inform future HIV interventions, and to begin to develop a system suitable for the region.[13] The OCEAC, _ (Coordination Organization for the fight against endemic diseases in Central Africa) was mandated to develop and coordinate the implementation of the HIV and AIDS strategic plan 2006-2010, aimed at strengthening national AIDS responses within ECCAS.

32. Although the RECs have done a lot is the response to HIV/AIDS, they need to integrate Malaria and TB control together with general health and development programmes, especially where there are no corresponding RHOs.

RESOURCE MOBILIZATION

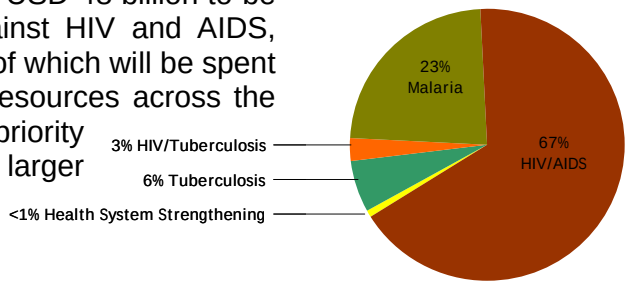
33. There has been a considerable increase in the available funding to fight HIV and AIDS, tuberculosis and malaria across Africa in the last five years. At the end of 2009, six AU Member States had reached the goal of allocating 15% or more of their national budgets to health as pledged in the 2001 Abuja Declaration, with just over half of all African countries reporting (26 out of 50), indicating that they had allocated 9% or more of their national budgets for health expenditures. Across these 50 Member States, national contributions to health as a percentage of total national expenditure averaged 8.7% in 2009, compared to nearly 15% and 17% in Europe and the Americas respectively. Average government per capita expenditure on health in Africa is only $27, far below the $1,250 to $1,350 per capita expenditures

[12] www.sadc.int
[13] www.cemac.cf

that occur in Europe and the Americas. Countries with higher government per capita expenditure on health alongside higher investment in initiatives such as clean water, sanitation and environment, nutrition, gender equity in health, and higher numbers of health workers distributed geographically utilize health resources more efficiently and have overall higher life expectancy.[14] But higher per capita investment in health alone is not enough.

34. To reduce debt burden to a manageable level in many Africa countries, 29 Member States have successfully negotiated debt reduction packages through the "Heavily Indebted Poor Countries" Initiative jointly managed by the International Monetary Fund and the World Bank.

35. The Global Fund for HIV and AIDS, Tuberculosis, and Malaria (GFATM) has mobilized over USD 11.5 billion in funding for Africa since 2002, while the US government recently authorized almost USD 48 billion to be used over five years in the fight against HIV and AIDS, tuberculosis, and malaria, the majority of which will be spent on the African continent.[15] Gains in resources across the continent are helping to scale up priority interventions, though a significantly larger amount of funding is needed to reach the Abuja targets.



HIV and AIDS

36. Since the adoption of the Abuja Call in 2006, significant increases in funding have been committed to the fight against HIV and AIDS in Africa. Domestic government spending in African countries south the Sahara has increased 32% from an estimated USD 986 million in 2006 to USD 1.3 billion in 2008. At the same time, domestic private spending has increased at a similar rate, from USD 247 million in 2006 to USD 327 million in 2008[16].

37. Despite this laudable increase in domestic spending, external funding has accounted for an increasingly large portion of the financial resources for HIV and AIDS in Africa, accounting for 75% of the total funding for HIV and AIDS programs in 2008, compared to 69% in 2006. Overseas development assistance for HIV and AIDS programs in countries south of the Sahara increased by 75% from USD 2.2 billion in 2006 to USD 3.9 billion in 2008[17]. The US Government and the Global Fund to Fight AIDS, Tuberculosis and Malaria were the largest contributors to this cause, with the remaining funds coming from other bilateral and multilateral donors.

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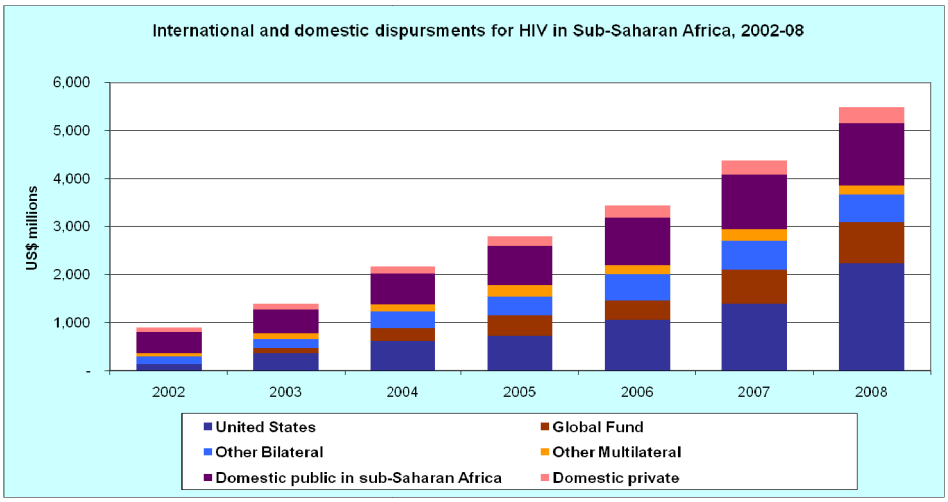
[14] "Scorecard on Health Financing in Africa" ***Africa Public Health Alliance & 15%+ Campaign*, 2009-2010.**

[15] "Progress Report on the Implementation of the Plans of Action of the Abuja Declaration", Division of AIDS, Tuberculosis and Malaria: World Health Organization Regional Office for Africa Brazzaville; 2009.

[16] Data compilation and analysis by UNAIDS Secretariat AIDS Financing and Economics Team, April 2010.

[17] Ibid.



38. Initiated in 2003, the United State's President's Emergency Plan for AIDS Relief (PEPFAR) provides funding to fight HIV and AIDS in numerous countries, including 15 focus countries, most of which are African. In 2009, PEPFAR allocated almost USD 6.5 billion for combating HIV and AIDS, tuberculosis, and malaria compared to less than USD 2.5 billion in 2007.[18] The World Bank Multi-Country HIV and AIDS Program for Africa has committed over USD 1.8 billion in 35 countries, including five regional projects addressing cross-border issues.[19]

39. In 2010, an estimated USD 13 billion is needed to adequately fund HIV and AIDS interventions in Africa. Of the total investments required, one third is for activities addressing behavioral change, social drivers of the epidemic, social mitigation and other services that are managed outside of the health sector through multisectoral programs. Another one third is aimed at strengthening health systems. The remaining one third will go towards HIV specific health services, such as programs to reduce mother-to-child HIV transmission, blood safety, and provision of antiretroviral therapy for those in need.[20]

[18] www.pepfar.gov
[19] www.worldbank.org
[20] "What Countries Need: Investments Needed for 2010 Targets", UNAIDS; 2009.

Tuberculosis

40. Funding for prevention and treatment of tuberculosis in Africa in 2009 was estimated to be just over USD 500 million compared to approximately USD 400 million in 2008, an increase of 25%.[21] While funding for tuberculosis has increased in recent years, and particularly in high burden countries in Africa, funding levels fall far short of what is required. Funding gaps reported by National Tuberculosis Programs (NTPs) since 2007 are larger than those reported during 2002–2006, as NTPs expand the range of interventions being planned in line with the Stop TB Strategy. In particular, funding for DOTS in Africa fell short of estimated need by about USD 200million in each year after 2007. Some countries continue to report funding gaps for first-line anti-tuberculosis drugs as well.[22]

41. While the majority of available funding was used to support DOTS implementation, the share for MDR-TB has increased since 2007. A relatively small amount of funding has been reported for collaborative TB/HIV activities reflecting the fact that funding for most of these interventions is channeled through national HIV programs and nongovernmental organizations, rather than via NTPs. Financing from the Global Fund has become increasingly important since 2004, while other donor funding has and will continue to rise in 2010.[23]

42. Greater support to tuberculosis programs is required to expand and strengthen laboratories services and improve community care to achieve and surpass the 70% target set for case detection rates in the Stop TB Plan, as well as to address the growing need for new medicines to fight drug resistant tuberculosis.

Malaria

43. Estimates for 2007 from the WHO World Malaria Report 2008 show that resources from endemic country governments in Africa account for 18% of the USD 622 million disbursed. The remaining disbursements came from international donors (notably The Global Fund 42%, the U.S. President's Malaria Initiative 20%, World Bank Booster Program 8%). Unfortunately, comparative data on household, government, and private institution spending on malaria in Africa remains insufficiently complete to allow a comprehensive analysis of trends. An important consideration however, is whether government financing for malaria remains stable, reduces or increases in the presence of large quantities of external financing. An analysis of 31 countries indicated that government expenditures had remained constant or slightly increased between 2004 and 2008.[24] Member States are also taking steps to assure that out of pocket spending on malaria is money well spent and that malaria prevention becomes more affordable by reducing or abolishing taxes and tariffs on the insecticides, nets and the materials used in their manufacture.

44. Of the 43 malaria endemic countries in Africa, 40 (93%) received external

[21] "Global Tuberculosis Control", World Health Organization; 2009.
[22] "Global Tuberculosis Control", World Health Organization; 2009.
[21] "Global Tuberculosis Report: A Short Update to the 2009 Report", World Health Organization; 2009.

[24] "World Malaria Report", World Health Organization; 2009.

funding between 2003-2009. During this interval, the total funding committed to malaria control in these countries reached almost USD 3.5 billion, the equivalent of USD 5.29 per person at risk in these countries.[25] Over the past five years, the malaria control landscape in malaria-endemic African countries has changed dramatically. Since 2004, malaria funding from the Global Fund has increased almost threefold and new funding mechanisms such as the World Bank's Booster Program and the U.S. President's Malaria Initiative have provided much-needed funding and implementation support for commodities in 15 of 47 African countries.[26]

45. In Africa, most of the malaria funding is directed to either prevention (42%) or treatment (38%) with the remaining 20% supporting program management and systems strengthening. Expenditures on LLIN and malaria drugs for treatment make up two-thirds of all expenditures; of note, expenditures on diagnostics have been quite low (roughly 2% of treatment costs) in relationship to expenditures on drugs.[27]

46. Scaling up malaria control to reach universal access enabling medium term elimination requires that national governments reach the 15% for health budget and retain their financial commitment, above and beyond time limited disease specific funding streams such as the global fund.

PROTECTION OF HUMAN RIGHTS

47. The AU Social Policy Framework adopted in 2008 states that HIV and AIDS, tuberculosis and malaria are symptomatic of deeper socio-economic and development problems and policies that seek to respond comprehensively to the pandemics through initiatives beyond the public health sector, such as the promotion of gender equality, should be of high priority. The AU Commission HIV and AIDS Workplace Policy issued in 2009, speaks directly to conditions at the work-place and provides a framework for enforcement of workers' rights and employers' responsibilities with respect to those living with HIV and AIDS.

