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Review of the Abuja call for accelerated action towards universal access to HIV/AIDS, TB and Malaria services & the AU Roadmap on shared responsibility and global solidarity for HIV/AIDS, TB and Malaria

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ABBREVIATIONS

AfDB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ALMA	African Leaders Malaria Alliance
AMREF	African Medical & Research Foundation
AMRH	African Medicine Regulatory Harmonisation Initiative
ART	Antiretroviral therapy
ARV	Antiretroviral
AU	African Union
AUC	African Union Commission
AWA	AIDS Watch Africa
CDC	Centre for Diseases Control and Prevention
CSO	Civil Society Organization
CSW	Commercial Sex Worker
DOTS	Directly Observed Treatment Strategy
EAC	East African Community
ECA	United Nations Economic Commission for Africa
ECSA-HC	East, Central and Southern Africa Health Community
ECCAS	Economic Community of Central African States
ECOWAS	Economic Community of West Africa States
EALA	East African Legislative Assembly
GCHL	Global Commission on HIV and the Law
GFATM	Global Fund to Fight AIDS, TB and Malaria
GIPA	Greater Involvement of People Living with HIV
HIV	Human Immunodeficiency
HOSG	Heads of State and Government
IDPs	Internally displaced persons
IGAD	Intergovernmental Agency for Development
IPTp	Intermittent Preventive Treatment for pregnant women
IPU	Inter-Parliamentary Union
IRS	Indoor Residual Spraying
ITN	Insecticide-Treated mosquito Net
LLIN	Long Lasting Insecticidal Net
MAP	Multi-country AIDS Programme
MDG	Millennium Development Goals
MDR-TB	Multi drug resistant TB
MICS	Multiple Indicator Cluster Surveys
MMC	Medical Male Circumcision
MP	Member of Parliament (Parliamentarian)
NCDs	Non communicable diseases
NSP	National strategic plan on HIV
NEPAD	New Partnership for Africa's Development
NPCA	NEPAD Planning and Coordination Agency
OECD	Organization for Economic Co-operation and Development
ORID	Other related infectious diseases
PAP	Pan African Parliament
PEPFAR	President's Emergency Plan for AIDS Relief

PF	Parliamentary Forum
PLWHA	People living with HIV and AIDS
PMI	President's Malaria Initiative
PMPA	Pharmaceutical Manufacturing Plan for Africa
PMTCT	Prevention from Mother-to-Child Transmission of HIV
RBM	Roll Back Malaria
RDT	Rapid Diagnostic Test
REC	Regional Economic Communities
RHO	Regional Health Organization
SADC	Southern African Development Community
TB	Tuberculosis
TDR	Tropical Diseases Research
TRIPS	Trade-related Aspects of Intellectual Property Rights
UN	United Nations
UNAIDS	United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNECA	United Nations Economic Commission for Africa
UNGASS	UN General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
USA	United States of America
WAHO	West African Health Organization
WARN	West Africa Roll Back Malaria Network
WHO	World Health Organisation
WTO	World Trade Organisation
XDR-TB	Extremely Drug Resistant Tuberculosis

EXECUTIVE SUMMARY

Significant progress has been made in the implementation of the Abuja commitments, although that progress remains partial and uneven. Since the 2000 and 2001 Abuja Declarations, national governments have taken steps towards ownership of Africa's health challenges. This includes the establishment of dedicated offices, coordination mechanisms and the implementation of national strategic plans for all major diseases including AIDS, TB and malaria. The AU Commission supports Member States within the framework of the Africa Health Strategy (2007-2015) and the AIDS Watch Africa (AWA) strategic framework that operationalise the 2006 Abuja Call. However the success of these efforts are predicated on the need to address health systems including human resources. While Africa bears 24% of the global disease burden it has only 3% of the world's health workforce. WHO estimates that the African region faces an acute shortage of more than 800,000 doctors, nurses, and midwives, and a shortfall of nearly 1.5 million health workers overall.

The 2013 Abuja Declaration comes at a critical juncture when the continent has made significant gains in controlling the three epidemics. Further Africa's strong economic growth has provided a great sense of optimism for increasing financing for health on the continent that will make disease responses more sustainable. According to a 2014 World Bank report Africa south of the Sahara has been growing faster than the average of the world economies, at around 5 per cent per year and even faster in certain years.

However while health funding increased in Africa since 2001 it has not yet reached the level that the Abuja Declaration set. This is not withstanding the significant progress that has been made towards achieving this target. For instance between 2001 and 2013 health budgets in AU Member States increased from 9% to 11% of public expenditure. Six AU Member States (Liberia, Madagascar, Malawi, Rwanda, Togo and Zambia) achieved the Abuja target of allocating 15% of public expenditure to health and a number of other countries such as Djibouti, Ethiopia, Lesotho and Swaziland are within reach of the 15% target.

In 2012 AU Member States built on this progress by adopting a historic Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa. Member States pledged concerted action to (i) strengthen and diversify health funding sources in order to increase domestic resource allocation to AIDS, TB and malaria, (ii) strengthen health leadership and governance including partnerships with people living with HIV and other affected populations and (iii) enhance access to affordable and quality-assured medicines. The Pharmaceutical Manufacturing Plan for Africa and its business plan is operationalizing pillar three.

Significant progress has been achieved in reducing new HIV infections, putting people on ART and reducing AIDS-related deaths. However Africa remains the most affected region. AIDS remains the major public health threat on the continent killing more than a million people each year. In 2013, there were an estimated 24.7 million people living with HIV in Africa south of the Sahara which is approximately 70% of the global total. Ten countries— Ethiopia, Kenya, Malawi, Mozambique, Nigeria, South Africa, Uganda, Tanzania, Zambia and Zimbabwe—account for 81% of all PLWHA in the region and half of those are in only two countries—Nigeria and South Africa.

By June 2014 ARV therapy reached more than 10 million people in Africa, representing three quarters of all persons on treatment. However this represents only 37% treatment coverage in Africa south of the Sahara. In Nigeria 80% of people do not have access to treatment and accounts for 19% of AIDS-related deaths in the region. More pregnant women living with HIV are getting services with Botswana, Namibia, South Africa and Swaziland having reached 90% or more of pregnant women living with HIV with ARVs for PMTCT in 2013. There were however declines in PMTCT coverage of at least 10% in Chad, Ghana, Lesotho and Zambia from 2012 to 2013. In addition, there is a huge gap in paediatric HIV treatment with less than one third of the children having access.

In 2013 there were 1.5 million new HIV infections in Africa south of the Sahara. However, new infections are on the decline. There was a 33% drop in new HIV infections among all ages in the region between 2005 and 2013. While AIDS-related deaths declined by 39% between 2005 and 2013 the region still accounts for 74% of all the people dying from AIDS-related causes with 1.1 million deaths in 2013. Among the 21 priority countries in Africa the number of children newly infected with HIV has fallen by 43% since 2009 while between 2012 and 2013 an 11% reduction was recorded. Eight countries—Botswana, Ethiopia, Ghana, Malawi, Namibia, South Africa, Mozambique and Zimbabwe—reported declines of more than 50% in new HIV infections among children between 2009 and 2013.

Botswana appears to have accomplished the goal of virtual elimination of mother-to-child transmission. South Africa is not far behind with a transmission rate of 6%. The AU has elaborated an African Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive which domesticated the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive. This has provided an overarching framework for the continent's response. The dramatic expansion of ART transformed the regional AIDS response. In 2001 when Heads of State and government committed to the Abuja Declaration it was extremely difficult to access HIV treatment in Africa. Fourteen years later, more than 10 million people in Africa are receiving ART.

While the world is winning the fight against TB, the path to victory in Africa is much less certain. Worldwide the global TB epidemic is on track to be reversed by 2015, just as envisioned in the Millennium Development Goals. Yet even as the world makes great strides, Africa remains the only continent that is not yet on track to achieve a 50% reduction in TB mortality by 2015. Africa has 24% of the world's TB cases, nearly 80% of TB cases among PLWHA, and the highest proportion of TB cases co-infected with HIV (39%). In 2013 the case detection rate was relatively low in Africa (52%). However the number of TB cases globally that were detected and treated through Global Fund grants rose by 30% in the 18 months prior to mid-2014.

The number of TB patients tested for HIV in Africa increased from 3% in 2004 to 69% in 2011. In the 18 months prior to mid-2014 the number of individuals receiving dual HIV and TB treatment supported by the Global Fund (GFATM) rose by 38%. More than 75% of all estimated HIV incident TB cases are in just 10 countries, 9 of these are in Africa south of the Sahara. These are Ethiopia, Kenya, Mozambique, Nigeria, South Africa, Tanzania, Uganda, Zambia and Zimbabwe. Of the global results of 12.3 million people tested and treated for TB with Global Fund funding only 3 million were in the Africa region.

In 2013 the treatment success rate continued to be high at 86% among all new TB cases in the African region. Today, countries are working to roll out new rapid TB test, Xpert MTB/RIF. While there is some progress in responding to multidrug-resistant TB (MDR-TB) this remains slow. From mid-2013 through end-2014 the number of MDR-TB patients receiving treatment with Global Fund support rose by 42%. It should also be noted that 5 out of the 27 high MDR-TB burden countries achieved a treatment success rate of 70% or more.

While malaria was eliminated from most places in the world, Africa remains the continent most heavily affected by this epidemic. It is estimated that 198 million cases of malaria occurred globally in 2013. Of these 82% were in the African region. The disease led to 584 000 deaths, representing a decrease in malaria case incidence and mortality rates of 30% and 47% respectively since 2000. An estimated 90% of all malaria deaths occur in the Africa region and in children aged less than 5 years. The Democratic Republic of Congo and Nigeria together accounted for 39% of the global total of estimated malaria deaths and 34% of cases in 2013. In the Africa region, the average infection prevalence in children aged 2–10 years declined by 48% between 2000 and 2013. Declines were particularly pronounced in central Africa.

Eight countries in Africa South of the Sahara are estimated to have achieved declines of more than 75% in plasmodium falciparum parasite rate (PfPR). Additionally 14 countries achieved declines of more than 50% between 2000 and 2013. The biggest reductions in numbers of people infected were in high-burden countries with large populations and substantial PfPR declines. Despite the huge population growth, Nigeria saw an estimated 20% decline in the average number of concurrent infections, from 47 million in 2000 to 37 million in 2013.

There were exponential increases in funding and implementation for malaria control programmes over the past decade. International disbursements for malaria control significantly increased rising from less than US$ 0.5 per case which translated to US$ 100 million total spend in 2000 to more than US$ 8 per case in 2012 (US$ 1.84 billion total spend). These increased funds were focused on Africa. The investments substantially improved the outlook for malaria control in Africa. The percentage of households owning at least one Insecticide Treated Net (ITN) in Africa south of the Sahara rose from 3% in 2000 to 54% in 2013. Every year, at least 150 million ITNs are needed to maintain a supply of 450 million ITNs in households over each 3-year period to protect all populations at risk of malaria in Africa south of the Sahara.

The progress is equally encouraging for households protected by indoor residual spraying. In 2005 indoor spraying protected fewer than 5% of homes. Procurement of rapid diagnostic tests and artemisin-based combination therapies has also surged as a result of increased funding. Despite impressive increases in malaria intervention coverage it is estimated that in 2013 about 278 million of the 840 million people at risk of malaria in Africa south of the Sahara lived in households without even a single ITN. Additionally 15 million of the 35 million pregnant women did not receive even a single dose of Intermittent Preventive Treatment in pregnancy (IPTp). Between 56 and 69 million children with malaria did not receive an Artemisinin-based Combination Therapy (ACT).

Despite these significant efforts Africa's disease response is faced by many challenges. These include (i) the heavy dependence of many African countries on external financial support making financing for AIDS, TB and malaria services neither predictable nor sustainable; (ii) weak planning capacity, implementation and performance-based management partly because of lack of institutional and human resource capacity at national level; (iii) insufficient policy planning and programming for addressing health in national development frameworks which is reflected in inadequate health system development, low coverage and access to services and (v) difficulty in translating political declarations to concrete and measurable actions.

Some of the challenges that are faced by various countries include inadequate laboratory networks for diagnosis of diseases and human resources in terms of numbers, mix of skills, motivation, and retention. The responses are affected by inadequate access to essential medicines, preventative commodities and technologies across much of the continent. The lack of adequate policies and legislation protecting the rights of PLWHA and TB patients by most countries hinder efforts at effective responses. This is further compounded by many other factors that include stigma and discrimination, gender inequity, inadequate coordination at national, regional and international level. These challenges are furthermore interlinked with crosscutting issues such as poverty reduction, nutrition, food security, migration and development.

Within the context of the post-2015 development agenda there are three critical health concerns that should be considered in the future directions of the continent's health response. These are managing communicable diseases, non-communicable diseases and diseases surveillance and control. The outbreak of Ebola in the West Africa sub-region provides important lessons on the primacy of strengthening health systems and the impetus for the establishment of the African Centre for Disease Control and Prevention for early detection and response.

However it should be emphasised that AIDS, TB and malaria remain as the three biggest threats to Africa's health and development agenda. Hence African Heads of State and Government reaffirmed their commitments in the 2013 Abuja +12 Declaration and set new bold targets to end the three diseases by 2030. This review provides recommendations for achieving this vision in nine key areas that are highlighted below.

Leadership and governance- there is need to further strengthen leadership and governance at various levels.

Resource mobilisation- There should be strong focus on advocacy and resource mobilisation efforts for the three diseases including domestic financing for health.

Protection of human rights- promote human rights-based responses to health through better access to justice, law and policies enforcement at national and regional level to ensure that the needs of vulnerable and key populations are taken into account in an adequate way.

Strengthening health and community systems-Member States with support of partners should further strengthen health system and community service delivery for greater efficiency with focus on integrated AIDS, TB and malaria services.

Prevention, treatment, care and support- The Abuja Call and the AU Roadmap should be extended for the period 2015 to 2030.

Access to affordable, quality assured medicines and technologies-Member States should develop and implement national action plans to ensure reliable access to affordable and quality-assured medicines and health-related commodities.

Research and Development-there is need to further strengthen capacity on biological, clinical and socio-cultural research, including traditional medicines and vaccines research to generate evidence to improve and adapt policies and programmes.

Partnerships-AUC and Member States to diversify and strengthen partnerships with NGOs, CSOs, private sector and international community in the fight against the three diseases to advance the agenda of shared responsibility and global solidarity and create a conductive environment for this to happen.

Monitoring, Evaluation and Reporting- there is need to further strengthen monitoring, evaluation and reporting mechanisms for more effective responses.

1. INTRODUCTION

This final assessment reviews the progress and challenges in the implementation of the Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, TB and Malaria and the AU Roadmap on Shared Responsibility and Global Solidarity for HIV/AIDS, TB and Malaria Response. The review documents the status of implementation of the Abuja call since 2006. It also evaluates the implementation progress of the AU Roadmap. The report provides the opportunities, challenges and lessons learnt in the implementation of both the Abuja Call and the AU Roadmap by Members States. The report provides recommendations for accelerating action towards universal access to AIDS, TB and malaria services in Africa in the context of the post 2015 development agenda and the new health targets and architecture in as laid out in new sustainable development goals.

2. BACKGROUND TO THE ABUJA CALL FOR ACCELERATED ACTION TOWARDS UNIVERSAL ACCESS TO HIV AND AIDS, TB AND MALARIA

The Abuja Special Summit held in May 2006 adopted the Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis and Malaria (ATM) Services in Africa. Africa's leaders at this summit called for "Universal Access to HIV/ AIDS, Tuberculosis and malaria services by a united Africa by 2010." This call was subsequent to a review of the progress made in implementing (i) the Abuja Declaration and Plan of Action on Roll Back Malaria (RBM) of April 2000, and (ii) the Abuja Declaration and Plan of Action on HIV/ AIDS, TB and Other Infectious Diseases (ORID) of 2001.

The 2000 Abuja Declaration on Roll Back Malaria in Africa and its plan of action committed to addressing the scourge of malaria in Africa. African Head of States and Governments committed themselves to halving malaria mortality by 2010 (a target later extended to 2015). This Abuja Declaration on Roll Back Malaria was subsequent to the 1998 launch of the Roll Back Malaria (RBM) movement as an advocacy platform for coordinated action in the global goal of halving the malaria burden by 2010. In 2001 African Heads of State and Government adopted the Abuja Declaration and Framework for Action for the Fight against HIV/AIDS, Tuberculosis and other Related Infectious Diseases, which became Africa's Common Position for the 2001 United Nations General Assembly Special Session on HIV/AIDS.

At the 2001 summit, AU Member States offered unprecedented commitments to strengthen their responses not just to AIDS, but also to TB and malaria. African Heads of States committed themselves to assume full responsibility for and ownership of the AIDS, TB and malaria response. The signatories of the Abuja Declaration pledged to allocate at least 15% of their national budgets to public health by 2015. They also promised to remove all taxes, tariffs and other economic barriers that hindered the AIDS response. They pledged to support vaccine development, to make medical commodities and technologies more available, and to intensify their efforts to mobilise resources for the AIDS response.

Deeply concerned with the impact of the AIDS epidemic, eight Africa Heads of State and Government at the Abuja Summit created AIDS Watch Africa (AWA) as an

advocacy platform at the Heads of States and Governments' level. AWA's mandate was to monitor the African response and to mobilise resources. AWA was envisioned as a key instrument in the continent's fight against AIDS, seeking to mobilise comprehensive local responses and the resources needed to address the epidemic. AWA was also intended to serve as an instrument for peer review, accountability and the measurement of commitments made by Member States. In January 2012, AWA's mandate was expanded to include TB and malaria and its representation was broadened continent-wide. African Heads of State and Government also ensured that HIV/ AIDS, TB and malaria remained high on the development and political agenda of Africa's Regional Economic Communities (RECs).

While the Millennium Development Goals (MDGs) helped catalyse unprecedented efforts to improve health outcomes the set targets have not been fully met. This underscores the urgent need to intensify efforts to implement renewed commitments and strategic actions. This also entails adjusting the targets to improve the health and well-being of Africa's people to ensure that the gains on HIV/ AIDS, TB and malaria control will not be reversed. The Abuja call consists of eleven strategic pillars namely (1) leadership role at national, regional and continental levels; (2) resource mobilisation; (3) protection of human rights; (4) poverty reduction, health and development; (5) strengthening health systems; (6) prevention, treatment, care and support; (7) access to affordable medicines and technologies; (8) research and development; (9) implementation; (10) partnerships and (11) monitoring, evaluation and reporting.

The AU Commission has developed three strategic plans to drive implementation of the Abuja Call on the continent. (2004- 2007, and 2014-2017). The review of the implementation of the second Strategic Plan (2009 – 2012) identified one of the main gaps in implementation as sub-optimal impact of the Commission's interventions due to the fact that most of its actions were focused on achieving outputs and not outcomes. While generating many important outputs ,the lack of focus on outcomes at country and sub-regional level and inadequate capacity to track these outcomes at country level were identified as key shortcomings. These lessons were taken into account in the preparation of the 2014-2017 Strategic Plan. The 2014-2017 Strategic Plan is particularly evidence-informed in its development.

Each strategic plan had mid-term, end-term and regular periodic review activities as inbuilt mechanisms for implementation, review and monitoring of the AU call. A five-year review on progress in implementing the Abuja Call was undertaken. It was aimed at aligning the indicators of the Abuja Call to the MDG 6 targets and indicators. The results of the review included a comprehensive set of monitoring and evaluation indicators aligned with the MDG 6 and progress report on the status of implementation of the Abuja Call as part of the preparation for the review of MDGs in 2015 by the AU Commission.

3. THE AU ROADMAP ON SHARED RESPONSIBILITY AND GLOBAL SOLIDARITY FOR HIV AND AIDS, TB AND MALARIA

In January 2012 the African Union requested the African Union Commission (AUC) through Assembly Decision /AU/ Dec.413 (XVIII) to work out a roadmap of shared

responsibility to draw on African efforts for viable health funding with the support of traditional and emerging partners to address AIDS dependency. The overarching goal of the AU Roadmap is to support African countries to exercise leadership to meet AIDS, TB and malaria targets by 2015. The roadmap provides a framework for sourcing African solutions to ensure universal access to health-related services for all those in need on a sustainable basis. The AU Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response builds on a number of AU initiatives, including the Abuja Declaration on HIV/ AIDS, TB and other related diseases (2001) and the Abuja Call for Accelerated Action Towards Universal Access to HIV/ AIDS, TB and Malaria Services (2006). The Roadmap presents a set of practical African-sourced solutions for enhancing shared responsibility and global solidarity for AIDS, TB and malaria responses in Africa on a sustainable basis by 2015. To attain this goal, the solutions are organised around the 3 strategic pillars.

The first pillar is on diversified, balanced and sustainable financing models. Specifically it elaborates three priority actions which are (1) developing country-specific financial sustainability plans with clear targets through a partnership approach, including with PLHIV and affected populations; (2) ensuring development partners meet existing commitments and with long-term and predictable commitments that are aligned with Africa's priorities and (3) identifying and maximising opportunities to diversify funding sources in order to increase domestic resource allocation to AIDS, TB and malaria.

The second pillar on access to medicines through local production and regulatory harmonisation focuses on four priority actions which are (1) promoting and facilitating investments in leading medicines hub manufacturers in Africa – focusing initially on AIDS, TB and malaria medicines; (2) Accelerating and strengthening regional medicines regulatory harmonisation initiatives and laying foundations for a single African regulatory agency; (3) acquire essential skills through technology transfers and south-south cooperation and create incentives to ensure that new capabilities are truly embedded in Africa; and (4) create a legislative environment that incorporates the full use of the Trade-Related Aspects of Intellectual Property Rights Agreement (TRIPS) flexibilities and develops awareness to avoid the incorporation of "TRIPS-plus" measures in trade agreements.

The third pillar on leadership, governance and oversight for sustainability outlines the following priority actions (1) countries use strategic investment approaches, including in social and legal enablers, for effective scale-up of a set of basic programmes; (2) invest in programmes that support people and communities to prevent HIV, HIV/TB co infection, TB and malaria, to know and claim their rights and to enable effective participation in planning and evaluating HIV and AIDS, TB and Malaria programmes; (3) ensure HIV and AIDS, TB and Malaria investments are strategically allocated to contribute to health system strengthening; and (4) ensure that leadership at all levels is mobilised to implement the Roadmap.

To promote partnerships and mutual accountability different agencies are held accountable for delivering on specific roles and responsibilities for the implementation of this Roadmap based on their comparative advantage. In particular, Member States have the overall responsibility of implementing priority actions at country level to achieve the results of the Roadmap. The AU Commission has the responsibility of coordinating the delivery of the Roadmap results. It leads the coordination process of

monitoring and reporting to the AU organs and systems. The NEPAD Agency, in collaboration with the Regional Economic Communities (RECs) and the AUC, facilitates the implementation of the priority actions contained in this Roadmap. UNAIDS, WHO and other UN partners as well as other key stakeholders such the African Development Bank, provide technical support and undertake strategic advocacy for the implementation of the Roadmap as well as provide targeted investments and assist Member States as they report.

4. OBJECTIVES OF THE REVIEW

The final assessment of the Abuja Call and AU Roadmap has the following objectives:

1) Document the Abuja call status in the continent since 2006 and prepare the progress report on its implementation in Africa;
2) Evaluate and document the implementation progress of the AU Roadmap and prepare a technical report;
3) Detail the opportunities, challenges and lessons learnt in the implementation of both the Abuja call and AU Roadmap by Members States;
4) Determine the relevance of the Abuja Call and the AU Roadmap and assess the extent of adaptation of both policy documents in national and regional policies;
5) Cognisant of the post 2015 development agenda, provide recommendations for accelerating action towards universal access to HIV/AIDS, TB and malaria services in Africa.

5. METHODOLOGY OF THE REVIEW

The review utilised a mixed methodology that included the following tools:

1. A retrospective analysis of both the Abuja Call and the AU Roadmap's development processes - using the JANS tool that includes the following criteria (i) situation analysis and programming; (ii) process; (iii) implementation and management and (iv) monitoring and evaluation. The criteria related to costs and budgetary framework was not assessed due to the fact that Abuja Call does not have a budgetary framework.

2. Each Abuja Call's pillar was systematically assessed through its strengths, weaknesses, opportunities, threats, constraints and lessons learned including best practices documented if any. The review also assessed the degree of achievement of general and sectoral objectives in terms of impact and effect. The assessment focused on reviewing the continent's health status through priority diseases including HIV/ AIDS, TB and malaria.

3. The review used the AU Roadmap implementation practical guide to assess the AU Roadmap. The review considered the proposed targets expressed in the approved indicators contained in the Practical Guide with a special focus on the following three priority actions: (i) develop country-specific financial sustainability plans with clear targets through a partnership approach, including with PLHIV and affected populations; (ii) ensure development partners meet existing commitments

and with long-term and predictable commitments that are aligned with Africa's priorities; (iii) identify and maximise opportunities to diversify funding sources in order to increase domestic resource allocation to AIDS, TB and malaria. Using the goals, results, benchmarks, key implementation actions, roles and responsibilities mentioned in the AU Roadmap Practical Guide the final review assessed the strengths, weaknesses, opportunities, threats, constraints and lessons learned including best practices documented if any for each of the 3 strategic pillars.

4. Technical discussions were conducted with various institutions including interview with senior and technical staff from UNAIDS, Roll Back Malaria, Stop TB Partnership and WHO to ensure Abuja Call and AU Roadmap are aligned global frameworks and take into account the key issues for health in the on-going post 2015 agenda negotiations.