48. There have been important efforts to reform the legal environment related to HIV in a number of African countries. These reforms have focused on non-discrimination in areas such as employment, education, housing, and access to health care. At the end of 2005, 16 of 29 reporting AU Member States (55%) had anti-discriminatory measures. Two years later, 28 of 42 reporting AU countries (67%) had such measures in place. Progress has been even greater regarding laws and regulations protecting most-at-risk and vulnerable populations. In 2005, only nine of 30 reporting AU countries (30%) had laws or regulations in place. By 2007, 33 of 43 reporting countries on the continent (77%) were providing legal or regulatory protection to at-risk groups.

49. Currently, four AU Member States still have some form of restriction on the entry, stay and residence of people living with HIV. Such restrictions have no public

[25] "Malaria Funding and Resource Utilization: The First Decade of Roll Back Malaria", Roll Back Malaria Progress and Impact Series Number 1, World Health Organization: March 2010.
[26] "Progress Report on the Implementation of the Plans of Action of the Abuja Declaration", Division of AIDS, Tuberculosis and Malaria: World Health Organization Regional Office for Africa Brazzaville; 2009.
[27] "Malaria Funding and Resource Utilization: The First Decade of Roll Back Malaria", Roll Back Malaria Progress and Impact Series Number 1, World Health Organization: March 2010.

health rationale and constitute an inappropriate infringement of the rights to dignity, liberty, equality and non-discrimination. At a time of renewed global commitment to the elimination of restrictions on the entry, stay and residence of people living with HIV, it is urgent that these measures be lifted, and that AU members vigorously advocate for their removal.

50. In most countries, legislative endeavours have been insufficient to address the deep rooted causes of HIV-related vulnerability, stigma, and discrimination. As a result, the content, scope and scale of programs to address stigma and discrimination in most African countries are far from satisfactory. In 2007, 41 of 44 reporting AU countries reported the existence of restrictive measures targeting members of key populations, in particular, men who have sex with men and sex workers. More than 30 countries have laws prohibiting same-sex relations between consenting adults and the punishment for violations is often severe. In some countries, new legislation targeting members of key populations have been adopted or are being considered. These restrictive laws are known to negatively impact access to HIV-related services for members of key populations.

51. The insufficient focus on the HIV-related needs and rights of key populations, in particular sex workers, prisoners, men who have sex with men and people who inject drugs remains a challenge for the AIDS response. Effective HIV-related prevention, treatment, care and support addressing the specific needs and circumstances of these populations must be considered in all key national planning documents, and carried through the full planning process.

52. Tuberculosis (TB) prevention, care and control raise important ethical and policy issues that need to be adequately addressed. These concerns have been accentuated by the problem of multidrug-resistant TB (MDR-TB) and, most recently, by the emergence and spread of “extensively” drug-resistant TB (XDR-TB) which is especially difficult to detect and treat. In this regard, if a patient wilfully refuses treatment and, as a result, is a danger to the public, the serious threat posed by XDR-TB means that limiting that individual's human rights may be necessary to protect the wider public.

53. The important relationship between human rights and malaria has not received sufficient attention. The obligation to respect, protect and fulfill human rights provides a powerful impetus to control and, where possible, eliminate malaria in endemic countries. The scale-up and maintenance of malaria prevention and treatment now underway in many African countries contributes importantly to the fulfillment of the obligation of States to progressively realize for their people the Right to Health.

54. With the majority of the nearly one million deaths per year from malaria occurring in young African children, the right to life and the rights of the child are directly relevant to the fight against malaria[28] [29].

55. Given the documented economic burden of malaria in malaria-endemic

[28] http://www.afmeurope.org/site/IMG/pdf/Paludisme-et-droit-a-la-sante.pdf
[29] http://www.unicef.org/rightsresults/index 23693.html

countries in Africa[30], the fight against malaria is a crucial component in the overall right to economic and social development. With loss of productivity and income, poor individuals and families face severe challenges to afford the higher costs of effective anti-malarial medicines, specifically ACTs. Seven African countries are participating in the first phase of the Affordable Medicines Facility- malaria, an innovative financing mechanism to expand access to ACTs designed by the Roll Back Malaria Partnership and hosted by GFATM. By subsidizing effective antimalarial medicines, this innovative financing mechanism helps to fulfill the human right to health, life and non-discrimination.

56. The introduction of universal access to treatment and prevention by all populations at risk was introduced through the RBM Global Strategic Plan in 2006. The introduction of the long term disease control target with subsequent possibility of attempting regional malaria transmission control requires that to-date, highly mobile cross border, IDPs and refugees become an important target population as national malaria control efforts hardly ever have the geographic reach to touch these populations. African Union RECs such as IGAD start addressing the needs of these marginal populations[31].

POVERTY REDUCTION, HEALTH AND DEVELOPMENT

57. Roughly 40% of Africa's population lives on less than a dollar a day. Low incomes reduce access to good nutrition, which further exacerbates the health problems of the very poor. While relatively inexpensive health commodities to prevent HIV and malaria transmission and affordable medicines to cure tuberculosis and malaria and treat HIV are increasingly available across Africa, poorer populations have more difficulty in accessing them. Economic growth in Africa, which had accelerated from 3.1% in 2000 to 6.1% in 2007, was projected to be only 1.7% for 2009 – down from the anticipated 6.4 percent, and far below the average growth rates of 5.3% posted by the continent's best 15 performing countries for more than a decade. This will slow progress toward the Millennium Development Goals, even for countries that were close to halving poverty by 2015.

58. Poverty Reduction Strategy Papers (PRSP) are prepared by Member States in collaboration with the World Bank, the International Monetary Fund, civil society and development partners. These documents describe the country's macroeconomic, structural and social policies and programs to promote growth and reduce poverty, as well as, associated external financing needs and major sources of financing. Thirty-six Member States have PRSPs, and continue to work alongside partners to improve these and their implementation[32].

59. The Africa Health Strategy emphasizes the need to provide social protection for the vulnerable. Furthermore, Member States are increasingly committed to Poverty Reduction Strategic Plans, the Highly Indebted Poor Countries initiative and other debt cancellation programs governed by the World Bank, the International Monetary Fund, and other international agencies. These macro-level approaches, if

[30] http://www.ncbi.nlm.nih.gov/pubmed/17265753
[31] http://www.rollbackmalaria.org/worldmalariaday/
[32] www.worldbank.org

successful in reducing poverty and inequality, will eventually have a positive impact on the health of the poor in Africa.

HIV and AIDS

60. The social dimensions of HIV infection and the need for a multisectoral response that extends beyond the health sector has been well recognized by AU Member States, who are integrating AIDS responses into national development plans, including Poverty Reduction Strategies and UN Development Assistance Frameworks. In 2005, 28 of 32 reporting countries (88%) reported that HIV had been included in their development plans. By 2007, all 43 reporting countries (100%) said that HIV was included in their national poverty reduction strategic plans.[33]

61. In the past five years, governments across Africa have shown growing insight and leadership in food security and nutrition as related to HIV and AIDS. In the highly affected Eastern and Southern African regions, 17 of 19 national strategic plans include food and nutrition related situation analysis and a broad spectrum of related intervention strategies.[34] Food and nutrition are also an important component of national funding proposals, with just over half of awarded Global Fund proposals in Africa considered to be 'nutrition aware'. However, more can be done to leverage financial and technical support to expand food and nutrition support across care and treatment programs.

Tuberculosis

62. Tuberculosis infection is transmitted more readily in the environmental conditions associated with poverty: overcrowding, inadequate ventilation and malnutrition. The poor are at higher risk of contracting the disease and also lack access to high-quality tuberculosis care due to financial and other access barriers. Strengthening policy and strategies to improve tuberculosis case detection and treatment efforts close to point of care is essential to provide maximum benefit to the poor and target scarce resources where the diseases burden is heaviest.

63. By 2008, 59% (27/46) of the member states had developed tuberculosis strategic plans aligned with national poverty reduction strategies.

Malaria

64. Malaria is understood to be both a consequence of poverty but at the same time a cause of poverty. Malaria has significant and measurable direct and indirect costs and has recently been shown to be a major constraint to economic development. In some countries with a heavy malaria burden, the disease may account for as much as 40% of public health expenditure, 30-50% of inpatient admissions, and up to 50% of outpatient visits. Annual economic growth in countries with high malaria transmission has historically been lower than in countries without

[33] Aggregated Data from AU Country Reports for NCPI on HIV and policy, 2005 and 2007.
[34] World Food Program Review of National Strategic Plans, 2009.

malaria. Economists believe that malaria is responsible for a 'growth penalty' of up to 1.3% per year in some African countries.[35]

65. Conscious of the drain on their economies, governments in Africa are now increasing resources for malaria control, in line with the resolutions made at the Abuja Summit of 2000. Malaria is also becoming an important topic within discussions of poverty reduction and debt relief.

HEALTH SYSTEMS STRENGTHENING

66. In April 2007, the 3rd Session of the AU Conference of Ministers of Health on *"Strengthening of Health Systems for Equity and Development"* was held in Johannesburg, South Africa and resulted in the adoption of the Africa Health Strategy. This document is a framework to facilitate Inter-Ministerial and Inter-Country collaboration for an integrated, coordinated, harmonized and comprehensive response to health challenges facing Africa. Between 2007 and 2009, major activities undertaken to address the need to strengthen health systems across the continent include, the development of the Social Policy Framework for Africa, the Africa Health Strategy (2007-2015), the Pharmaceutical Manufacturing Plan for Africa, the Development of Human Resources for Health and the Global Health Workforce Alliance, and the Declaration and Plan of Action on Africa Fit for Children.

67. In most of AU Member States, a mere 3% of the world's health workers combat 24% of the global disease burden. The World Health Organization (WHO) estimates that African regions face an acute shortage of more than 800,000 doctors, nurses, and midwives, and a shortfall of nearly 1.5 million health workers overall. Resolving this crisis would require African governments to more than double the size of their health workforce. Health system strengthening is currently under way, including health worker training conducted jointly by Ministries of Health and the African Medical & Research Foundation (AMREF) and the drive to capture reliable health data by the Health Metrics Network. AMREF is training a wide range of health workers in close to 40 African countries, including more than 10,000 community health workers each year in Africa's most marginalised communities.

68. Evidenced based information on human resources to be used for policy, planning and implementation is now available for 46 Member States. With technical support from WHO, fact sheets were compiled using data collected in a comprehensive human resources for health data collection exercise in 2005.[36] Despite challenges in the completeness of the information, these fact sheets provide a strong foundation to guide Africa's strategies and activities to improve human resources for health.