6. FINDINGS OF THE ASSESSMENT

7. ABUJA CALL FOR ACCELERATED ACTION TOWARDS UNIVERSAL ACCESS TO HIV/AIDS, TB AND MALARIA SERVICES

7.1 Leadership at national, regional and continental level

Within the framework of the Abuja Declarations African leaders have provided leadership and consistently renewed political commitments to AIDS, TB and malaria. This includes AU initiatives to develop continental policy frameworks, strategies, implementation plans. Additionally they have mobilised resources and consolidated partnerships for AIDS, TB and malaria. At the sub-regional level RECs and RHOs have mobilised support and harmonised responses in law, policy and programmes within their regions for all three diseases.

At the national level AU Member States exercised leadership through setting up national coordinating bodies for AIDS, TB and malaria. Sustained financial and on-going political support and policies increased staff retention and helped maximise the success of National AIDS Commissions/Councils. The AU held the first Session of the Conference of Ministers in charge of Social Development in Windhoek, Namibia in October 2008 and adopted the Social Policy Framework for Africa. The framework assists AU Member States in the development of integrated national social policies to promote human empowerment and development.

The AU Ministers of Health Conference adopted the Africa Health Strategy (2007–2015) to contribute to socio-economic development by improving the health. The strategy seeks to ensure access to essential health care for all Africans by 2015. It also sought to build stronger collaboration between health and other sectors to improve the socio-economic and political environment for improving health and to facilitate the scaling up of health interventions by Member States, regional and inter-governmental bodies.

The East, Central and Southern African Health Community (ECSA-HC) has strengthened policies, strategies and protocols across all countries in the region. It has provided technical assistance for expansion of prevention and treatment services, advocacy for an integrated approach to HIV and reproductive health. The region has

also developed a regional pharmaceutical strategy and harmonised standardised treatment guidelines for all three diseases[1]. The Economic Community of West African States (ECOWAS) developed a strategic plan on HIV to assist Member States to improve their policies and strategies was developed based on an epidemiological analysis of its Member States conducted in 2008. ECOWAS included a support Programme on AIDS as one of its five priority programmes in education.

7.1.1 Leadership in the AIDS Response

African leaders committed to "take personal responsibility and provide leadership for the activities of the National AIDS Commissions/ Councils" in the 2001 Abuja Declaration. The African Union developed AIDS Strategic Plan (2005-2007) and the AIDS Watch Africa strategic framework to harmonise the continent's efforts. SADC has implemented an HIV prevention and treatment services programme for mobile populations in the region under Global Fund grant's Round 9. The Inter-Governmental Authority on Development (IGAD) Ministerial Committee on AIDS created the "IGAD Regional HIV and AIDS Partnership Programme (IRAPP)" in 2007. Preparatory activities took place in 2008, and activities to reach populations in need commenced in 2009[2].

The Community of Central African States (ECCAS) created an AIDS and Health Committee to increase understanding of the epidemic in the region. The committee also sought to accelerate a coordinated response to this situation. The Coordination Organisation for the fight against endemic diseases in Central Africa (OCEAC) was mandated to develop and coordinate the implementation of the AIDS Strategic Plan (2006-2010), aimed at strengthening national AIDS responses within ECCAS.

The Great Lakes Initiative against AIDS and the Corridor Project in West Africa Region have actively engaged in prevention, treatment, care and support. These include prevention of HIV transmission among mobile populations and vulnerable groups, which are not addressed by National AIDS Programs. These initiatives have also facilitated information exchange between countries. They have also facilitated care and support of People Living with HIV/AIDS (PLWHA) and the integration of the response into the socio-economic development agenda. The projects have promoted operational research; development of co-ordination and collaboration systems between countries and resource mobilisation. In 2012, Heads of State and Government revived AIDS Watch Africa (AWA) as a platform for advocacy, resource mobilisation and accountability for AIDS, TB and malaria.

7.1.2 Leadership in the tuberculosis response

Ten African countries declared officially TB as a national emergency. While highlighting the need for urgent action to address TB in the mining sector in 2012, the SADC Head of States and Governments reaffirmed their collective commitment to eliminate TB. SADC issued a declaration on TB in the mining sector that expressed strong political support for a strengthened response to TB (including TB/HIV co-infection). African

[1] 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

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

Head of States called for urgent extraordinary action to address the TB emergency in Africa through the Maputo resolution issued in 2005.

7.1.3 Leadership in the malaria response

The African Leaders Malaria Alliance (ALMA) launched in September 2009 unites Heads of State and Government of 49 African countries. The leaders harness their collective will to strengthen malaria control and to ensure that malaria remains high on the global policy agenda. ALMA is dedicated to ending malaria deaths in Africa, ensuring efficient procurement, distribution and utilisation of Malaria control interventions. Heads of State and Government committed to an intensive effort to halve the malaria mortality for Africa's people by 2010. The Campaign for Malaria Elimination in Africa was launched to supplement the acceleration of malaria control efforts during the third Session of AU Conference of Ministers of Health in April 2007 in Johannesburg.

SADC undertook initiatives to fight against malaria and TB including some of the first MDR-TB cases to be identified on the continent. The Directorate of Social and Human Development and Special Programmes supported the provision of essential, affordable, quality assured and safe medicines for all three diseases. The programme targeted urban and rural communities and promoted sustainable participation of all stakeholders, including the private sector, in the provision of services.

Numerous regional networks to respond to the epidemic throughout Africa with Roll Back Malaria providing technical support are fully operations. These are the Central Africa Roll Back Malaria Network (CARN), East Africa Roll Back Malaria Network (EARN) West Africa Roll Back Malaria Network (WARN) and the Southern Africa Roll Back Malaria Network (SARN). Various strategic plans for borders were designed including MOZIZA for Mozambique, Zimbabwe and South Africa; Trans-Kunene Malaria Initiative (Angola and Namibia); Trans-Zambezi Malaria Initiative (Angola, Botswana, Namibia, Zambia and Zimbabwe); Lubombo Spatial Development Initiative (LSDI) and Mazamo-mi (Malawi, Zambia and Mozambique).

In 2014 the West African Health Organisation (WAHO) developed a Regional Strategic Plan for Malaria Control and Elimination in ECOWAS (2014-2020). Initiatives in the region include Transborder Initiatives on Accelerating the Fight against Malaria being implemented by Gambia, Mali, Mauritania, Niger, Senegal and Chad. The WAHO regional programme on "Reproductive Health and HIV Prevention in the ECOWAS region" includes the development of a regional financing facility for reproductive health products. This includes on-going support for regular meetings of the ECOWAS Health Ministers to discuss health programmes and access to treatment. Similarly in the East, Central and Southern Africa Health Community (ECSA-HC) on-going activities to support health services include a project in collaboration with the United Nations Economic Commission for Africa (UNECA) to strengthen diagnosis, surveillance and research on TB (including Multi-Drug Resistant TB (MDR-TB).

7.2 RESOURCE MOBILISATION

The Abuja Call committed Member States to mobilising local resources for sustainable and predictable financing for AIDS, TB and malaria. Low and middle-income countries,

including AU Member States have significantly increased domestic investments in health for the first time exceeding global donations. New investments have reduced the global gap between resources available and those needed to address AIDS, TB and malaria to around 30%. Among low and middle-income countries, South Africa made the greatest domestic investments in AIDS, spending US$ 1.9 billion in 2012.

Between 2006 and 2011 public sector AIDS spending in South Africa increased five-fold. Similar trends in domestic financing are visible in a number of other countries. Kenya doubled its AIDS investments from 2008 to 2010, Togo did the same between 2007 and 2010 and Zambia increased its health spending by 45% in 2012. Rwanda also devoted considerable national resources to HIV treatment and it has also created pioneering health financing systems to address HIV and other public health threats.

Predictability of aid from international donors contributed in improving efforts to respond to AIDS, TB and malaria. Several partners contributed financial support between 2010 and 2012 for responses to the three diseases. Funding for Malaria increased to US$2 billion in 2011. Of the US$ 26 billion until 2014, US$ 16 billion or 62% of all investments were allocated to the Africa region. The first phase of the Global Fund new funding model (2014 – 2016), 64% of funds raised are allocated towards programmes in Africa south of the Sahara. PEPFAR contributed US$48 billion towards AIDS, TB and malaria for the period 2009- 2013 to respond to AIDS compared to less than US$ 2.5 billion in 2007[3].The World Bank Multi-Country AIDS Programme for Africa committed over US$ 1.8 billion in 35 countries, including five regional projects addressing cross-border issues[4].

Resources for health have more than doubled over the past 5 years. However, resource mobilisation will remain a critical challenge towards achieving the MDGs and addressing health within the new Sustainable Development Goals framework. To sustain the progress that has been achieved there is need to address Africa's over reliance on donor support. Key priorities include the need for increased investment in basic prevention programmes and the procurement of anti-retroviral treatment for HIV/AIDS. Additionally the lack of funding for TB prevention and treatment, especially expensive to treat drug resistant TB and the resources needed to achieve and maintain malaria targets threaten to side step the progress achieved. To achieve MDG 6 goals international investments still remain indispensable. This should be complemented implementation of cost-effective and efficient programme at national level.

7.2.1 AU investment commitments

Although per capita health spending arguably provides a better financial test of a strong health system, achieving the 15% Abuja target remains desirable. It can provide substantial protection against possible global economic shocks to the national responses to the three priority diseases. Only six Member States of the African Union currently meet the 15% benchmark. These are Rwanda (24%), Liberia (19%), Malawi (19%), Zambia (16%), Togo (15%) and Madagascar (15%).

[3] www.pepfar.gov

[4] www.worldbank.org

While the achievement of the Abuja targets remain unfulfilled by most countries there is on average an increase in the proportion of total government expenditures allocated to health which ranges between 9% and 11% between 2001 and 2013. Among the countries that have not achieved the Abuja benchmark, a number substantially increased the proportion of government expenditures allocated to health. Djibouti, Ethiopia, Lesotho and Swaziland have all shown consistent increases in health expenditures and are only slightly below the 15% target. However overally 47 AU Member States have not reached the Abuja target of 15% public funding allocation for health and 32 AU Member States invest less than US$ 29 per capita on health.

7.2.2 Ending AIDS in Africa south of the Sahara will require increasing and sustaining investments

To end the AIDS epidemic by 2030, resources allocated to health in lower and middle-income countries will need to increase[5]. In low-income countries US$ 9.7 billion will be required in 2020. In lower and middle-income countries US$ 8.7 billion will be required while the figure in upper-middle-countries will be US$ 17.2 billion. Upper-middle-income countries finance most of the total HIV-related investments from domestic public sources (80% in 2013). Lower middle income and low-income countries contribute 22% and 10% respectively. The global resource needs will start to reduce from 2020 and by 2030 the annual resources required in all low- and middle-income countries will decline to US$ 32.8 billion. This is down 8% from the amount needed in 2020. These resources will provide antiretroviral treatment to twice as many people in 2020 than in 2015.

Preliminary estimates for 2012 indicate that around $6.6 billion was invested in the AIDS response in Africa south of the Sahara, 47% of which came from domestic sources. An analysis of countries' AIDS investments, excluding South Africa, clearly indicates that many remain dependent on external resources. At the same time as African economies grow, domestic investments are increasing, demonstrating a widespread commitment to the shared responsibility agenda. However with external financing stagnating, it is crucial to maximise value for money, efficiency and strategic investments as essential touchstones for success. UNAIDS outlined an investment approach to maximise the impact of finite AIDS resources, calling for focused funding for high-impact, high-value basic programmatic activities, supported by critical enabling policies and synergies with other development efforts.
Efficiency improvements are needed for other diseases as well. With respect to TB, persistent gaps in access to first-line treatments for drug-susceptible TB vastly reduce the efficiency of efforts to control the disease. These gaps encourage the emergence of drug resistant TB, and treatment regimens for drug-resistant TB are more than 100 times more expensive than those for basic TB. While countries need to increase domestic health funding, they also need to explore options to diversify funding sources, as outlined in the AU Roadmap.

Many of the countries with the heaviest disease burden in Africa have limited means of self-financing their responses to AIDS, TB and malaria. As a result, global solidarity in the fight against these three priority diseases will remain essential. This underscores

[5] UNAIDS, Fact sheet 2014 – Regional statistics

the pivotal importance of sustained G8 engagement in the response to AIDS, TB and malaria in Africa.

7.2.3 G8 investment commitments

Over the past 14 years, G8 funding saved millions of lives in Africa. Building on this historic record of achievement and partnership with the AU, the G8 has recently taken steps to extend these advances to other health challenges in Africa, including maternal, new-born and child health. The G8 either fully achieved, or began to approach achievement of its specific commitments to fund global health in general, and for AIDS, TB and malaria responses specifically.

The GFATM serves as an essential pillar for financing health programmes in Africa. Between 2001 and 2014 G8 contributions to the Global Fund (including those from the European Commission) totalled US$ 25.7 billion, 74% of all contributions to the Fund[6]. UNAIDS reported Global Fund contribution as 12% of all total HIV funding in LMICs in 2013. For TB WHO reported Global Fund contribution as 17% of total TB funding in Low to Medium Income Countries (LMICs) in 2014. Between 2004 and 2012 the Organisation for Economic Co-operation and Development (OECD) estimates that 66% of international TB funding was Global Fund contribution. Global Fund contribution to Malaria funding was 40% (UNAIDS Fast Track Report, Global TB Report 2014 and WHO World Malaria Report 2014).

Several G8 members met the commitment to double aid to Africa. These include the United Kingdom, USA and Canada. Significant increases were observed from several other countries including France and Japan. However the collective target has not been met as Africa only received an additional US$ 11 billion. Critical gaps in the response threaten to jeopardise the gains made which further underscores the need for strengthened resource mobilisation.

7.2.4 Investing in the AIDS response

Domestic government spending in countries in Africa south of the Sahara increased to 32% from an estimated US$ 986 million in 2006 to US$ 1.3 billion in 2008. At the same time, domestic private spending increased at a similar rate, from US$ 247 million in 2006 to US$ 327 million in 2008[7]. The African region reached another milestone in 2013 when domestic financing accounted for the majority of global AIDS spending for the first time. This reflects a broader trend among many low and middle-income countries that increased their domestic investments for HIV treatment. The significant needs of the AIDS response requires sustained domestic and international funding. The current funding levels should steadily increase to meet the 2030 targets.

7.2.5 Investing in tuberculosis

A relatively small amount of funding was reported for collaborative TB/HIV activities reflecting the fact that funding for most of these interventions is channelled through national HIV programmes and nongovernmental organisations, rather than National TB Programmes (NTPs). Funding for tuberculosis has increased in recent years

[6] Pledges and contributions available at http://theglobalfund.org/en/

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

particularly in high burden countries in Africa. However funding levels fall far short of what is required. Financing from the Global Fund became increasingly important since 2004, while other donor funding continued to rise from 2010[8]. Most G8 spending on TB control activities is channelled through the Global Fund, which accounts for 88% of all external financing for TB programmes in Africa. Out of every US$ 100 provided to African countries by the Global Fund up to the end of 2014 only US$ 8 was allocated to TB control efforts[9].

7.2.6 Investing in malaria

There was an exponential increase in funding and implementation for malaria control programmes over the past decade. International disbursements for malaria control significantly increased, rising from less than US$ 0.5 per case (US$ 100 million total spend) in 2000 to more than US$ 8 per case in 2012 (US$ 1.84 billion total spend). International investments represented 82% of total malaria funding in 2013[10] totalling US$ 2.18 billion. International investments grew at an annual average rate of 22% per year between 2005 and 2013 in the African region compared to 15% across all other regions[11]. During the same period, domestic investments grew at an annual average rate of 4% in the African region compared to 2% in other regions.

In 2013 Africa accounted for 72% of total malaria funding compared to 50% in 2005. International investments accounted for 91% of the total investments in the African region as compared to 41% in other regions. These increased funds were focused on African countries with the lowest Gross National Income (GNI) per capita and countries with the highest malaria mortality rates. The majority of these funds were channelled through GFATM. At the end of 2013, 49% of the population at risk of malaria had access to an insecticide treated net in their household[12]. Today more households than ever before own at least one insecticide treated bed net (ITN).

In Africa most of the malaria funding is directed primarily to prevention (42%) and treatment (31%). Health systems strengthening receive 14% of the funding while 13% is allocated to programme support. Scaling up malaria control to reach universal access requires that national governments reach the 15% health budget target. This will ensure sustainability and prevent overreliance on time limited disease specific funding streams such as GFATM.

7.3 PROTECTION OF HUMAN RIGHTS

The AU has emphasised the critical role of protecting human rights in responses to AIDS, TB and malaria. It has developed policy instruments and advocated for human rights based approaches in various platforms over the years.

7.3.1 The AIDS response and protection of human rights

8 "Global Tuberculosis Report: A Short Update to the 2009 Report", World Health Organization; 2009.

9 Global Fund Results Factsheet – December 2014

10 WHO – Roll Back Malaria, Malaria World Report 2014

11 WHO – Roll Back Malaria, Malaria World Report 2014

12 WHO – Roll Back Malaria, Malaria World Report 2014

In the 2006 Abuja Call AU Member States committed to promote an enabling policy, legal and social environment to reduce vulnerability and promote human rights in the context of HIV[13]. The Call in particular focused on vulnerable and key populations that include women, youth and children, conflict-affected and displaced persons, refugees and returnees. The AU also adopted the Continental Framework for Harmonisation of Approaches among Member States and Integration of Policies on Human Rights and People Infected and Affected by HIV/AIDS in Africa. Furthermore, AU Member States joined the world through the United Nations General Assembly Special Session (UNGASS) on AIDS in 2011 to commit to national AIDS strategies that promote and protect human rights, eliminate gender inequalities, review inappropriate laws and address the specific needs of vulnerable populations.

However 25 countries in Africa[14] still have existing or draft laws criminalising HIV transmission with the most recent enactment in May 2014. Many countries in West and Central Africa have broad criminalisation provisions based on the N'djamena Model Law[15]. Punitive laws, policies and practices increase the vulnerability of people living with HIV and affect their ability to access voluntary testing and treatment.

At its 47th Ordinary Session held in Banjul in May 2010, the African Commission on Human and Peoples' Rights (ACHPR) established a "Committee on the Protection of the Rights of People Living with HIV and those at Risk, Vulnerable to and Affected by HIV" ('PLHIV Committee'). The mandate of the committee was renewed in 2012. The Committee in 2013 called upon States Parties to the African Charter and African Women's Protocol to adopt legal frameworks to protect the rights of women living with HIV and other vulnerable persons. In the same year the Pan-African Parliament committed to continue working with legislators to promote accountability, implementation of laws and resource mobilisation for the HIV response.

The Report on Progress Towards Achieving Law & Human Rights goals within the AU Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa (2012-2015)[16] focused on six priority areas on law and human rights. It recommended that these key priorities should be addressed to ensure adequate access to AIDS, TB and malaria prevention and treatment for all vulnerable and affected populations[17]. The report was prepared for the AWA Consultative

[13] UNDP, A report on progress towards achieving law & human rights goals within the AU Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa (2012-2015)

[14] UNDP, A report on progress towards achieving law & human rights goals within the AU Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa (2012-2015)

[15] Laws may include vague and ambiguous provisions criminalising a range of acts that may expose a person to HIV (potentially including mother-to-child transmission of HIV in some cases), as well as intentional, reckless and negligent actions. Stigma, discrimination and other human rights violations against people living with HIV limit their access to HIV services. These violations also negatively affect their ability to lead full and dignified lives. Human rights violations affect people living with HIV in the workplace and affect their access to insurance, social security, housing and education.

[16] UNDP, A report on progress towards achieving law & human rights goals within the AU Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa (2012-2015)

[17] The 6 priority law and human rights issues are namely: (i) Stigma and Discrimination in the context of HIV, TB and Malaria; (ii) Criminalisation of HIV Transmission; (iii) Gender Inequality, Harmful Gender Norms and Gender-Based Violence; (iv) Criminal Laws Affecting Key Populations at higher risk of HIV exposure; (v) Young Peoples' Sexual and Reproductive Health and Rights; and (vi) Intellectual Property Law and Access to Medicine.

Experts' Committee Meeting of the African Union that took place in Nouakchott in May 2014. Other challenging issues of concern, although not receiving specific focus in this report, include the health care rights of mobile, migrant and displaced populations, prisoners' rights, children's rights and the rights of people with disabilities.

The Global Commission on HIV and the Law (GCHL) supported by UNDP[18] works on strengthening legal and regulatory frameworks for HIV through regional dialogues on the impact of laws, policies, human rights issues and practices on HIV. The dialogues bring together AU Member States' and civil society to discuss key HIV issues. In 2011, the GCHL held 7 regional dialogues across Africa that include Cairo for the North Africa and Middle East region and in Johannesburg for Africa south of the Sahara. The discussions and recommendations fed into the GCHL's 2012 report[19].

The East African Legislative Assembly (EALA) passed the East African Community (EAC) HIV and AIDS Prevention and Management Act in 2012. The law provides rights-based regional law for PLHIV and vulnerable populations such as women, children and people with disabilities. It also covers refugees, internally displaced persons and 'most-at-risk populations' in East Africa. The Act was assented to by 3 of the 5 Partner States, namely Burundi, Kenya and Uganda.

The West African Health Organisation (WAHO) and the Economic Community of West Africa States (ECOWAS) are currently supporting the roll-out of 15 PLHIV Stigma Index across West Africa. The index provides a framework to better understand and respond to HIV-related discrimination. ECOWAS is finalising a Minimum Legal Framework for rights-based responses to HIV in Member States. The Southern African Development Community (SADC) is advocating for national legal and regulatory frameworks in SADC, based on "the SADC Parliamentary Forum (PF) Model Law on HIV & AIDS for Southern Africa, 2008". Countries across Africa are taking steps to review criminalisation of HIV transmission provisions. Namibia, Ghana, Malawi and Seychelles assessed their legal and regulatory frameworks for HIV.

Various countries are reviewing restrictive laws for people living with HIV. Namibia repealed its travel restrictions on people living with HIV. Senegal, Togo, Congo and Guinea narrowed criminalisation of HIV provisions in HIV law in line with UNAIDS guidance. Gabon recently rejected a proposal to criminalise HIV transmission. The most recent draft HIV laws in Nigeria and Malawi now exclude the criminalisation of HIV transmission. In 2014, parliamentarians in Mozambique and the Democratic Republic Congo were considering revising provisions in their existing HIV laws to remove the criminalisation of HIV transmission to protect human rights.

[18] UNDP, A report on progress towards achieving law & human rights goals within the AU Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa (2012-2015)

[19] The GCHL report of July 2012 contains important findings and recommendations which if acted upon, can save lives and money, while playing a transformative role in the AIDS response. The report cited evidence indicating that law, enforcement and justice systems that protect equality of access to health care and prohibit discrimination, are able to better the lives of HIV-positive people and help turn the HIV epidemic around.

CSOs including PLHIV networks continue to play a critical role in advocating for and implementing human rights programmes for HIV and TB. In December 2012, almost 50 African countries reported the full involvement of CSOs in developing their HIV strategies and participating in national AIDS structures. The PLHIV Stigma Index studies, undertaken by PLHIV networks and partners, were completed in over 15 countries in West, Central, East and Southern Africa and were underway in a number of other countries.

Since 2012 countries such as Burkina Faso, Cameroon, Democratic Republic of the Congo, Lesotho, Malawi, Nigeria and Swaziland have undertaken legal environment assessments with the support of UNDP to analyse and strengthen enabling environments for AIDS responses. Thirty-five AU Member States report having laws that protect people living with HIV from discrimination, many of which are HIV-specific laws. Most national strategic plans on HIV (NSPs) committed to rights-based responses. It should also be noted that 90% of the NSPs include stigma and discrimination reduction programmes and many include training for health workers.

7.3.2 Tuberculosis and the protection of human rights

TB prevention, care and control raise important ethical and policy issues that need to be adequately addressed. These concerns were 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) that is difficult to detect and treat.

7.3.3 Malaria and the protection of human rights

The 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 realise the right to health.

7.4 POVERTY REDUCTION, HEALTH AND DEVELOPMENT

Africa’s strong economic growth is an encouraging trend in the continent's development trajectory. Africa has the second highest rate of economic growth in the world. The region’s economy grew by 5.1% in 2011 and was projected to accelerate to 5.8% in 2014. In this decade alone, Africa is expected to add 122 million people to its labour force. This economic growth could be game changing for the continent. While Africa has the lowest life expectancy in the world (54.4 years), every additional year of life expectancy will raise the region’s GDP by an estimated 4%. Thus an investment in health is an investment in economic growth and a stronger continent in every imaginable way. About 65% of the total population of Africa is under the age of 35, and

some 10 million young people enter the job market every year. Health, education and employment opportunities increasingly will be entwined.

AU Member States recognised and committed to addressing the link between poverty, health and development in the Abuja Call by integrating AIDS, TB and malaria programmes into poverty reduction strategies and programmes. To date 42 African countries developed full or interim Poverty Reduction Strategy Papers and by 2013, 28 countries benefited from debt relief under the Heavily Indebted Poor Countries Initiative. However more should be done to leverage financial and technical support to expand care and treatment programmes.

Tuberculosis infection is transmitted more readily in the environmental conditions associated with poverty. The poor are at higher risk of contracting the disease and also lack access to high-quality TB 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.