69. In rural areas, the distance to the nearest health facility can be 10 kilometres or more, and often these facilities are not equipped to provide essential health services. Many health facilities in Africa still lack basic infrastructure like clean water and a reliable supply of electricity. Where functioning health facilities exist, user fees often block access to essential health services. However where Member States

[35] www.rollbackmalaria.org
[36] www.afro.int/hrh-observatory/country_information/fact_sheets/index.html

have removed such fees, health facility attendance has shot up by as much as 50-100%. Insufficient health budgets compounded with logistical problems mean that many people cannot access even the most basic medicines. According to the latest available data from the World Health Organization, the majority of people in most African countries do not have sustainable access to affordable essential drugs or the basic equipment or tools needed to deliver adequate medical care. [37]

70. In 2008, 46 Member States attended the International Conference on Primary Health Care and Health Systems co-organized by the United Nations, the African Development Bank and the World Bank and hosted by the Government of Burkina Faso, where the "Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium" was adopted, and a generic framework for implementation of this Declaration was prepared. To improve provision of essential health care services through an integrated primary health care approach, regional targets were set. The table below shows the targets for 2010 - 2011 and for the 6-year target for 2013:

Indicator	**Baseline**	**2010-2011**	**2013**
#of countries that increased or improved distribution of health facilities/service delivery per 10,000 population	7	15	36
#of countries that increased outpatient visits per 10,000 population per year by sex, age and rural/urban location	2	12	38
#of countries that have developed or updated a comprehensive national health policy and plan	20	27	46
#of countries that have conducted a regular evaluation of the implementation of their national health plans	10	15	40
#of countries that have established effective mechanisms for harmonization and alignment of partners	5	11	26

71. During the last four years there was a 47% increase in Member States - from 19 to28 countries - that have institutionalized an annual health sector review. However, up to 16 countries are yet to institutionalize health sector reviews. Standardization of this approach is in development to facilitate the process.

72. Alongside AU Member States commitment and progress towards increasing their national expenditure on health, foreign aid is also increasing to address this need**.** The United States passed the African Health Capacity Investment Act in 2007, which authorized $650 million over three years for training and retaining health workers in Africa, as well as to build basic infrastructure for health facilities. The Global Fund provides funds for funds to support health system strengthening activities, and to date, out of 36 eligible African countries, 22 countries have had their proposals approved for more than USD 300 million. In 2009, the World Bank launched its Health Systems for Outcomes, a new program to support 12 member States in the areas of health financing, human resources for health, pharmaceuticals and supply chains, governance and service delivery, infrastructure, and information and communication technology.

73. Malaria control activities have a significant impact on health system strengthening, at many levels. Malaria diagnostics have strengthened peripheral

[37] www.afro.who.int/en/divisions-a-programmes/dsd/division.html

health centers by either deploying rapid diagnostic tests or enhancing the use of light microscopy. In both cases, substantial training capacities of health professionals are involved in this deployment, and confirmation or exclusion of other diseases, and thus management guidance, becomes also possible with the use of such tools. This implies a major accuracy gain in terms of the diagnosis of childhood illness in the context of the existing Integrated Management of Childhood Illness (IMCI) strategy. Malaria intermittent preventive treatment strategies have also contributed to the reinforcement of health systems during antenatal visits. Distribution of bednets in health centers have encouraged more clients to visits health centres. Some countries are starting community management of malaria, a platform that can be used to improve treatment of common illnesses at the community level, including pneumonia and diarrhea. Malaria control is decreasing the burden on the health system and makes available human resources to address other health priorities.

PREVENTION

74. The African continent has witnessed significant results in reductions in disease transmission as a result of increased efforts to scale up proven prevention programs. Cumulatively, the number of adults and children newly infected with HIV has dropped by 17.4% between 2001 and 2008. Africa continues to record tuberculosis incidence, prevalence and mortality rates that are among the highest in the world, although these appear to have stabilized since 2004. The tuberculosis epidemic in Africa is driven by the spread of HIV; hence the leveling-off of the tuberculosis incidence rate in the region may be in part associated with the reported progress in reducing HIV incidence. There has been commendable progress in the widespread distribution of long-lasting insecticidal nets (LLINs), while the combined and comprehensive expansion of access to LLINs, insecticide spraying campaigns and preventive treatment in pregnant women, is showing impressive results in stemming the burden of malaria. Improvement in integration of these preventive efforts would increase impact further.

HIV and AIDS

75. HIV Testing and Counseling (HTC) is critical to the achievement of universal access to HIV prevention, care and treatment, as HTC serves as an essential gateway to HIV-related services. Across Africa, there was a vast increase both in the number of health facilities providing HTC and the number of tests conducted in recent years. Amongst Member States where the HIV burden is highest, the total number of health facilities providing HIV testing and counseling services increased by 50%, from 11,000 in 2007 to over 16,500 in 2008. As a result, in 2008, these facilities provided HTC to over 17 million people aged 15 years and above. Despite this increase in service provision, the median percentage of health facilities that provide HTC is 30%, indicating that access to HTC could still be greatly expanded.[38] The scaling up of various models of HTC services, notably provider-initiated approaches in health care settings, has been a promising trend in Africa, though more work is needed.

[38] "Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector: Progress Report 2009" World Health Organization, 2009.

76. Prevention of mother-to-child transmission (PMTCT) services have witnessed similar expansion, though there remains substantial unmet need. The percentage of pregnant women who received an HIV test in Eastern and Southern Africa increased substantially from 29% in 2007 to 43% in 2008 and from 7% to 16% in Western and Central Africa over the same period.[39] In 2008, almost 580,000 HIV-positive pregnant women in Africa received anti-retroviral drugs (ARVs) for PMTCT purposes, representing a 24% increase from 2007 and a 93% increase since 2006. The 2008 figure represents approximately 45% of the total number of HIV-infected pregnant women in need of ARVs for PMTCT, compared to 34% coverage in 2007. The coverage of infant antiretroviral prophylaxis also increased, reaching 32% in 2008, up from 20% in 2007.[40]

77. Access to PMTCT services is poorest in selected West and Central African countries. In 2008, it is estimated that 4,600 children in these areas became newly infected with HIV. Prevention coverage in antenatal settings in these regions remains virtually non-existent, with estimated coverage below 1% as of December 2008.[41] .

78. Thirty out of the 44 countries, who reported on blood screening in 2007, reported screening 100% of donated blood for HIV. Still, a troubling nine countries reported testing less than 90% of donated blood.[42]

79. Improved knowledge about correct and consistent condom use, delayed age of sexual debut, and the risk of multiple concurrent partnerships, alongside activities to combat stigma and discrimination, are critical to prevention of HIV, particularly among at risk populations. Evidence suggests that HIV prevention programs may be having an impact on sexual behaviors in some African countries. In southern Africa, a trend towards safer sexual behavior was observed among both young men and young women (15–24 years old) between 2000 and 2007. Though some individual countries report increases in condom use, rates of condom use still remain low in many high prevalence African countries. The age of sexual debut appears to be increasing, with 13% males and 14% females reporting sex before age 15 in 2007, down from 16% and 15% in 2005, though this might not hold true for all countries. Rates of concurrent sexual partnerships remain disturbingly high with 22% men and 6% women reporting multiple partners in 2007.[43]

80. While progress has been made in many areas, prevention strategies often fail to address the key drivers of national epidemics. Even though a significant share of new infections in many African countries occurs among older heterosexual couples, relatively few prevention programs have specifically focused on older adults. Although sero-discordant couples account for a substantial percentage of new infections in some African countries, HIV testing and counseling programs are seldom geared specifically for sero-discordant couples. Many programs focused on

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[39] "Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector: Progress Report 2009" World Health Organization, 2009.
[40] "Report on the Global AIDS Epidemic", UNAIDS, July, 2008.
[41] "Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector: Progress Report 2009" World Health Organization, 2009.
[42] Aggregated Data from AU Country Reports on HIV for UNGASS, 2005 and 2007.
[43] Aggregated Data from AU Country Reports on HIV for UNGASS, 2005 and 2007.

adolescents and young people fail to address some of the key determinants of vulnerability, such as the high prevalence of intergenerational partnerships, youth unemployment, and gender inequality in many countries.[44]

81. Across Africa, approximately 70% of sex workers had been reached with some HIV outreach and education, but only 36% of these sex workers possessed correct knowledge about HIV transmission and prevention. While only 42% of sex workers had been tested and knew their status in 2007, an impressive 81% of these sex workers reported consistently using condoms.

Tuberculosis

82. Prevention activities for tuberculosis have four main objectives: (a) To improve case detection and treatment adherence, (b) To combat stigma and discrimination, (c) To empower people affected by tuberculosis, and, (d) To mobilize political commitment and resources for tuberculosis. Improved detection and treatment of infected individuals and improved linkages with HIV services are the most effective tuberculosis prevention methods.

83. Across Africa, community involvement is a key mechanism to expanding access to high-quality tuberculosis care. There has been considerable progress in involving communities in tuberculosis care and prevention across the continent in recent years. In 2006, 65% of Member States reported community involvement.[45] However, the available data does not shed much light on the specific activities that are being implemented at the community level, or on the contribution of communities to case detection and treatment success. More information, and indeed more emphasis, on these important activities are needed if Africa is to see a reduction in the burden of tuberculosis.

84. Given the very high rates of co-infection, HIV is the main reason for failure to meet tuberculosis control targets in high HIV settings. Of the African countries with a high HIV prevalence, 41% tested their notified tuberculosis cases for HIV in 2007, signaling important progress from the 14% tested in 2005. Conversely, among high prevalence HIV countries within Africa, 63% of people living with HIV were reported as tested for tuberculosis in 2007. Unfortunately, the number of HIV-positive tuberculosis patients who were given cotrimoxazole preventive therapy (CPT) and anti-retroviral treatment (ART) remains low in Africa and provision of isoniazid preventive therapy (IPT) for HIV-positive people without tuberculosis remains extremely limited.[46]

Malaria

85. An increased focus on distribution of LLINs, indoor residual spraying (IRS), and intermittent preventive treatment (IPT) programs has produced impressive

[44] "Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector: Progress Report 2009" World Health Organization, 2009.
[45] "The Global Plan to Stop TB 2006-2015: Progress Report 2006 2008", Stop TB Partnership of the World Health Organization; 2009.
[46] "The Global Plan to Stop TB 2006-2015: Progress Report 2006 2008", Stop TB Partnership of the World Health Organization; 2009.

results: nine countries in Africa documented reductions in malaria cases of more than 50% in 2008 compared to 2000.[47] In a number of countries, these reductions have been matched by similar drops in overall child mortality rates, suggesting that malaria control will be a critical element in achieving not only MDG 6, but also MDG 4.