Malaria is understood to be both a consequence and cause of poverty. Malaria has significant and measurable direct and indirect costs and was recently 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 malaria. Economists believe that malaria is responsible for a 'growth penalty' of up to 1.3% per year in some African countries.

There is thus an urgent need for AU Member States to implement effective and targeted poverty reduction strategies and social protection programmes that integrate AIDS, TB and malaria, for all populations, and in particular vulnerable populations.

7.5 HEALTH AND COMMUNITY SYSTEMS STRENGTHENING

Africa bears 24% of the global disease burden yet have only 3% of the world health workers. WHO estimates that the African region face an acute shortage of more than 800,000 doctors, nurses, and midwives, and a shortfall of nearly 1.5 million health workers overall. Health and community systems strengthening remain essential in almost all African countries. Resolving this crisis would require African governments to more than double the size of their health workforce.

Limited health facilities particularly in rural areas and lack of basic infrastructure (such as clean drinking water and electricity) in existing facilities remain key challenges. Health institutions also lack regular access to essential medicines. African leaders recognise that strengthening health systems, including human resource capacity building is critical for accelerating universal access to prevention, treatment, care and support for AIDS, TB and malaria services. Consequently national expenditure and foreign aid continues to increase and is steadily addressing health systems strengthening. The African Union continues to push for health systems strengthening through implementing the Africa Health Strategy (2007-2015), the Global Health

Workforce Alliance Strategy (2013-2016), the Call for Accelerated Action for the Implementation of the Plan of Action Towards Africa Fit for Children and the African Health Initiative.

Health system strengthening initiatives include health worker training conducted jointly by Ministries of Health and the African Medical & Research Foundation (AMREF). This is complemented by 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.

The programme on nursing and midwifery education, designed as a need- and demand-driven source of education for primary health care, developed curricula for a clinical course work and research Master's degree that will be approved by universities in five targeted countries (Chad, Kenya, Republic of Congo, Rwanda and the United Republic of Tanzania) and by development partners. ECOWAS through WAHO has harmonised the curricula for health personnel training in the West Africa region to facilitate integration.

The G8 is actively assisting the AU's efforts to build strong and durable health systems, with particular emphasis on strengthening human resources for health. The US passed the African Health Capacity Investment Act in 2007, authorising US$ 650 million over three years for training and retaining health workers in Africa, and for building basic health infrastructure. GFATM partnered with GAVI Alliance, World Bank and WHO to establish a health systems funding platform. To date 22 of 36 eligible African countries received funding totalling US$ 300 million from the Global Fund for activities intended to strengthen health systems. From 2002 to 2014, the GFATM disbursed US$ 388 million to support HSS grants and US$ 5.8 million "person-episodes" of training for health or community workers[20].

7.5.1 The AIDS Response and systems strengthening

AIDS put serious pressure on the health sector particularly on hospital resources. Moreover, there is a chronic shortage of healthcare workers. HIV is being integrated into sexual and reproductive health services throughout Africa. Botswana, Burkina Faso, Malawi, Tanzania and Zimbabwe recently completed rapid assessments to inform their strategies and determine priorities for their national plans towards the scale-up and intensification of integration.

Kenya is evaluating a national strategy, launched in 2002 that integrated HIV counselling and testing in family planning services. The number of health facilities with integrated HIV and TB screening, diagnosis and treatment has rapidly increased in Africa since 2005. Swaziland recently demonstrated that integrating TB case-finding in routine HIV care delivery in rural community clinics and district hospitals is both operationally feasible and effective. In 2012, South Africa launched an integrated five-year strategy addressing AIDS, TB and sexually transmitted infections. There is now a course held in West Africa for integrated HIV/TB for French speaking countries in

[20] Global Fund Results Factsheet – December 2014

Ouidah (Benin) and for English speaking countries in Kemri (Nairobi – Kenya). WAHO/ECOWAS and WHO jointly support these courses.

7.5.2 Tuberculosis and systems strengthening

Enhancing laboratory capacity for TB control also benefited management of other diseases, as the diagnostic tools used for TB are often applicable to other conditions. As health workers are a high-risk group for TB, implementation of infection control efforts in health-care settings help preserve vital human resources for health, ensuring that physicians and nurses are available to care for patients with a wide range of health problems.

7.5.3 Malaria and systems strengthening

Malaria diagnostics strengthened peripheral health centres by either deploying rapid diagnostic tests or enhancing the use of light microscopy. This resulted in extensive training for health professions that is useful for the confirmation, exclusion and management of other diseases. Intermittent preventive treatment strategies for malaria reinforce antenatal care systems, while distribution of bed nets in health centres encouraged more clients to access other health services. Some countries are starting community management of malaria. This has improved the treatment of other common illnesses at the community level, including pneumonia and diarrhoea. By decreasing the overall disease burden, malaria control frees up limited human resources to address other health priorities.

7.6 PREVENTION

Prevention is recognised as a key, cost-effective response to AIDS, TB and malaria in the Abuja Call. AU Member States committed to increasing investments in evidence-based prevention, in particular for young people, women, girls and other vulnerable populations. In recent years, African countries have made significant progress in scaling up prevention of HIV, TB and malaria.

7.6.1 Prevention in the AIDS response

Reports show increased prevention services and facilities for HIV in AU Member States as well as reduced rates of HIV infection. UNAIDS reports that 25 low and middle-income countries, half of which are in Africa, reduced rates of new HIV infection by 50% between 2001 and 2013. Significantly, in Southern Africa, with high HIV prevalence rates, the incidence of HIV fell by 73% in Malawi, 71% in Botswana, 68% in Namibia, 58% in Zambia, 50% in Zimbabwe, 41% in South Africa and 37% in Swaziland. In West and Central Africa, rates of new HIV infections fell by 66% in Ghana, 60% in Burkina Faso and 58% in Djibouti, with reductions of over 50% in Central African Republic, Gabon, Rwanda and Togo.

However young women and adolescent girls are being left behind. While the majority of new HIV infections occur among adults above the age of 25, a large proportion occur among young women and adolescent girls. Young women and adolescent girls experience gender-based violence including sexual abuse, lack access to education and health services and social protection. How they cope with these inequities and

injustices will determine their protection from HIV and access to services such as antiretroviral therapy.

Eliminating new HIV infections in children and keeping mothers alive

Declines in new HIV infections were recorded in all priority countries between 2009 and 2013, but at varying rates. Malawi had the largest decline at 67% (although they started from a higher transmission rate than many other countries). New HIV infections among children fell by 50% or more in seven other countries: Botswana, Ethiopia, Ghana, Mozambique, Namibia, South Africa and Zimbabwe. However, between 2012 and 2013 the pace of progress in reducing new HIV infections among children across the 21 Global Plan countries slowed.

While a number of countries made impressive gains, others stagnated or lost ground. On aggregate countries recorded a 12% reduction in new infections between 2009 and 2010, a 9% reduction between 2010 and 2011 and a 19% reduction between 2011 and 2012. However the 21 countries recorded an 11% reduction between 2012 and 2013. Nigeria continues to carry the highest burden of new HIV infections among children. This has declined by only 19% since 2009. The country is home to one quarter of all new HIV infections among children in the priority countries in 2013 which is nearly 51 000 cases[21].

Great strides were made in 21 African countries[22] (with the highest number of pregnant women living with HIV in need of services) covered by the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive. With a modelled transmission rate of 2% in 2013, Botswana appears to have accomplished the goal of virtual elimination of mother-to-child transmission, and South Africa is not far behind at 6%. The remaining 19 priority countries have transmission rates of over 10%, with ten of them having transmission rates of over 20%. Considerable efforts, including high HIV testing and counselling, high coverage with effective PMTCT regimens and support for adherence are needed to achieve the Global Plan goals. The number of women requiring services to prevent mother-to-child transmission remains high[23] at 1.3 million among the 21 priority countries. Given the slow decline in new HIV infections among women of reproductive age, this number is likely to remain high for the foreseeable future.
Infant diagnosis rates (both early diagnosis and final diagnosis after 18 months) remain poor in many countries[24], creating a bottleneck to scaling up treatment for children especially those younger than 18 months of age. Despite significant investment, among the priority countries, only 39% of children exposed to HIV received HIV virological testing within the first two months of life. Only six of the priority countries were providing early infant diagnosis to more than 50% of children exposed to HIV in 2013. These are South Africa (94%), Swaziland (89%), Botswana (58%), Namibia (56%), Zambia (55%) and Zimbabwe (50%). In the remaining priority countries, the number of infants receiving virological testing was less than 50%, and was unchanged or decreased slightly from previous years. In the other nine priority countries, the

[21] UNAIDS Global Plan progress, 2014
[22] 21 African countries with the highest number of pregnant women living with HIV in need of services Angola, Botswana, Burundi, Cameroon, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, India, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Uganda, United Republic of Tanzania, Swaziland, Zambia and Zimbabwe (Global Plan progress, 2014).
[23] The Gap Report – UNAIDS, 2014

number of children exposed to HIV receiving virological testing was less than 25% (WHO, 2014).

Pregnant women living with HIV are getting services but critical gaps remain.

The proportion of pregnant women living with HIV who received antiretroviral medicines for PMTCT has doubled over the past five years. It increased from 33% [31–35%] to 68% [64–74%] and the regimens being received are now more efficacious. In Botswana, Namibia, South Africa and Swaziland 90% or more of pregnant women living with HIV were receiving antiretroviral medicines in 2013 for PMTCT. In addition Namibia, South Africa and Swaziland are moving to Option B+, so more progress is anticipated.

However, there is concern about stagnation, between 2012 and 2013 the percentage of women receiving antiretroviral medicines rose only marginally from 64% to 68%. In the same period, only 37 000 additional pregnant women living with HIV were reached with antiretroviral prophylaxis or treatment. This can be compared to nearly 97 000 between 2011 and 2012. In some countries there was a stalling and in some cases a decrease. Stalling was documented in Botswana, South Africa, Tanzania, Uganda and Zimbabwe, while declines of at least 10% were documented in Chad, Ghana, Lesotho and Zambia.

Ensuring that women living with HIV have the ability to make informed and safe fertility decisions is critical. According to most recent population-based surveys, more than half of the 21 priority countries are failing to meet the needs for family planning among at least 25% of all married women. This is the case in Burundi, Côte d'Ivoire, the Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Tanzania, Uganda and Zambia[25].

Adolescent boys and young men are heavily impacted[26]

In Nigeria, HIV prevalence among adolescent boys aged 15–19 years was already 2.9% according to a Nigerian national HIV and reproductive health survey from 2012. However, in most countries, HIV prevalence among young men is much lower, suggesting a significant age differential in the sexual debut between women and men. A review of more than 45 studies from throughout Africa south of the Sahara revealed that relationships between young women and older male partners were common. Relationships with huge differences in age are associated with unsafe sexual behaviour and low condom use.

Substantial access gap exists for male and female condoms

Regarding condom use most countries do not seem to have set national distribution targets. On average there are still only 8 condoms per male per year available across Africa, while UNAIDS recommends 25-40 and even more in countries with the highest

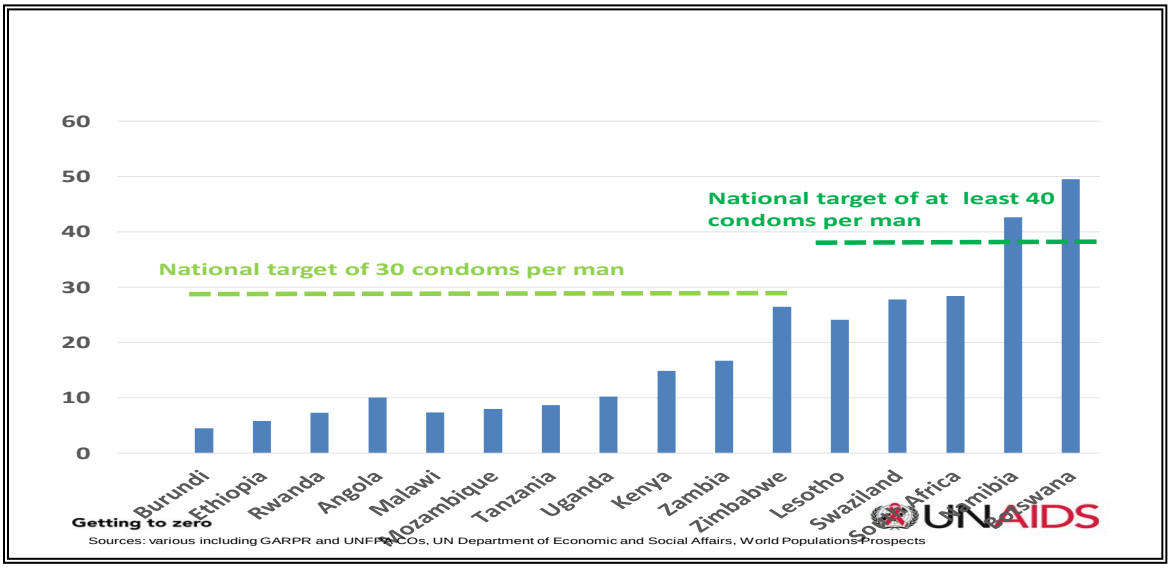
[25] UNAIDS Global Plan progress, 2014

[26] The Gap Report – UNAIDS, 2014

prevalence. Condom use with non-regular partners varies significantly. Approximately 70% of sex workers were reached with some HIV outreach and education, but only 36% of these sex workers possessed correct knowledge about HIV transmission and prevention.

On-going challenges include the fact that condom use is still below target in most countries reporting. Only 5 countries namely Algeria, Nigeria, Kenya, Swaziland and Côte d'Ivoire reported 50% of women and men 15 to 49 years with more than one partner using a condom during last sexual intercourse. In addition, the scale-up of medical male circumcision (MMC) services remains a challenge. In southern Africa, a trend towards safer sexual behaviour was observed among both young men and young women (15–24 years old).

Figure 1: Condom distribution per man per year: potential to close gaps



HIV testing and Counselling (HTC) is the critical entry point into care and treatment for people who are HIV-positive to achieve universal access to HIV prevention, care and treatment. There was a significant increase both in the number of health facilities providing HTC and the number of tests conducted in recent years, but HTC remains inadequate. Most programmes across Africa south of the Sahara have a limited scale, scope and coverage[27].

Declining new HIV infections

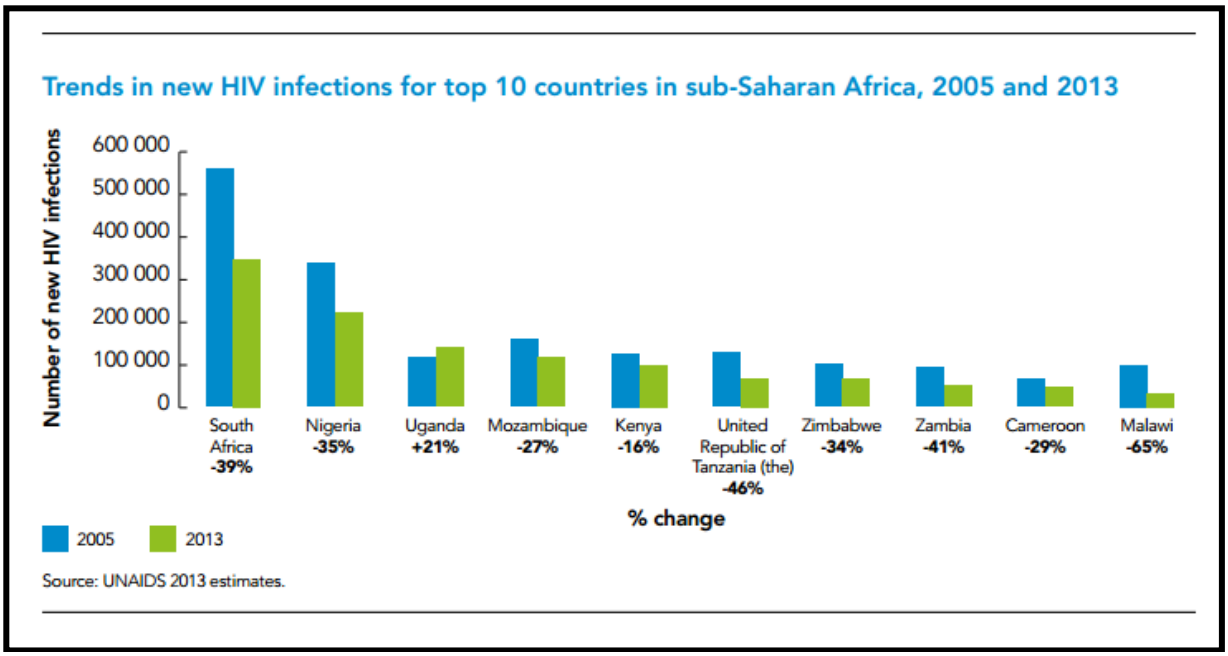
There were 1.5 million [1.3 million–1.6 million] new HIV infections in Africa south of the Sahara in 2013 including 210 000 [180 000 – 250 000] new HIV infections among children. However new HIV infections are on the decline with a 33% drop in new HIV infections among all ages in the region between 2005 and 2013.There has been a 43% decline in new HIV infections among children in the 21 priority countries of the Global Plan in Africa since 2010. The number of new HIV infections is falling in every country in the region except in Angola and Uganda where increases were recorded. South Africa, the country with the largest number of people living with HIV, recorded the

[27] The Gap Report – UNAIDS, 2014

largest decline in new infections in absolute numbers, with 98 000 fewer new HIV infections than in 2010.

Despite gains in preventing new HIV infections, Africa south of the Sahara remains the region most severely affected, with nearly 1 in every 25 adults (4.4%) living with HIV [28]. Only 3 countries—Nigeria, South Africa and Uganda—represented almost 48% of the new HIV infections in the region. While the majority of new HIV infections occur among adults above the age of 25, a large proportion occur among young women and adolescent girls. Some African countries are not on track to achieve the 2015 target of reaching 80% of men with voluntary medical male circumcision. The progress towards agreed targets is very uneven.

Figure 2 : ***Trends in new HIV infections for top 10 countries in Africa south of the Sahara, 2005 and 2013***



7.6.2 Preventing Tuberculosis

Tuberculosis' prevention activities pursues four main objectives namely: (i) to improve case detection and treatment adherence, (ii) to combat stigma and discrimination, (iii) to empower people affected by TB, (iv) and to mobilise political commitment and resources for TB. Improved detection and treatment of infected individuals and improved linkages with HIV services are the most effective TB prevention methods. Across Africa, community involvement is a key mechanism to expanding access to high-quality TB care. Important progress in involving communities in TB care and prevention was noted across the continent in recent years. In 2006 65% of Member States reported community involvement.[29] While Africa had 24% of the world's TB cases and the highest morbidity and mortality per capita, the number of new TB cases was decreasing for several years and falling by about 2% between 2010 and 2011. However, Africa

[28] The Gap Report – UNAIDS, 2014
[29] "The Global Plan to Stop TB 2006-2015: Progress Report 2006 2008", Stop TB Partnership of the World Health Organization; 2009.

is not yet on track to meet the goal of halving TB mortality from 1990 to 2015 and of particular concern is the slow progress towards diagnosis of MDR-TB.

7.6.3 Preventing malaria

Malaria interventions are highly effective and affordable. The main interventions comprise (i) vector control (which reduces transmission by the mosquito vector from humans to mosquitoes and then back to humans), (ii) using insecticide-treated mosquito nets (ITNs) or indoor residual spraying (IRS), (iii) chemoprevention (which prevents the blood stage infections in humans) and case management (which includes diagnosis and treatment of infections).

Significant progress was made to strengthen preventive measures against malaria during recent years, leading to remarkable changes in incidence rates since 2006. According to 2012 data, there is now an average incidence rate of 19 200 Malaria cases per 100 000 inhabitants across the 54 AU Member States, down from over 23 000 cases per 100 000 inhabitants in 2010. In 2013[30], 584 000 deaths globally occurred across the world. About 90% of all malaria deaths occur in Africa south of the Sahara. About 78% of these occur in children under five. In 2013, 97 countries reported malaria transmission. About 80% of estimated malaria deaths occur in 18 most affected countries. About 40% of malaria deaths occur in just two countries, which are Nigeria and Democratic Republic of Congo. The malaria mortality rate was reduced by 54% in the African Region between 2000 and 2013 [31].

Insecticide-treated mosquito nets (ITNs)

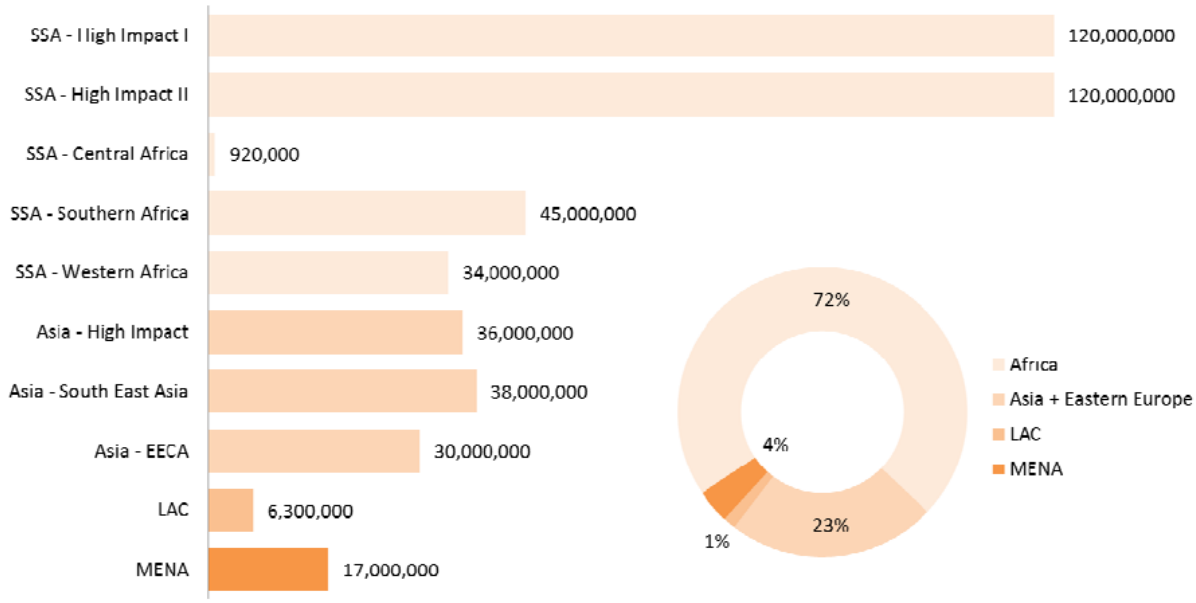
ITNs are estimated to reduce Malaria mortality rates by 55% in children under 5 years of age in Africa south of the Sahara. In these settings, the proportion of the population with access to an ITN in their household increased dramatically from 2005 to 2011 but the rate flattened during the last 2 years, reaching 42% in 2013. Increased deliveries of ITNs during the next 2 years should increase ITN coverage. By 2012, 34 countries in the African Region and 83 countries worldwide adopted the WHO recommendation to provide ITNs to all persons at risk for Malaria. A total of 88 countries, including 39 in Africa, distribute ITNs free of charge.

Every year, at least 150 million ITNs are needed to maintain a supply of 450 million ITNs in households over each 3-year period. This can protect all populations at risk of malaria in Africa south of the Sahara. The estimated numbers of ITNs delivered in 2013 (136 million) and funded by donors for 2014 (approximately 200 million) are close to the number of ITNs required annually to protect all populations at risk. However, even with the increase in yearly deliveries, the projected 3-year total of ITNs delivered between 2012 and 2014 (about 400 million) is still below the minimum number needed to protect all persons at risk of malaria.

The appropriate levels of ITN deliveries need to be maintained each year to ensure the availability of ITNs in households and access to an ITN for every person at risk of malaria. The percentage of households owning at least one ITN in Africa south of the Sahara is estimated to have risen from 3% in 2000 to 54% in 2013.

[30] World Malaria Report, WHO 2013
[31] World Malaria Report, WHO 2014

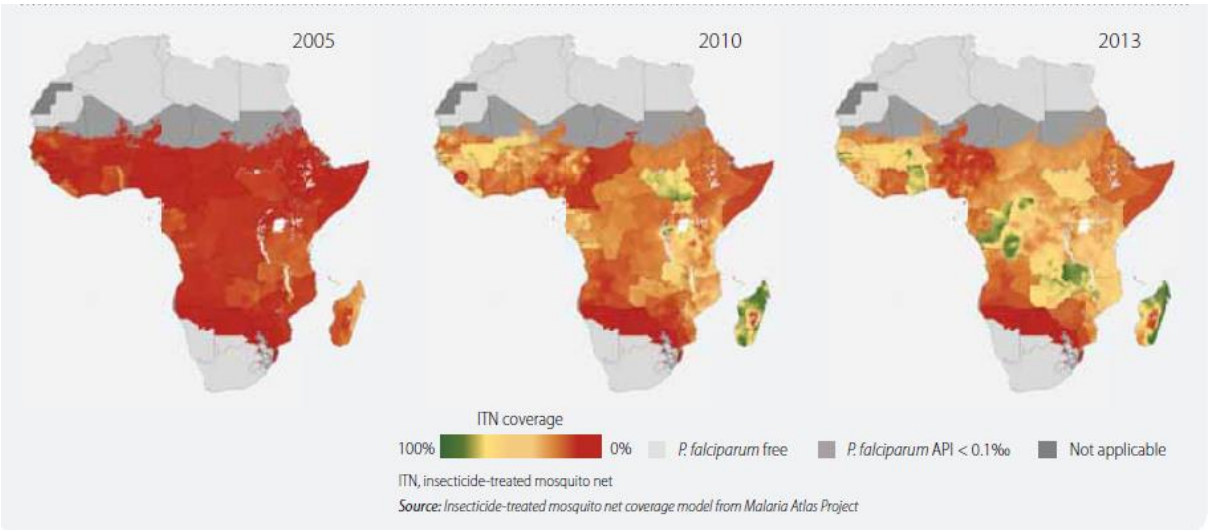
Figure 3: Nets distribution results by region[32]



Indoor residual spraying (IRS)

In 2012, a total of 88 countries, including 40 in the African Region, recommended IRS for Malaria control. In 2012, 135 million people (4% of the global population at risk of malaria) were protected by IRS worldwide. In the African region, the proportion of the population at risk that was protected rose from less than 5% in 2005 to 11% in 2010, but fell to 8% in 2012, with 58 million people benefiting from the intervention.