86. In 2008, 23 countries in Africa had adopted the WHO recommendation to provide bed nets for all age groups at risk for malaria, not just women and children (universal coverage); this represents an increase of 13 countries since 2007. The distribution of over 140 million LLINs across Africa between 2006 and 2008 – primarily through integration with immunization campaigns and maternal and child health services - resulted in 31% of African households reporting owning at least one LLINs in 2008, nearly double the 17% reported in 2006. Household LLINs ownership reached more than 50% in 13 of 35 high burden African countries, while seven countries reached a household LLINs ownership rate of more than 60% by 2008. Increased emphasis on mass distribution programs of free or highly subsidized nets contributed heavily to this high uptake. A further 200 million more nets are expected to be delivered in 2010 and early 2011, to achieve universal coverage. For 2008, WHO estimates that coverage of households with at least one ITN had risen from 1-2% in 2000 to 31% in 2008; it is expected based on LLIN procurements and distributions that this will be >40% at this time in 2010. While this is short of the universal coverage targets recently adopted, it does represent a remarkable increase across the continent. Similarly, in 27 countries with IPTp policies in place, coverage with IPTp has risen from ~1% in 2000 to ~22% of pregnant women in 2010 in these 27 countries. However, in two of four African countries in which repeated national surveys were carried out, household LLINs ownership decreased by 13% and 37% within 24–36 months of mass distribution, suggesting that strong programs for routine follow-up distribution of LLINs are needed.[48]

87. ITN use at household level is consistently and significantly lower than net ownership. This implies a continued need for behavior change communication strategies that reach the community. While subsidized and free nets are largely targeted to those most at risk of malaria-related mortality, namely children under 5 and pregnant women, household use of these items does not always correspond to this goal. While net use varies widely across the five regions in Africa, on average, only 25% of children slept under an ITN in 2008. Although this is a considerable increase from the less than 10% estimated to use an ITN in previous years, it remains well below the WHO target of 80%. Use by pregnant women is lower yet; in 2006, only 5% of pregnant women were estimated to use ITNs, though this figure has increased substantially in recent years in countries with dedicated mass distribution programs.[49]

88. Indoor residual spraying (IRS) with approved insecticides remains one of the main interventions for reducing and interrupting malaria transmission on the continent. In 2008, 19 Member States reported implementing IRS, and the number

[47] "World Malaria Report", World Health Organization; 2009.

[48] "World Malaria Report", World Health Organization; 2009.
[49] "World Malaria Report", World Health Organization; 2009.

of persons protected by IRS nearly quadrupled between 2006 and 2008, from 15 to 59 million. Nevertheless, in the majority of African countries, IRS programs require increased focus as current data suggests that only 9% of the at-risk population is protected.

89. Intermittent preventive treatment (IPT) is recommended for pregnant women in areas of high transmission. Thirty-five African countries had adopted an IPT policy by 2009, though only 20 countries were implementing this policy countrywide, and the rest on a limited scale. IPT coverage remains low across Africa, with most countries reporting coverage of less than 15%. In 2007–2008, across nine high burden countries in Africa, 20% of pregnant women received two doses of IPT treatment.[50] The potential for scaling up IPT in malaria-endemic countries is linked closely to the coverage and quality of antenatal care (ANC) services, as the two doses are generally administered in the second and third trimester of pregnancy.

TREATMENT, CARE AND SUPPORT

90. Remarkable achievements in increasing access to treatment, care and support programs are evident across the continent. Improvements in ART coverage are the most significant: in 2005, only 2% of people in need of ART had access to these; in 2008, the coverage rate of ART programs had grown to an impressive 43%, or nearly three million people. Still, over half of the population in need of ART have no access, and the growing numbers of people living with HIV present a formidable challenge in the future. While tuberculosis case detection remains a challenge at 46%, treatment success rate on the continent has made great progress, reaching 82% in 2008, just below the global Stop TB Plan target set for Africa of 85%. Despite the widespread adoption of policies for ACT as first-line treatment for malaria, access remains low across Africa, especially in rural areas where it is most needed. Greater attention to improvements in access to medicines for all three diseases is required.

HIV and AIDS

91. At the end of 2008, there were estimated to be nearly 7 million HIV-infected people in need of antiretroviral treatment (ART) in high burden countries in Africa, with coverage of 43% of those in need or 3 million people. The number of facilities providing anti-retroviral treatment, an important indicator of access, also increased by 51% between 2007 and 2008 in high-prevalence countries in Africa.[51]

92. The greatest increase in ART occurred in Eastern and Southern Africa, reaching 2,395,000 people living with HIV in 2008, signifying 48% of those in need, and a 43% increase over the prior year. In West and Central Africa, 530,000 individuals received ARVs, representing 30% of those in need, and a 26% increase from 2007. Women represent 64% of adults receiving ARVs in countries south of the Sahara. In North Africa, less than 10,000 people or 14% of those in need accessed ART, an increase from approximately 7,000 (11% of need) in 2007.

[50] "World Malaria Report", World Health Organization; 2009.
[51] "Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector: Progress Report 2009" World Health Organization, 2009.

93. The number of health facilities providing ART increased by 51% in countries south of the Sahara in 2008, compared to 40% in North Africa. Progress was especially significant in the 26 sub-Saharan countries reporting comparable data, increasing by 264% from 1,440 health facilities in 2005 to 5,240 in 2008.

94. While overall ART coverage has increased across the continent, coverage of children under 15 years old remains low at less than 18%, or an estimated 35% of those in need. Regionally, this figure varies: ART coverage reached only 6% of children in North Africa and 15% in West and Central Africa, while coverage of children in East and Southern Africa reached 44% in 2008, up from 30% in 2007.[52] Ongoing provision of ART for mothers is also critical to the survival of their children. Studies have shown that when mothers die, the survival of infants is reduced to less than two years.[53] The development and implementation of national policies and recommendations specific to the use of co-trimoxazole prophylaxis for infants and children has started to improve the coverage and uptake of this important intervention in Africa. In Eastern and Southern Africa, coverage increased from 5% in 2007 to 9% in 2008. Increased efforts to introduce and/or scale up co-trimoxazole programs are needed across the continent.

95. Despite the impressive scale-up, considerable challenges and weaknesses in ART provision remain. More than half of all Africans in need are not on ART, and retention rates for those on ARVs remain a challenge. In high burden countries in Africa, the retention of people receiving ARVs was estimated at 75% at 12 months (22 countries reporting) and 67% at 24 months (13 countries reporting).[54]

96. Furthermore, many people living with HIV in Africa continue to be diagnosed late, preventing timely initiation of antiretroviral therapy when its impact on survival would be greatest. Recent data shows that late access to antiretroviral therapy remains the most important threat to survival. Improved patient monitoring, expanding earlier access to HIV diagnosis and screening for treatment eligibility are required to improve retention rates and ultimately the impact of ART programs across the continent.

97. Among the most devastating effects of the AIDS epidemic in Africa is the rupturing of families and the orphaning of children. The cumulative number of African children orphaned or made vulnerable due to AIDS is estimated at 15.7 million in 2010.[55] As the numbers of orphans and vulnerable children (OVCs) increase, so does the stress of traditional coping systems of extended families. Many Member States have begun to address this growing need through implementation of programs to support the needs of OVCs and their families and communities. The number of countries reporting on programs to provide care and

[52] "Report on the Global AIDS Epidemic", UNAIDS, July, 2008.
[53] http://www.unicef.org/india/SOWC09-FullReport-EN.pdf
[54] "Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector: Progress Report 2009" World Health Organization, 2009.
[55] www.unaids.org

support for OVCs increased substantially from only eight in 2005 to 26 in 2007, representing a considerable increase of coverage from 12% to 53%.[56]

Tuberculosis

98. Tuberculosis treatment is largely measured by case detection and treatment success rates. While the case detection rate in Africa has increased over the past five years to 46%, it is still significantly below the 70% target. Similarly treatment success has been increasing progressively over the same period of time, reaching 79% in 2007, and 82% in 2008, just short of the 85% target.[57] Some countries are doing better than others; 2009 country reports indicate that nine Member States achieved the goal of 70% case detection while ten countries reached the 85% treatment success rate target. Only four Member States achieved both targets. Despite much progress across the continent in tuberculosis control, North African countries lag behind other sub-regions in achieving the global targets for tuberculosis control.

99. Access to tuberculosis prevention, diagnosis, and treatment services for people living with HIV across Africa remains grossly inadequate; less than 1% of people living with HIV were screened for tuberculosis or started on isoniazid preventive therapy in 2007. Less than half of tuberculosis patients were tested for HIV in 2006 and 2007. Based on available data for these years, it is estimated that 50% of tuberculosis patients are co-infected with HIV. Of those testing positive, 37% were started on ART and between 75-90% were receiving cotrimoxazole preventive therapy (CPT).[58] To improve on this, many countries with high HIV prevalence have established pilot projects for collaborative TB/HIV activities, or are scaling up TB/HIV activities nationally.

100. Although solid progress has been made in recent years to expand the DOTS program across the continent and which now covers 94% of Africa, those efforts have not translated into widespread success in reversing tuberculosis incidence and meeting Millennium Development and Stop TB goals. Forty-one of the 46 countries reporting in Africa have adopted DOTS as the national strategy for tuberculosis control, though some core elements of the strategy have not yet been implemented.

101. Drug resistant tuberculosis constitutes a silent and dangerous aspect of the tuberculosis epidemic in Africa. Although coverage of drug resistance surveillance is increasing across the continent, more work must done. In 2009, a total of 32 AU Member States reported at least one case of MDR-TB, while eight of these countries reported at least one case of XDR-TB. In 2007, 8,474 MDR-TB cases were identified from 28 Member States and 541 XDR-TB cases were reported in four of them. Twenty of the 32 African nations have structured treatment programs for MDR-TB, while 12 African countries are without local laboratory capability to

[56] "Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector: Progress Report 2009" World Health Organization, 2009.
[57] "Global Tuberculosis Control", World Health Organization; 2009.
[58] "Global Tuberculosis Report: A Short Update to the 2009 Report", World Health Organization; 2009.

diagnose MR-TB and ten countries still lack facilities for tuberculosis culture and drug susceptibility testing.[59]

Malaria

102. Access to treatment, especially artemisinin-based combination therapy (ACT), is still low in Africa, despite the adoption in the recent years of policies which include ACTs as first line treatment for malaria in all but two malaria-endemic countries. At the end of 2007, no African country had begun implementing ACT use in home management of malaria except in a few pilot projects.