Figure 4: Proportion of population sleeping under an ITN, Africa (Source: World Malaria Report 2014)



[32] Global Fund Results Factsheet – December 2014

Mosquito resistance to at least one insecticide used for Malaria control

Resistance was identified in at least 64 malaria-endemic countries worldwide. In May 2012, WHO and RBM released the Global Plan for Insecticide Resistance Management (GPIRM) in Malaria vectors. The GPIRM is a five-pillar strategy for managing the threat of insecticide resistance. Stakeholders in the global malaria community have begun activities related to implementing the strategy laid out in the GPIRM. Monitoring insecticide resistance is a necessary element of the implementation of insecticide-based vector control interventions. In 2012, a total of 58 countries reported that they adopted a policy of routine monitoring of insecticide resistance.

Progress on chemoprevention

Among African countries reporting this information to WHO, the median percentage of pregnant women attending antenatal care (ANC) who received at least one dose of intermittent preventive treatment (IPT) during pregnancy in 2012 was 64%. About 38% received at least two doses and 23% received at least three doses indicating that there is considerable scope for improving protection for pregnant women. In Africa south of the Sahara, an estimated 35 million pregnant women and a large portion of the estimated 26 million infants born each year would benefit from IPT. A total of 37 Africa south of the Sahara countries with moderate to high malaria transmission adopted IPT for pregnant women (IPTp) as national policy by the end of 2013[33]. In Africa south of the Sahara in 2013, an estimated 278 million people lived in households without an ITN, 15 million pregnant women did not receive IPT, and 56-69 million children with malaria did not receive an ACT.

7.7 TREATMENT, CARE AND SUPPORT

AU Member States committed to promoting and integrating access to treatment, care and support for AIDS, TB and Malaria in the Abuja Call. Measurable progress was achieved over the period between 2010 and 2014 to increase access to antiretroviral therapy.

7.7.1 Treatment, Care and Support in the AIDS response

In 2013 there were 24.7 million [23.5 million – 26.1 million] PLWHA in Africa south of the Sahara. Ten countries namely Ethiopia, Kenya, Malawi, Mozambique, Nigeria, South Africa, Uganda, Tanzania, Zambia and Zimbabwe account for 81% of all PLWHA in the region. Half of those living with HIV are only in two countries—Nigeria and South Africa. Women account for 58% of the total number of PLWHA in Africa south of the Sahara. Treatment coverage is 37% of all PLWHA in Africa south of the Sahara. An

[33] WHO – RBM, Malaria World Report 2014

estimated 67% of men and 57% of women were not receiving ART in Africa south of the Sahara in 2013. It is estimated that three out of the four people on ART live in Africa south of the Sahara.

In Nigeria nearly 80% of people do not have access to treatment. On the other hand, South Africa—with double the number of PLWHA —increased treatment coverage from one person in ten in 2010 to four people in ten by 2013, while also reducing AIDS-related deaths by 48%. In Africa south of the Sahara, the number of AIDS-related deaths fell by 39% between 2005 and 2013. The region still accounted for 74% of all the people dying from AIDS-related causes in 2013. A significant decline (48%) was seen in South Africa. Other countries that recorded major declines in AIDS-related deaths include Rwanda (76%), Eritrea (67%), Botswana (58%), Burkina Faso (58%), Ethiopia (63%), Kenya (60%), Zimbabwe (57%), Malawi (51%) and Tanzania (44%).

7.7.2 Tuberculosis

Africa has 24% of the world's TB cases which is nearly 80% of TB cases among people living with HIV. It also has the highest proportion of TB cases co-infected with HIV (39%). Nearly 4 in 10 TB cases in Africa remained undetected in 2011. The number of TB cases globally that were detected and treated through Global Fund grants rose by 30% in the 18 months prior to mid-2014[34].

The number of TB patients tested for HIV in Africa increased from 3% in 2004 to 69% in 2011. Africa has thus vastly outpaced other regions (global average of 40%) in determining the HIV status of all people with TB. In Africa 46% of TB patients known to be living with HIV in 2011 were started on ART. This is an improvement over the previous years. However this is about half of what is required to ensure prompt HIV therapy for TB patients living with HIV. In the 18 months prior to mid 2014, the number of individuals receiving dual HIV and TB treatment supported by the Global Fund rose by 38%[35]. Of the global results of 12.3 million people tested and treated for TB with GFATM funding, only 3 million were in the Africa region. This amounts to 24% of all results[36].

The treatment success rate among new cases of TB continues to be high, but major efforts are needed to ensure all cases are detected, notified and treated. In 2013 about 6.1 million TB cases were reported to WHO. Of these, 5.7 million were people newly diagnosed and another 0.4 million were already on treatment. Notification of TB cases has thus stabilised in recent years. In 2013 about 64% of the estimated 9 million people who developed TB were notified as newly diagnosed cases. This is estimated to have left about 3 million cases that were either not diagnosed, or diagnosed but not reported to national TB programmes (NTPs). Significant efforts are needed to close this gap. In 2013 the treatment success rate continued to be high at 86% among all new TB cases.

There is a continued need for the integration of services notably for TB and HIV. More than 75% of all estimated HIV incident tuberculosis cases live in just 10 countries, nine of them in Africa south of the Sahara. These are Ethiopia, Kenya, Mozambique,

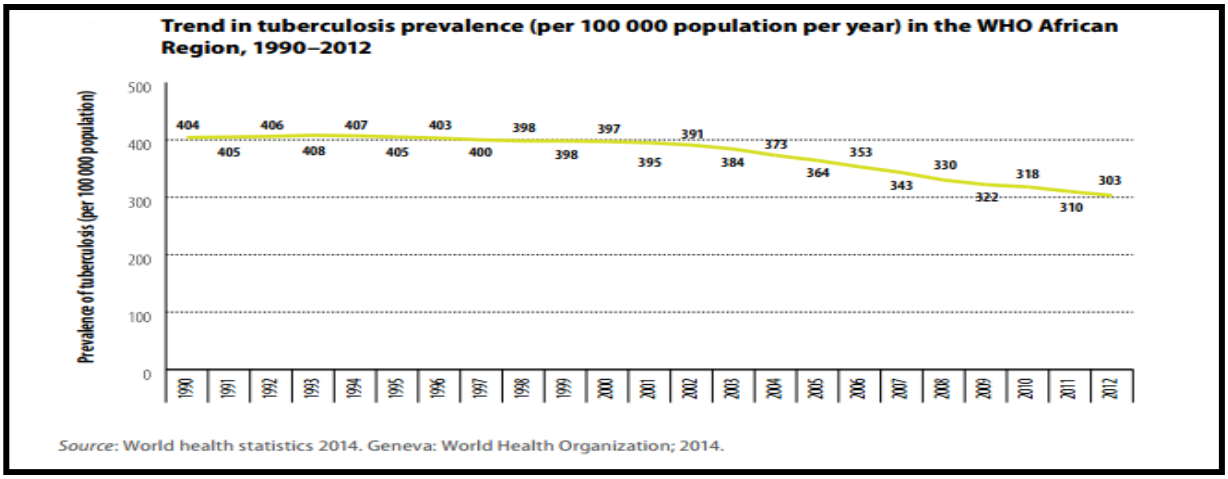
[34] TB Global Report 2014

[35] Global Fund Results Factsheet – December 2014

[36] Global Fund Results Factsheet – December 2014

Nigeria, South Africa, Tanzania, Uganda, Zambia and Zimbabwe. Significant progress was reported in the region where 74% of all notified tuberculosis cases were tested for HIV in 2012.

Figure 5: Trend in tuberculosis prevalence (per 100 000 population per year) in the WHO African region, 1990-2012



Major efforts to ensure that all detected cases are reported to NTPs and to improve access to care to reduce levels of under-diagnosis are needed. The first-ever national TB prevalence survey in Nigeria showed that there were many people with undiagnosed TB and typical TB symptoms in the community. Access to basic diagnostic and treatment services needs to be substantially improved to ensure that people with TB are promptly identified and treated.

MDR-TB detection and treatment outcomes

Increased use of new diagnostics is ensuring that significantly more TB patients are correctly diagnosed. However major treatment gaps remain and funding is insufficient. Globally 3.5% of new and 20.5% of previously treated TB cases was estimated to have had MDR-TB in 2013. On average an estimated 9% of patients with MDR- TB had extensively drug resistant TB (XDR-TB).

Progress in the detection of drug-resistant TB was facilitated by the use of new rapid diagnostics. A total of 97 000 patients were started on MDR-TB treatment in 2013, a three-fold increase compared with 2009. However, 39 000 patients (plus an unknown number detected in previous years) were on waiting lists. The gap between diagnosis and treatment widened between 2012 and 2013 in several countries. The most recent treatment outcome data are for patients started on MDR-TB treatment in 2011. Globally the success rate was 48%.

The progress in responding to multidrug-resistant TB (MDR-TB) however remains slow. While the number of cases of MDR-TB notified in the 27 high MDR-TB burden countries is increasing, only one in five (19%) TB patients estimated to have MDR-TB are identified. Despite these challenges there are some encouraging signs. From mid 2013 through end-2014 the number of MDR-TB patients receiving treatment with Global Fund support rose by 42%. In the high MDR-TB burden countries 5 out of 27

achieved a treatment success rate above 70%. Ethiopia is among the countries that achieved this.

7.7.3 Malaria

Globally an estimated 3.2 billion people in 97 countries and territories are at risk of being infected with malaria and developing disease. Of these 1.2 billion are at high risk. According to the latest estimates 198 million cases of malaria occurred globally in 2013. Most of these cases (82%) were in the Africa region. The disease led to 584 000 deaths representing a decrease in malaria case incidence and mortality rates of 30% and 47% respectively since 2000 [37].

The malaria burden is highest in the African region

An estimated 90% of all malaria deaths occur in the Africa region and children aged less than 5 years account for 78% of all deaths. The Democratic Republic of Congo and Nigeria together accounted for 39% of the global total of estimated malaria deaths and 34% of cases in 2013.

In Africa south of the Sahara the average infection prevalence in children aged 2–10 years declined by 48% between 2000 and 2013. The decline was particularly pronounced in central Africa[38]. Eight countries in Africa south of the Sahara are estimated to have achieved declines of >75% in PfPR while 14 countries achieved declines of >50% between 2000 and 2013. The biggest reductions in numbers of people infected were in high-burden countries with large populations and substantial PfPR declines. Despite the high population growth, Nigeria saw an estimated 20% decline in the average number of concurrent infections, from 47 million in 2000 to 37 million in 2013.

Malaria treatment involves two key elements-diagnostic testing and access to recommended treatment. In 43 AU Member States, treatment requires combination therapy with the use of artemisinin derivatives (artemisinin combination therapies (ACT) due to chloroquine-resistance and the risk of multi-resistance. The continent has made great strides in malaria treatment although significant challenges remain. By 2011, 41 AU Member States adopted a policy to provide parasitological diagnosis for all age groups, against 39 countries in 2010. Strong support from international donors and partners, such as GFATM, the World Bank, the (US) President's Malaria Initiative (PMI), the RBM Partnership and UNICEF in recent years have increased the number of treatments of ACT delivered to public and private sectors in the world. This increased from 11 million in 2005 to 278 million in 2011.

However, access to ACT-based malaria treatment remains low in many AU Member States. Data from household surveys in different countries show that despite adopting ACT treatment policies, mono-therapies continue to be used in many countries due to cost and poor supply chain management. Reports of treatment of children under 5 years for malaria remains below set targets. Among the 33 countries for which information is available, around 10.9% of children are treated adequately. In 20 of the

[37] WHO, RBM – Malaria World Report 2014

[38] WHO, RBM – Malaria World Report 2014

33 countries less than 10% of children are treated appropriately. WHO reports that by the end of 2011, 36 of the 45 affected African countries had adopted IPTp as national policy. In 25 of the 36 most affected countries adopting the policy and for which data are available, 44% of pregnant women received 2 doses of IPTp at antenatal care facilities.