103. Still, in 11 of 13 countries surveyed in 2007-2008, fewer than 15% of children under 5 years of age with fever had received ACTs, well below the World Health Assembly (WHA) target of 80%. Other statistics are even more troubling: the median percentage of children with fever in the two weeks preceding the survey who received any anti-malarial was 48% in 2006, compared to just 33.5% in 2008.[60] . Stock-outs of ACT at the national and health facility levels and inadequate monitoring of stocks using health information systems contributed to the inadequate performance

104. Most suspected malaria cases are not being tested for malaria. In 18 high-burden WHO African Region countries for which data were available, only 22% of the reported suspected malaria cases were confirmed with a parasite-based test in 2008. As of 2010, WHO recommends parasitological confirmation (either by light microscopy of with the use of a rapid diagnostic test) before the administration of any antimalarial drug, wherever this is possible. This strategy will limit the use of unnecessary antimalarials for non-malaria cases - potentially diminishing the spread of antimalarial drug resistance, and improve the treatment of non-malarial illnesses, and allow for timely and complete malaria surveillance.

105. The major constraints to scaling up of ACT in Africa are funding, since the medicines are considerably more expensive than their predecessors and inadequate supply chain management infrastructures.[61] As a result, most fevers are still treated with less efficacious medicines, including chloroquine and artemisin-based mono-therapies. Resistance to artemisinin are a potential threat to the only currently effective treatment for falciparum malaria in most parts of the world. Efforts are underway to remove artemisinin-based mono-therapies from the market. Twenty one African countries have taken regulatory measures to withdraw oral artemisinin-based mono-therapies from the market and 11 countries have made commitments to take regulatory measures to withdraw artemisinin-based mono-therapies from the market, though they have not yet started.[62] Sixteen countries in Africa still provide marketing authorization for these medicines.

[59] "Progress Report on the Implementation of the Plans of Action of the Abuja Declaration", Division of AIDS, Tuberculosis and Malaria: World Health Organization Regional Office for Africa Brazzaville; 2009.
[60] Aggregated Data from AU Country Reports on malaria, 2006-2008.
[61] "World Malaria Report", World Health Organization; 2009.
[62] "World Malaria Report", World Health Organization; 2009.

ACCESS TO AFFORDABLE MEDICINES AND TECHNOLOGY

106. At the third session of the African Union Conference of Ministers of Health in April 2007, Member States adopted the Pharmaceutical Manufacturing Plan for Africa to strengthen Africa's ability to locally manufacture and supply essential drugs and commodities to fight HIV and AIDS, tuberculosis, and malaria. This long-term approach aims to reduce Africa's dependence on external suppliers, as well as the financial burden of diagnosis, prevention and care, while simultaneously improving commodities supply. The political will to boost the African drug industry is further cemented by the adoption of the Global Strategy on Public Health, Innovation, and Intellectual Property at the World Health Assembly in May 2008. Sub-regional initiatives with EAC and SADC demonstrate further commitment to improving access to affordable medicines and technology on the continent.

HIV and AIDS

107. While approximately 80% of the 39 AU Member States reported having a national procurement and supply chain management system for HIV-related commodities (including ARVs and test kits) in 2008, 18 countries (46%) reported varying degrees of ARV stock outs in one or more facilities that provide anti-retroviral treatment. North Africa suffered considerably less stock outs in comparison to all other regions in Africa.[63] This situation is further aggravated by increasing drug resistance and the need to shift treatment towards more effective – and more expensive - first line treatment regimes, such as tenofovir.

108. While improvements have been widely felt in the procurement and provision of condoms and HIV tests kits, challenges remain in provision of CD4 testing, especially as countries move towards policies to treat patients with higher CD4 counts. Similarly, many countries still lack the required technology for early diagnosis (before six months) of infant HIV infection.

109. During 2007 and 2008, in close collaboration with international partners, 15 high-prevalence countries in Africa evaluated their national procurement and supply management systems. The studies revealed inadequate coordination among national authorities and partners and a lack of adequately trained human resources. In response, nine countries are now participating in a regional project to establish harmonized procedures for procurement and supply management. In addition, a number of Member States are now working alongside the WHO to develop an early warning system to prevent drug stock-outs, treatment interruption and the emergence of drug resistance that result.[64]

110. In 2008, the price of the most widely used first-line antiretroviral medicines (ARVs) ranged from USD 88 to USD 261 per person per year—more than 10% lower than the price in 2007. The price of a second line regimen has been reduced from

[63] "Progress Report on the Implementation of the Plans of Action of the Abuja Declaration", Division of AIDS, Tuberculosis and Malaria: World Health Organization Regional Office for Africa Brazzaville; 2009.
[64] "Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector: Progress Report 2009" World Health Organization, 2009.

USD 1,000/1,500 in 2007 to USD 579 in 2009 and for paediatric regimens, from USD 200 to USD 66 in 2009.[65] The decline in drug prices between 2004 and 2008 is cumulatively estimated to be almost 50%. Factors contributing to such drastic reduction include: the sustained scaling up of treatment programs; growing transaction volumes and predictability of demand; competition between a growing number of products pre-qualified by WHO; regional bulk purchasing efforts, and favorable pricing policies by pharmaceutical companies.

111. Other activities are improving access to affordable commodities in Africa. Regional initiatives are also helping to lower the costs of commodities. The PPSAC (AIDS Prevention Project in Central Africa, collaboration between the Central African Economic and Monetary Community, KFW, and the UNFPA) aims to develop a regional grant for the procurement of male and female condoms at affordable prices.

112. Further reductions are expected to occur in coming years, as the ART scale-up effort reaches additional poor and disadvantaged populations and local production of ARVs increases. Currently, as many as six plants in Africa are producing generic ARVs mainly for local consumption, though some are prequalified for export to other countries.

Tuberculosis

113. In Africa, there is an increasing emergence of multi drug-resistant tuberculosis (MDR-TB), primarily improper treatment of standard tuberculosis, though resistant strains may also spread from person-to-person. MDR-TB is particularly difficult to diagnose and extremely costly to treat – factors which lead to a major treatment access gap. Of the 26 countries that reported at least one case of MDR or XDR-TB in 2007, only 17 countries had an established treatment program.

114. African Union Member States, working jointly with groups such as UNITAID, the Global Drug Facility (GDF) of the Stop TB Partnership, the Green Light Committee, and the Global Fund, are working to improve the global response to tuberculosis by: (a) helping expand access to quality-assured MDR-TB treatment and push for price reductions; (b) promoting the scale-up of MDR-TB diagnosis using new rapid diagnostic tests; (c) supporting the development of, and access to, child-friendly tuberculosis medicines; and (d) helping curb the emergence of resistant tuberculosis strains by ensuring that first-line tuberculosis treatment is readily accessible and available in countries.

115. The overall availability of first line anti-tuberculosis drugs has improved tremendously. By the end of December 2007, all 36 African countries that applied to the Global Drug Facility had secured three-year first-line anti-tuberculosis drug grants, including paediatric formulations for some countries. For the treatment of drug resistant tuberculosis, 16 countries had been approved for concessionary priced second line anti-tuberculosis drugs through the WHO Green Light Committee, while applications from four more countries were still under review, an increase from

[65] "Progress Report on the Implementation of the Plans of Action of the Abuja Declaration", Division of AIDS, Tuberculosis and Malaria: World Health Organization Regional Office for Africa Brazzaville; 2009.

11 countries at the end of 2008.[66] Production capacity for high quality, second line drugs is being established in at least one Member State, however, with increasing incidence of drug resistant tuberculosis in Africa, the cost of such treatment poses a considerable challenge.

116. Development and supply of new child-friendly tuberculosis formulations is also anticipated by 2011. The first-ever pediatric tuberculosis medicine has already been prequalified by WHO. With increased number of manufacturers, price reductions for pediatric tuberculosis medicines of 18% have been achieved.[67]

Malaria

117. Although in a number of countries ACTs are distributed free of charge or at low price in the public sector, they are very expensive in the private sector where many patients may initially seek treatment for malaria. Several initiatives across Africa have emerged in recent years to increase access to affordable malaria control commodities. The Rollback Malaria (RBM) Partnership was established in 1998. Consequently, all malaria endemic countries in Africa have established partnerships at the country level. Also, sub-regional RBM partnership networks have been established to bring together all key partners in the various malaria-endemic regions to consolidate support for malaria control in their respective countries.

118. The Affordable Medicines facility for Malaria (AMFm) was established to bring down the cost of artemisinin-based combination therapy (ACT) through subsidies and help phase out mono-therapies to avoid the development of resistance. Following a initial successful pilot project of this approach in East Africa, eight countries[68] in Africa have submitted successful proposals to the Global Fund (through whom this program is managed) and the first co-paid drugs will be rolling out in June 2010. There will be an evaluation at the end to measure whether the objectives were met.

119. In further recognition of the need for affordable commodities to combat malaria, 74% of African nations have waived taxes on anti-malarials, 64% have removed taxes or introduced waivers on ITNs, while about half have waived taxes and tariffs on nets, netting materials and insecticides.[69]

120. To ensure access to quality ACT in Africa, all ACT manufacturers must undergo a WHO-led stringent prequalification process before countries purchase the medicines. Compared to 2006, there are significantly more companies manufacturing ACT globally, one of them in Northern Africa.

121. In 2008, 42 of the 43 malaria endemic countries in Africa were distributing ACT for treatment of malaria, and in 23 of these countries, ACT was free of charge for children under 5 years old. The number of ACT distributed at country level increased significantly between 2004 and 2006, while the rate of increase in 2006–

[66] "Progress Report on the Implementation of the Plans of Action of the Abuja Declaration", Division of AIDS, Tuberculosis and Malaria: World Health Organization Regional Office for Africa Brazzaville; 2009.
[67] "Global Tuberculosis Control", World Health Organization; 2009.
[68] Ghana, Kenya, Madagascar, Niger, Nigeria, Rwanda, Tanzania and Uganda
[69] www.rollbackmalaria.org

2008 was lower.[70]. Data from manufacturers showed an 18% increase in ACT sales to the public sector in 2008 as compared with 2007.[71] The Global Fund, working closely with many African countries and manufacturers, has moved to voluntary pooled procurement of commodities to reduce unit prices and enhance access to commodities whose accessibility was previously hampered by inefficient procurement and supply Chain management systems.

122. The number of rapid diagnostic tests (RDTs) delivered to and distributed across Africa increased rapidly in 2007 and 2008, from close to zero in 2005. The total number of RDTs distributed in 2008, however, corresponded to only 13% of all malaria cases in the 12 countries reporting, indicating a continuing gap in malaria diagnostic capacity. In 18 high-burden African countries for which data were available, only 22% of the reported suspected malaria cases were confirmed with a parasite-based test in 2008.[72] The 2010 WHO recommendation for universal parasitological confirmation of malaria cases prior to antimalarial treatment, will likely contribute to a rapid increase in RDT procurement and distribution.

123. In 2003, as a result of technology transfer from the Sumitomo Corporation of Japan, the A to Z Textile Mill in Tanzania gained the ability to manufacture long lasting insecticide treated nets (LLINs). A to Z now manufactures up to 10 million LLINs per year, a significant increase in local capacity.[73] Global production of ITNs doubled from 30 million in 2004 to 63 million in 2006. This increase in production coupled with increased funding and new distribution channels for free or highly subsidized nets led to a steep rise in the number of nets reaching end-users, and ensured more equitable access to ITNs.

124. Challenges remain regarding the forecasting of needs and timely flow of information of these commodities, from producers and suppliers, to Government bodies, implementing agencies and consumers. Unless these factors are addressed, there is a risk of shortage of ACT and other essential commodities.

RESEARCH AND DEVELOPMENT

125. Increased focus on research to drive evidence-based decision making in policies and programs to combat HIV/AIDS, tuberculosis, and malaria are evident across Africa. Recent evidence of the protective effect of male circumcision for HIV prevention has led to the scaling up of its implementation in 13 Member States. Ongoing research is still required in the use of antiretroviral drugs for HIV prevention, pre-exposure prophylaxis and microbicides. With the emergence of extremely drug-resistant (XDR) tuberculosis in high-HIV-burden areas across Africa, the need for rapid culture confirmation of smear positive disease, rapid culture to detect smear negative disease, and rapid drug susceptibility testing (DST) and drug resistance surveillance (DRS) is moving to the top of the tuberculosis research agenda, along with the need for new anti-tuberculosis drugs active against MDR- and XDR-TB

[70] Aggregated Data from AU Country Reports on Malaria, 2006-2008.
[71] "World Malaria Report", World Health Organization; 2009.
[72] "World Malaria Report", World Health Organization; 2009.
[73] "Status Report on Malaria in Africa", Special Session of the AU Conference of Ministers of Health, African Union, Geneva, Switzerland; 2008.

disease. Advancements in research for malaria vaccines, rapid diagnosis, and treatment are also underway.

HIV and AIDS

126. A number of informative research studies have been undertaken in recent years, and the findings and best practices documented and shared across the continent. The result has been an increase in evidence based policies and strategies to improve prevention, treatment and care for those living with HIV.

127. Recent studies have proven the sustained protective effect of male circumcision on HIV acquisition for at least 42 months. Three randomized controlled trials carried out in East and Southern Africa showed a strong protective effect, with an approximately 60% reduction in the risk of acquiring HIV. The consensus reached from these findings was that countries with HIV prevalence above 15%, generalized heterosexual HIV epidemics and low rates of male circumcision should consider urgently scaling up access to male circumcision services. As a result, all 13 priority countries with high rates of heterosexual HIV transmission and low rates of male circumcision have established policies and programs to scale up male circumcision to reduce the risk of heterosexually acquired HIV infection. A recent analysis determined that the scale-up of adult male circumcision in 14 African countries would require considerable funding (an estimated USD 919 million over five years) and substantial investments in human resources development, but that scale-up would save costs in the long run by altering the trajectory of national epidemics.[74] Political commitment has been strong, with active political involvement at the highest levels. The successful engagement of traditional leaders and elders in selected countries supporting male circumcision has been pivotal, as has been the effective involvement of women's groups in others. Partnerships involving national and local governments, donors and technical support agencies – such as the Male Circumcision Consortium and the Male Circumcision Partnership – have been created to sustain and accelerate progress.

128. A number of studies have recently examined the potential for HIV prevention through reductions in concurrent sexual partnerships and use of microbicides. A recent analysis of household survey data from 18 countries in Africa found no significant correlation between prevalence of sexual concurrency and HIV prevalence at the country or community level.[75] Similarly, a four-year clinical trial conducted in East and Southern Africa to determine the efficacy of a vaginal microbicide gel found it to be ineffective at preventing HIV infection.

129. Surveys in different settings across the African continent have demonstrated complex and variable in the relationship between HIV and income. In eight African countries where surveys have been conducted, HIV prevalence is higher among adults in the wealthiest quintile than among those in the poorest quintile. In five of six West African countries where survey data are available, women living in the wealthiest households have higher HIV prevalence than other socioeconomic groups

[74] "Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector: Progress Report 2009" World Health Organization, 2009.
[75] "AIDS Epidemic Update", UNAIDS; November, 2009.

of women, but the relationship between wealth and HIV is less clear for African men.[76]

130. Since 2001, national HIV surveys have been conducted in 31 high-prevalence countries in Africa, and eight of these countries have conducted more than one. Household surveys that include a component to assess HIV prevalence have been conducted in 28 African countries, nine of them in 2007 and 2008.[77] While these surveys vary considerably in quality, they have provided more representative population-based estimates of HIV prevalence than was possible with previous extrapolations from sentinel surveillance of women attending antenatal clinics.

131. Recent research studies have modeled the effects of antiretroviral therapy on HIV prevention. In one study, researchers assessed the effect of expanding antiretroviral therapy coverage on the number of individuals testing newly positive for HIV and on related costs over the next 25 years. They estimated that expanding antiretroviral therapy can substantially reduce the growth of the epidemic and related costs. WHO also presented a model of the potential impact of universal voluntary HIV testing and counseling followed by immediate antiretroviral therapy, irrespective of clinical stage or CD4 count. Most remarkably, the results of the modeling exercise suggested that, in a generalized epidemic as severe as that in Southern Africa, HIV incidence may be reduced by 95% in 10 years and this approach may save money in the medium term.[78]

132. Ongoing research is still required in the use of antiretroviral drugs for HIV prevention, pre-exposure prophylaxis and microbicides.

Tuberculosis

133. With the emergence of extremely drug-resistant (XDR) tuberculosis in high-HIV-burden areas across Africa, the need for rapid culture confirmation of smear positive disease, rapid culture to detect smear negative disease, and rapid drug susceptibility testing (DST) and drug resistance surveillance (DRS) is moving to the top of the tuberculosis research and development agenda, along with the need for new anti-tuberculosis drugs active against MDR- and XDR-TB disease.

134. Four countries in East and Southern Africa have undertaken pilot tests for rapid tests for the diagnosis of MDR-TB. Based on early results of these applied studies, South Africa is currently scaling up this approach through an increased number of laboratories to speed up identification of drug resistant tuberculosis forms. Eight more countries in Africa have also been earmarked to benefit from an expanded program to introduce this technology through a collaborative project between WHO and UNITAID.[79]

Malaria

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[76] "AIDS Epidemic Update", UNAIDS; November, 2009.
[77] "AIDS Epidemic Update", UNAIDS; November, 2009.
[78] "AIDS Epidemic Update", UNAIDS; November, 2009.
[79] Feuer, Cindra. "Tuberculosis Research and Development: A Critical Analysis", The Treatment Action Group; October 2006.

135. Ministries of Health have well-established mechanisms for developing and coordinating their priority research agenda in malaria-endemic countries in Africa. Across the continent, there is continuing collaboration aimed at the development of novel technologies and improving implementation Countries partner with WHO/TDR and other research initiatives such as the Malaria Vaccines Initiative and the Medicines Malaria Venture (MVI), the Medicines for Malaria Venture (MMV),the Innovative Vector Control Consortium (IVCC) and FIND for diagnostics, all supported, both by the Bill and Melinda Gates Foundation, to improve implementation and develop novel technologies. Examples of current activities include clinical trials with the most advanced malaria candidate vaccine RTS underway at 11 sites in seven African countries. Also, there is ongoing research aimed at improving access to malaria diagnostic tests and ensuring that effective treatment using ACTs is accessible at community level. There is also ongoing research aimed at improving access to malaria diagnostic tests and ensuring that effective treatment using ACT is accessible at community level.[80] Finally, a global consultation during 2009 reviewed and defined the research agenda that will enable the global community to start working towards malaria eradication (malaria eradication research agenda - malERA).

IMPLEMENTATION

136. AU Member States committed in the Abuja Call to enhancing and supporting implementation of comprehensive strategic programs at country and regional levels against HIV and AIDS, tuberculosis, and malaria. Across all three disease areas, improvements in policies to promote better preventive measures, deliver more-effective medicines, and increase access to treatment and services has been significant. While it takes some time for new policies to be put in action and for measurable results to be seen, some notable achievements have been reached in the last five years.

HIV and AIDS

137. National AIDS coordinating authorities have been leading country-level efforts and aligning the efforts of major stakeholders around multisectoral strategic plans following the "Three Ones" principle adopted by Member States in 2003: (a) one agreed AIDS action framework that provides the basis for coordinating the work of all partners, (b) one national AIDS coordinating authority with a broad-based multisectoral mandate and (c) one agreed country level monitoring and evaluation system.

138. In 2005, 28 of 32 (87.5%) Member States reported having a national multisectoral strategy to combat AIDS. In 2007, all 44 reporting countries had a strategy in place. Of these, 43 out of 44 included formal program goals, and 42 out of 44 had clear targets or milestones indicated.[81] Whereas 31 out of 32 African nations reported having one national coordinating authority in 2005, 44 of 44

[80] "Progress Report on the Implementation of the Plans of Action of the Abuja Declaration", Division of AIDS, Tuberculosis and Malaria: World Health Organization Regional Office for Africa Brazzaville; 2009.
[81] Aggregated Data from AU Country Reports for NCPI on HIV and policy, 2005 and 2007.

countries reported having this in place in 2007.[82]

139. Much work has been done in recent years by Member States to align monitoring and evaluation needs around indicators previously agreed to in the United Nations Declaration of Commitment on HIV and AIDS, with additional elements that emphasize performance and accountability.

140. In 2007, 39 of 42 reporting AU countries (93%) stated that the strategic and/or operational plan for the national AIDS response included a monitoring and evaluation framework. These plans appear to be increasingly harmonizing the efforts of major stakeholders in the response. In 2005, 19 of 31 reporting AU member states (61%) reported the existence of one harmonized M&E plan, increasing to 33 of 44 reporting countries (75%) in 2007. Civil society involvement in the development of these M&E plans remains high, with all 37 reporting indicating civil society involvement in 2007.

Tuberculosis

141. Since the Abuja Call, tuberculosis has been declared a national emergency or targeted for special action in 26 of 46 countries reporting.[83] Ministers of Health from across Africa gathered in September 2007 in Brazzaville, Republic of Congo where they jointly adopted a regional strategy to combat the dual TB/HIV epidemic. More recently, in September 2009 at the 59thsession of the WHO Regional Committee for Africa, held in Kigali, Rwanda, Ministers of Health adopted a resolution to scale up efforts to attain the targets of the Maputo Declaration of 2005 and the May 2009 World Health Assembly commitment on drug-resistant tuberculosis control. Despite these repeated commitments and the development of regional strategies to fight tuberculosis, well-established national programs for diagnosis and treatment of MDR-TB are largely absent, with just 20 of the 32 Member States reporting cases of MDR-TB or XDR-TB having established programs to treat it.[84]

142. The case detection rate in Africa for tuberculosis is the lowest in the world: countries with high HIV prevalence (48%) and low HIV prevalence (46%) were significantly behind 2007 milestones (69% and 63% respectively). The milestone for treatment success rate was achieved in 2007 by all African countries with a high HIV prevalence (average of 78%). African countries with a low HIV prevalence fell short of their target by an average of 14%. DOTS coverage now exceeds 90% in African countries with a high prevalence of HIV.[85]

143. African countries with a high prevalence of HIV (accounting for approximately 75% of HIV-positive tuberculosis cases) tested 41% of their notified tuberculosis cases for HIV in 2007, signaling important progress from the 14% tested in 2005. While the proportion of tuberculosis patients who are HIV-positive in these countries has remained largely unchanged during the reporting period (at 42%), the estimated

[82] Aggregated Data from AU Country Reports for NCPI on HIV and policy, 2005 and 2007.
[83] "Progress Report on the Implementation of the Plans of Action of the Abuja Declaration", Division of AIDS, Tuberculosis and Malaria: World Health Organization Regional Office for Africa Brazzaville; 2009.
[84] "Progress Report on the Implementation of the Plans of Action of the Abuja Declaration", Division of AIDS, Tuberculosis and Malaria: World Health Organization Regional Office for Africa Brazzaville; 2009.
[85] "The Global Plan to Stop TB 2006-2015: Progress Report 2006 2008", Stop TB Partnership of the World Health Organization; 2009.

mortality rate of HIV-positive tuberculosis patients in those countries has declined (from 66 per 100,000 population in 2005 to 59 per 100,000 in 2007).[86]

Malaria

144. Since 2000, all malaria-endemic countries in Africa have established Roll Back Malaria (RBM) coordinating bodies and developed malaria strategic plans in line with WHO-recommended interventions and strategies. Globally, ACTs are the recommended first line treatment for uncomplicated malaria and as a result, all but two countries on the continent have adopted policies that introduce ACT as the first line treatment for malaria.[87]

145. Country Strategic Plans (CSP) are all based on the four technical elements of Roll Back Malaria and the evidence-based interventions associated with them: Prompt access to effective treatment, promotion of ITNs and improved vector control, prevention and management of malaria in pregnancy, and improving the prevention of, and response to, malaria epidemics and malaria in complex emergencies. Countries are now working through local partnerships to develop the capacity to fully implement their CSPs using ongoing health sector reforms and linkages to other initiatives, such as Integrated Management of Childhood Illness and Making Pregnancy Safer, to improve access to key interventions. CSPs and political commitment to the fight against malaria have also resulted in increased funding, notably from the Global Fund.

146. Most AU Member States are moving towards universal access to malaria prevention and control among all at risk of malaria, a recent shift away from targeting only those most at risk (pregnant women and children under five-years old). Increasingly, countries in Africa are implementing a comprehensive package of interventions in the same geographical area for increased impact. Investment in highly effective interventions is leading to demonstrable progress in a number of countries. Reductions of more than 50% in the numbers of reported malaria cases and deaths were observed in five high burden African countries. Reductions of more than 50% were also observed in five low transmission African countries.

PARTNERSHIPS

147. The New Partnership for Africa's Development (NEPAD), a program of the African Union, was established with the formal adoption of The NEPAD Strategic Framework at the 37th Summit of the Organization for African Unity (OAU) in July 2001. By their Decision Assembly/AU/Dec.283(XIV) in Jan 2010, Heads of State integrated NEPAD more closely into AU structures, replacing the NEPAD Secretariat with the NEPAD Planning and Coordinating Agency with the mandate to:

i. Facilitate and coordinate the implementation of the continental and regional priority programmes and projects;

[86] "The Global Plan to Stop TB 2006-2015: Progress Report 2006 2008", Stop TB Partnership of the World Health Organization; 2009.
[87] "Progress Report on the Implementation of the Plans of Action of the Abuja Declaration", Division of AIDS, Tuberculosis and Malaria: World Health Organization Regional Office for Africa Brazzaville; 2009.

ii. Mobilize resources and partners in support of the implementation of Africa's priority programmes and projects;
iii. Conduct and coordinate research and knowledge management;
iv. Monitor and evaluate the implementation of programmes and projects; and
v. Advocate on the AU and NEPAD vision, mission and core principles/values.

HIV and AIDS

148. In the Abuja Call, AU Member States committed to developing and supporting partnership mechanisms to coordinate the contributions of public, private, civil society, regional and international stakeholders in their efforts to achieve universal access to prevention, treatment, care and support for HIV, tuberculosis and malaria. In 2005, 30 of 32 countries reported the existence of such mechanisms, rising to 43 of 44 countries by 2007.[88]

149. Alongside a number of critical global partnerships that have significantly scaled up financing and technical support in Africa, other partnerships are providing technical and other assistance to countries. For example, UNITAID's partnership with African countries leverages quality drug and diagnostic price reductions and accelerates the pace at which these are made available and has resulted in 44 Member States benefiting from price reductions of up to 40% for first and second line ARVs and diagnostic facilities.[89]

Tuberculosis

150. To assist countries to coordinate their response to the increasing burden of tuberculosis in recent years, the Stop TB Partnership was established in 2001 with the strategy to assist African countries to design and implement recommended interventions to achieve the impact targets for global tuberculosis control. The Strategy has six major components:

151. UNITAID, along with the Global Drug Facility (GDF) of the Stop TB Partnership, the Green Light Committee and the Global Fund, are supporting Member States to improve the global response to tuberculosis by: (a) Helping expand access to quality-assured MDR-TB treatment and push for price reductions; (b) Promoting the scale-up of MDR-TB diagnosis using new rapid diagnostic tests; (c) Supporting the development of, and access to, child-friendly tuberculosis medicines; and (d) Helping curb the emergence of resistant tuberculosis strains by ensuring that first-line tuberculosis treatment is readily accessible and available in countries.

Malaria

152. Roll Back Malaria is a global partnership initiated by WHO, UNDP, UNICEF and the World Bank in 1998 that works with governments from malaria endemic and donor countries, multilateral development partners, NGOs, private sector,

[88] Aggregated Data from AU Country Reports for NCPI on HIV and policy, 2005 and 2007.
[89] www.unitaid.org

foundations and research & academia to reduce the human and socio-economic costs of malaria. All malaria endemic countries in Africa have established partnerships at the country level in support of achieving universal coverage targets. Sub-regional RBM partnership networks (SRNs) have been established in Eastern, Western, Central, and Southern Africa. The three primary task of these networks are i) the tracking of country roadmaps towards universal access, ii) the identification of implementation barriers that slow down roadmaps, and iii) the identification implementation support by mobilizing national / regional and global TA if and when required. RBM SRN has access to US $ 3 million PEPFAR TA funding annually for this purpose.

153. The Malaria Elimination Group (MEG) has catalyzed a Southern Africa Partnership known as the "E8", focussing on regional malaria elimination targets.

154. The Intergovernmental Agency for Development (IGAD), as a African Union Regional Economic Community (REC), has incorporated in its regional (7 countries) HIV/AIDS partnership programmes malaria prevention, diagnosis and treatment addressing needs of highly mobile cross border and internally displaced populations, refugees as well as for populations living in high transmission areas for HIV.

155. By working in partnership with national malaria control programs and non-governmental organizations, the AMP supports the development of appropriate and effective behaviors that lead to better prevention and management of malaria, particularly for young children and pregnant women.

156. The Intergovernmental Agency for Development (IGAD), as a African Union Regional Economic Community (REC), has incorporated in its regional (7 countries) HIV and AIDS partnership programmes malaria prevention, diagnosis and treatment addressing needs of highly mobile cross border and internally displaced populations, refugees as well as for populations living in high transmission areas for HIV.

MONITORING, EVALUATION AND REPORTING

157. Strategic information systems provide country programs with three key elements: surveillance data to assess changes in disease burden (including incidence, prevalence, mortality rates and drug resistance) monitoring and evaluation of interventions and programs, and operational research. These three components provide vital information that drives the development of new strategies and policies, resource mobilization, and interventions.

HIV and AIDS

158. Forty-four countries in Africa reported having national monitoring and evaluation plans and submitted reporting forms in 2009 on the health sector response towards universal access for HIV prevention, care and treatment. Among 42 countries that submitted the reporting forms in 2008, 93% included surveillance data from antenatal clinics, while one third of the countries – mainly those with low or concentrated epidemics - implement special population surveillance, including

information on Commercial Sex Workers (CSWs). Slightly more than half of the countries reported having a national plan to prevent and monitor HIV drug resistance utilizing WHO-recommended methodology. Over 90% of high-prevalence countries and 50% of North African countries reported on progress towards implementation of 2001 Declaration of Commitment to HIV and AIDS, up from 80% and 20% respectively.[90]

Tuberculosis

159. While some progress has been made in the estimation of tuberculosis incidence, prevalence and mortality across Africa, estimates of disease burden could be substantially improved in the period up to 2015 with better surveillance systems, more extensive and in-depth analysis of available surveillance and programmatic data and additional survey data. For example, with the exception of one country in 2005, the last nationwide and population-based surveys of the prevalence of tuberculosis disease in Africa were undertaken between 1957 and 1961;only around 10% of tuberculosis-attributable deaths (in HIV-negative people) are recorded in vital registration systems; and most notification systems are recording only around 50–70% of estimated cases.[91]

160. Although challenges remain across the continent with regards to implementation of prevalence surveys, some progress was made during 2009, with at least five countries now in a strong position to start surveys in 2010.[92] Funding gaps remain a major bottleneck.

161. While the emergence of MDR-TB in Africa is clear, the full extent of the problem cannot be demonstrated due to weak diagnostic, surveillance and reporting systems. Due to the lack of equipment and trained staff to carry out investigations, only six countries in Africa provided drug resistance data. [93]

Malaria

162. Improvements have been made in malaria surveillance, monitoring and evaluation systems (SME) across Africa since 2000. As a result, Africa Malaria Country Profiles are available for many Member States and all contributed towards the World Malaria reports in 2008 and 2009. However, most countries have not been able to monitor impact from malaria interventions using their data from inpatient and outpatient health facilities because the health information and disease surveillance systems are not working adequately. In contrast, on the planning side, carefully developed, and costed SME plans also assisted Member States to leverage funds from the Global Fund, the World Bank and the President's Malaria Initiative. Over 25 African countries conducted household surveys between 2005 and 2008. An additional approximately 35 countries are expected to conduct nationally representative household surveys in 2009 and 2010 that will address malaria

[90] "Progress Report on the Implementation of the Plans of Action of the Abuja Declaration", Division of AIDS, Tuberculosis and Malaria: World Health Organization Regional Office for Africa Brazzaville; 2009.
[91] "Global Tuberculosis Control", World Health Organization; 2009.
[92] "Global Tuberculosis Control", World Health Organization; 2009.
[93] "The Global Plan to Stop TB 2006-2015: Progress Report 2006 2008", Stop TB Partnership of the World Health Organization; 2009.

prevention and control issues. All malaria endemic countries in Africa now have functional Health Information Systems (HIS), although interpretation of the trends in malaria cases and resulting mortality is complicated due to incomplete and non-standardized reporting and the ongoing reliance on clinical diagnosis.[94]

163. Despite these advancements, ongoing weaknesses in disease surveillance systems hinder many African countries from providing further evidence of changes in the malaria burden. Although many governments have scaled-up malaria control interventions massively, their impact is not being measured consistently and continuously. The ability of malaria-endemic countries to monitor changes in the numbers of confirmed malaria cases, admissions for severe malaria, and malaria-associated deaths must be strengthened. Once malaria transmission has been reduced, national programs must be able to detect malaria resurgence quickly and respond with appropriate resources. Strengthening of surveillance systems will require investment in diagnostic services, reporting systems and capacity building to manage systems and undertake appropriate data analysis and dissemination.

CHALLENGES

84. The major challenges identified in implementing the “Abuja Call” include the following:

i. Only a few countries have addressed health in their central development frameworks.

i. Health system strengthening, including inadequate infrastructure, equipment, human resources and supplies remain a major barrier to implementing disease control programmes. Although progress ha s been made towards universal coverage and access to health services including for the three diseases, this is nowhere near satisfactory, especially for the poor and vulnerable.

ii. Sustaining the pace of community education and mobilization, particularly towards prevention of the three diseases.

iii. Efforts towards integration of programmes have not moved far as national programmes for each disease remain separate (vertical), and thus funding for disease still separate.

iv. Health financing: although the available resources have generally increased, this has been mainly from international sources. Moreover, disbursement of fund, access of funds at operational levels, absorptive capacity, tracking and accountability of funding still remain major challenges. Most countries have not yet established sustainable financing mechanisms for services or regular supplies.

v. Coordination and harmonization of partnerships at all levels remains inadequate. Government oversight and supervision need more attention, including for the developing private sector in Africa.

[94] www.afro.who.int

vi. Most countries have still not adopted or are not applying policies and legislation protecting human rights, including the right to health, nutrition and social protection, particularly the rights of vulnerable children, and PLWHA and TB.

vii. There are specific challenges facing the implementation of respective programmes for each disease as well as HIV/TB co-infection, in addition to the above. Drug resistance or its threat, are added problems many countries face. Some other challenges were mentioned above against each priority area.

viii. Monitoring and evaluation systems are still weak in countries, making reporting difficult. Furthermore the Abuja Call indicators need to be looked at afresh and a more user-friendly the M&E framework developed.

CONCLUSIONS

164. Since 2006, significant progress has been made by Member States towards universal access to health services in general and HIV and AIDS, tuberculosis, and malaria in particular. There is clear political will and commitment to achieve universal access and the health-related Millennium Development Goals by 2015. Funding for the three diseases has increased significantly in recent years, with commensurate gains in impact. Furthermore, scaling up of proven HIV prevention interventions in high-prevalence countries in Africa has resulted in reduction in new cases. At the same time, there are more people living with HIV in Africa as a result of successful HIV testing initiatives and the rapid scale up of treatment programs.

165. Progress has been made in basic tuberculosis control especially DOTS coverage, case notification, and improvements in treatment success rates. As far as access to malaria services is concerned, investment in highly effective interventions including insecticide treated nets, indoor residual spray, and intermittent presumptive treatment; coupled with treatment with artemisinin combination therapy has led to notable reduction in malaria cases and deaths in some countries.

166. In spite of the above, the progress made is still insufficient to attain the Abuja target of universal access to HIV/AIDS, TB and Malaria services by 2010 and MDGs. The ‘final push’ towards universal access should be advanced through intensified implementation of national programmes with the support of the UN system and international partners, and better harmonization and coordination at national, regional and continental levels. Greater emphasis should be placed on longer-term sustainable financing through, inter alia, efficiency gains and mobilizing greater domestic resources. Drug resistance has been reported as huge challenge to treatment efforts for all the three diseases.

167. Reducing the impact of the three diseases would significantly propel efforts to achieve not only the Millennium Development Goals and the goal of combating the disease itself, but also goals related to women's and children's rights and rights to health, education and the reduction of extreme poverty.

RECOMMENDATIONS AND NEXT STEPS

168. The last five years have witnessed considerable, sustained progress in expanding access to prevention, treatment and care services for HIV/AIDS,

tuberculosis and malaria across AU Member States. With continued commitment and efforts spearheaded by the African Union and regional coordinating bodies, and led by implementing countries, technical partners, non-governmental organizations and communities and civil society, still greater progress can be achieved towards universal access for all by 2010.

169. More data is available than was in 2006 from a greater number of African countries, allowing policy to be effectively formulated/reviewed and the programmatic and policy gaps to be better understood. The following recommendations are proposed:

(1) General Recommendations

i. Extend the "Abuja Call for Accelerated Action towards Universal Access to HIV and AIDS, TB and Malaria Services" for the period 2010-2015 to enable further implementation of the commitments and to coincide with the target of the MDGs. Therefore, the indicators should be revised.

ii. Improve harmonization and coordination at all levels in order to ensure ownership, stewardship and accountability.

iii. Ensure effective leadership and governance including establishing mechanisms for accountability.

iv. Strengthen advocacy and resources mobilization for the three diseases.

v. Strengthen capacity on biological, clinical and socio-cultural research, including traditional medicines, vaccines research and traditional healers, to generate evidence to improve and adapt policies and programs.

vi. Ensure uninterrupted availability of quality, affordable AIDS, tuberculosis and malaria medicines and commodities by implementing adequate procurement and supply-chain management.

vii. Promote development and implementation of social protection measures to mitigate the impact of the three diseases particularly for the vulnerable groups.

viii. Support implementation of country road maps towards universal access by 2010 and beyond.

(2) Specific recommendations

a. Member States

i. Strengthen health system with focus on integrated HIV and AIDS, tuberculosis and malaria services to address inadequate human resources, weak laboratory and surveillance systems, procurement and supply management systems, primary healthcare, and operational research.

ii. Ensure timely access to appropriate, effective diagnosis, treatment care and support for the three diseases.

iii. Expand access to high impact prevention interventions for each of the three diseases while addressing human rights.

iv. Strengthen National Programmes for HIV and AIDS, Tuberculosis and Malaria Control in line with the national health plans and epidemiological settings while updating and implementing policies and strategic plans.

v. Scale up the momentum of ART and PMTCT efforts, to expand HTC services to all primary health care outlets as a gateway to HIV prevention, care, and treatment while aiming at elimination of pediatric HIV and keeping HIV Positive mothers alive.

vi. Put in place mechanisms and strategies to prevent, detect, and treat all confirmed Drug resistant tuberculosis, HIV and malaria.

vii. Strengthen partnership with NGOs, CSOs and private sector for the implementation of national programmes on the three diseases.

b. RECs and RHOs

i. Provide support to and mobilize resources for Member States for the implementation of initiatives on the three diseases.

ii. Intensify the implementation of inter-country and cross-border programs.

iii. Coordinate the regional operationalisation of the Pharmaceutical Manufacturing Plan for Africa through harmonization of medicine and commodities registrations and regulatory systems.

iv. Mobilize a harmonized effort for affordable pricing of medicines, for ensuring access to 2nd line drugs and support regionalization of purchasing and regulation.

c. AU and its Organs

i. The AU in partnership with REC's, needs to establish a task team to review current crises and propose alternative financing for health.

ii. Speed up the operationalization of the Pharmaceutical Manufacturing Plan for Africa.

iii. Collect and share good practices and experiences on the response to HIV and AIDS, tuberculosis and Malaria shared regional efforts to compile best practices and disseminate this information on all relevant topics.

iv. Diversify and strengthen partnerships with NGOs, CSOs, private sector and international community in the fight against the three diseases.

d. Partners

i. Ensure long-term predictable and sustainable financing aligned with Paris declaration and Accra plan of action.

ii. Provide financial and technical support to Member States, the AU Commission and RECs programmes in a coordinated, efficient manner aligned with country and AU priorities.

(3) Next steps

i. After adoption by the Special Session of the AU Conference of Ministers of Health, the Progress Report of 5–Year Review of “Abuja Call” will be submitted to the Executive Council and Assembly of Heads of State and Government for endorsement.

ii. This Progress Report will be disseminated for implementation of recommendations by stakeholders and partners at all levels.

iii. Biennial Progress Reports will be submitted to Ordinary Sessions of the AU Conference of Ministers of Health, and other relevant fora.

iv. The final Progress Report on the status of implementation will be submitted in 2013, in preparations for the review of MDGs in 2015.

ANNEX

DRAFT ASSEMBLY DECISION ON 5-YEAR REVIEW OF THE ABUJA CALL FOR ACCELERATED ACTION TOWARDS UNIVERSAL ACCESS TO HIV/AIDS, TUBERCULOSIS AND MALARIA (ATM) SERVICES IN AFRICA

DOC.ASSEMBLY/AU/…

The Assembly:

1. **TAKES NOTE** of the Progress Report on the 5-Year Review of the Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis (TB) and Malaria Services by 2010;

2. **NOTES WITH SATISFACTION** the progress made in the implementation of the "Abuja Call" for Accelerated Action Towards Universal Access to HIV/AIDS, TB and Malaria Services by 2010;

3. **AWARE** of the collective burden of these diseases on Africa's socio-economic development and the challenges faced in spite of the progress reported;

4. **REAFFIRMS** the commitments undertaken at the Special Summit on HIV/AIDS, TB and Malaria in 2000, 2001 and 2006, as well as the commitments made under the Millennium Development Goals (MDGs) and the Decade for Roll Back Malaria;

5. **APPRECIATES** the solidarity, support and encouragement by partners and stakeholders at national, regional and international levels;

6. **ENDORSES** the Progress Report on Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services in Africa;

7. **DECIDES to extend the Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services in Africa to 2015 to coincide with the MDGs**;

8. **URGES** Member States to accelerate the implementation of the "Abuja Call" through the strengthening of health systems, financing of health research,

partnerships with relevant stakeholders; and a multi-sectoral and integrated approach to disease control;

9. **CALLS UPON** Development Partners and stakeholders at national, regional and international level to provide sustained, well-coordinated and harmonized support, including fulfilling their commitment for adequate funding;

10. **REQUESTS** the Commission, in collaboration with other AU organs, RECs, UN Agencies and other Development partners to revise the reporting framework and disseminate it to Member States after consideration by the 5th Session of the AU conference of Ministers of Health;

11. **ALSO REQUESTS** the Commission, in collaboration with other AU organs, RECs, UN Agencies and other Development partners to monitor and conduct evaluation of implementation of the Abuja Call and to submit Progress Report in 2013 and final Report in June/July 2015 in preparation for the review of MDGs in 2015.