Most countries with plasmodium falciparum malaria adopted ACTs as a first-line treatment

WHO recommends that uncomplicated plasmodium falciparum malaria should be treated with an ACT. The proportion of children in Africa south of the Sahara with plasmodium falciparum malaria receiving an ACT has increased markedly since 2005. However this has remained below 20% in 2013. Although in a number of countries ACTs are distributed free of charge or at a 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 RBM Partnership was established in 1998. Consequently, all Malaria endemic countries in Africa have established partnerships at the country level. 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.

The low proportion of children in Africa south of the Sahara with Malaria receiving an ACT is due in large part to feverish children not being brought for care. Information from household surveys conducted during the last decade in Africa south of the Sahara indicates that approximately 40% of children with fever are not presented for treatment. In addition, of those who are brought for care, approximately 20% seek attention in the informal private sector (pharmacies and shops). The rates of malaria diagnostic testing in these places are low and ACT treatments are less likely to be available. There are efforts to increase access to treatment in the community but only a small proportion of feverish children in Africa south of the Sahara receive care there. Access to malaria treatment and efforts to encourage caregivers to bring children to health-care facilities need to increase, to ensure all patients with malaria are appropriately treated (World Malaria Report 2014).

Antimalarial drug resistance

The number of countries that allow marketing of oral artemisinin- based monotherapy medicines has declined rapidly. The use of such therapies threatens the long-term usefulness of ACTs through the spread of resistance to artemisinin. WHO recommends that oral artemisinin-based monotherapies be withdrawn from the market and that marketing of these therapies should cease. The number of countries that allow the marketing of oral artemisinin-based monotherapies has dropped markedly since the World Health Assembly adopted a resolution supporting the ban in 2007. As of December 2014 only 8 countries among them 7 from Africa region allowed the marketing of artemisinin-based monotherapies. These are Angola, Cape Verde, *Colombia,* Equatorial Guinea, the Gambia, Sao Tome and Principe, Somalia and Swaziland.

Although household surveys only record whether a child has a fever, the results of Rapid Diagnostic Tests (RDTs) performed at the time (to estimate parasite prevalence in children) can be used as a proxy for malaria parasite infection in the preceding 2 weeks. Data obtained from the same household survey can indicate whether the patient received an ACT. In Africa south of the Sahara the estimated proportion of children aged under 5 years with confirmed plasmodium falciparum malaria that received an ACT increased steadily from less than 5% in 2005 reaching a range of 9–26% in 2013. Among children who were brought for care at public health facilities, the proportion with confirmed plasmodium falciparum malaria who received ACT was higher than the overall total for Africa south of the Sahara ranging from 16 to 41% in 2013.

Challenges remain regarding the forecasting of needs and timely flow of information of commodities from producers and suppliers, government bodies, implementing agencies and consumers. Unless these factors are addressed, there is a risk of shortage of ACT and other essential commodities. Despite impressive increases in malaria intervention coverage, it is estimated that in 2013, 278 million of the 840 million people at risk of malaria in Africa south of the Sahara lived in households without even a single ITN. An estimated 15 million of the 35 million pregnant women did not receive even a single dose of IPTp. Between 56 million and 69 million children with malaria did not receive an ACT. Poverty and low levels of education are significant determinants of lack of access to these essential services. More can be done to ensure all those at risk receive appropriate preventive measures, diagnostic testing and treatment.

7.8 ACCESS TO AFFORDABLE MEDICINES AND TECHNOLOGY

The Abuja Call committed AU Member States to put in place measures to increase access to affordable medicines and technologies for AIDS, TB and malaria. This would be achieved through appropriate legislation and utilising international trade regulations and flexibilities. At the 3rd 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 respond to AIDS, tuberculosis, and malaria. This long-term approach aims to reduce Africa's dependence on external suppliers and the financial burden of diagnosis, prevention and care while simultaneously improving commodities supply.

To date national regulatory authorities of the individual AU Member States operate independently, and this could potentially result in waste, duplication of effort and substantial delays in accessing important new medical tools. In an effort to minimi**s**e fragmentation with respect to the regulation of essential medicines and devices, NEPAD is collaborating with partners to coordinate the African Medicines Regulatory Harmoni**s**ation (AMRH) initiative. AMRH aims to accelerate progress towards the health-related MDGs by generating a sound regulatory environment for the development of the pharmaceutical sector in Africa.
AMRH is assisting Regional Economic Communities (RECs) and countries in (i) developing harmonised, effective and efficient regulatory approval processes and (ii) instituting governance and accountability mechanisms to ensure transparency in

regulatory services delivery. In this way the AMRH initiative is designed to increase access to safe medicines throughout Africa, an important step towards the ultimate goal of a single African Regulatory Agency. AMRH's first project on harmonisation of medicines registration was successfully launched in the East African Community.
In 2012, following the adoption of the Pharmaceutical Manufacturing Plan for Africa (PMPA)[39], the AU Commission and other partners elaborated a business plan for its implementation. The Assembly of Heads of State and Government subsequently endorsed the plan. The business plan seeks to (i) develop strong, independent and predictable national regulatory authorities; (ii) build regulatory capacity; (iii) increase and enhance competition; (iv) reduce demand uncertainty; (v) strengthen forecasting capacity; (vi) increase investments in the development of needed medicines; and (vii) provide time-limited, easily understood and accessible incentives to accelerate progress towards pharmaceutical self-sufficiency in Africa.

Key principles of the business plan include the recognition of quality health care as a fundamental human right, a firm belief that promoting industrial development and safeguarding public health are not mutually exclusive. The business plan is premised on the understanding that production of quality medicines and the development of an international Good Manufacturing Practices-compliant industry in Africa are both feasible and desirable.

In October 2013, Ghana's request to the AU Commission to lead its PMPA consortium to explore 'phase 1' implementation was a clear demonstration of political commitment. This also served to highlight that the will necessary to deliver on the vision of the PMPA and the continent's commitments exists. Using the example set by Ghana as a springboard, the AU Commission undertook in Abidjan in November 2013 to stimulate dialogue and engage Member States and partners to facilitate the creation of an enabling environment for pharmaceutical production in Africa. The dialogue resulted in the adoption of a four-point action plan to catalyse existing efforts to create an enabling environment for local pharmaceuticals production. These include (i) facilitating synergies amongst key pharmaceutical initiatives on the continent, (ii) promoting the institutionalisation of Good Manufacturing Practice (GMP) and strengthening of regulatory capacity, (iii) strengthening market capacity to promote growth and (iv) investment as well as continued implementation of activities by the PMPA consortium at country level.

The PMPA business plan recognises the existence of initiatives on the continent geared towards strengthening the pharmaceutical industry. In support of the objectives of the PMPA, RECs are being supported to develop and implement medicines harmonisation projects as a key intervention to strengthen regulation of pharmaceuticals on the continent and to promote the expansion of potential markets for quality assured medicines. Complementary regional initiatives include the Southern African Development Community (SADC) Pharmaceutical Business Plan 2007-2013[40] and the EAC Regional Pharmaceutical Manufacturing Plan of Action 2012-2016[41]. ECOWAS is formulating a charter to facilitate Public Private Partnerships for the local production of ARVs and other essential medicines[42].

[39] AU Commission, Update of the implementation of Pharmaceutical Manufacturing Plan for Africa (PMPA), Department of Social Affairs – Dec 2014
[40] www.unido.org
[41] http://feapm.com
[42] www.wahooas.org

The development of a model law on medicines regulations is also being pursued within the same framework and with the support of relevant AU organs. The first meeting of experts to facilitate the implementation of the African Medicines Agency (AMA) that will further enhance the regulatory environment and curtail proliferation of Substandard Spurious Falsely-labelled Falsified Counterfeit (SSFFCs) medical products was held in Addis Ababa in November 2014. The meeting looked at access to quality, safe and efficacious medicines in the African market. The meeting sought to provide technical guidance to the AU Commission on policies and actions required to meet the agreed milestones for the establishment of AMA. This included providing advice on the legal framework, technical requirements, managerial structure, financial sustainability and administrative procedures of the AMA, mapping or modelling the business processes and their scope in their order of priority. This included how the institution can interface and partner with other institutions in the same areas of work. The meeting also worked on the selection criteria for the hosting country/institution for AMA.

Achieving the PMPA's vision of a competitive, sustainable and self-reliant industry will demand increased human resource capacity, access to affordable financing, strong regulatory systems, strategic partnerships and business linkages. It will also require enhanced market data and information systems. Various challenges that will need to be overcome include engaging with unfavourable international trade policies and a lack of support to implement TRIPS flexibilities. All these hinder local production of essential medicines.

The continent also leverages on UNITAID as an innovative financing mechanism that facilitates global price reductions, improvements in product quality and innovation. UNITAD increases funding for greater access to treatments and diagnostics for AIDS, tuberculosis and malaria in low-income countries. UNITAID has an expanding north-south membership that includes the Bill and Melinda Gates Foundation and various African countries such as Cameroon, Congo, Guinea, Madagascar, Mali, Mauritius and Niger. Civil society organisations participate in the governance of UNITAID thus providing a voice to communities affected by AIDS, tuberculosis and malaria. It is the first global health organisation to use buy-side market leverage to make life-saving health products better and more affordable for developing countries. UNITAID is financed through air tickets levies and multi-year contributions from governments and a foundation.

7.8.1 Access to HIV treatment and commodities

In the past decade, the annual price of first-line antiretroviral drugs has plummeted from over US$ 10 000 per person in 2000 to less than US$ 116 in 2010 (for the lowest cost WHO- recommended regimen). In 2013, the price[43] of the most widely used first-line antiretroviral medicines (ARVs) ranged from US$ 53 / 85 to US$ 260 per person per year—more than 10% lower than the price in 2007.

The main finding is that the price of antiretroviral medicines in low- and middle-income countries has continued to decrease. The least expensive way to administer this

[43] Global Price Reporting Mechanism (GPRM), WHO 2013. The data in the Global Price Reporting Mechanism (GPRM) for the years 2010 and 2012 cover around 70% of all public procurement of ARVs. The summary report features the transaction data for ARVs in 2010, 2011, 2012 and the first three quarters of 2013. In the report and in the GPRM, countries have been classified as low-, lower middle-, and upper middle-income countries according to the World Bank Atlas calculation method. All prices refer to WHO prequalified, or stringent regulatory authority approved formulations.

regimen is to give a fixed dose combination that has a median price of US$ 97 per patient year. This will likely become the new price benchmark for this regimen. The price of second-line treatment followed the same downward trend.

In low-income countries, the median price of all preferred and alternative second-line treatment regimens is now less than US$ 350 per patient year. However, some lower middle-income countries pay a higher price. Due to patent protection these countries are required to procure lopinavir / ritonavir from the originator of the company at a higher price (but this is still low compared to high-income countries).

For paediatric treatment, the median price of major first-line regimens followed the same downward trend as those for adults. For example, compared to 2010, the median price of the most commonly prescribed regimen for paediatric use (ZDV+3TC+NVP) dropped by 6% in low-income countries, 9% in lower middle-income countries and 4% in upper middle- income countries. The average price paid for second-line regimens however continues to be significantly higher. Treating children with any of the preferred regimens remains more expensive than treating adults – except when using the most widely used treatment regimen as the fixed dose combination (ZDV+3TC+NVP).

The factors contributing to sharp price reductions include the sustained scaling up of treatment programmes, growing transaction volumes and predictability of demand. The competition between a growing number of WHO-prequalified generic products, regional bulk purchasing efforts, and favourable pricing policies from pharmaceutical companies are also key factors. Further reductions are expected to occur in the coming years as treatment scale-up continues. Given the decline in multilateral AIDS funding in recent years sustainable financing has become a priority for African countries. Currently, as many as six plants in Africa are producing generic antiretrovirals (primarily for local consumption). However some have been prequalified for export to other countries.

7.8.2 Access to TB treatment and commodities

The availability of first-line anti-TB drugs has significantly improved. Since 2001 the Global Drug Facility has provided affordable drugs for 20 million TB patient treatments. It has offered first-line TB treatments to an average of 20 African countries and access to second-line drugs for the treatment of MDR-TB to six countries annually since 2005. In 2013, the Global Drug Facility was the exclusive source for second-line TB drugs in Africa. Production capacity for high-quality, second-line drugs is being established in at least one AU Member State, although the cost of such treatment poses considerable challenges as the incidence of drug-resistant TB increases in Africa. WHO also prequalified the first-ever paediatric TB medicine, and prices for paediatric therapies have fallen as the number of manufacturers has increased.

To expand access to MDR-TB diagnosis and treatment—and to push for price reductions, AU Member States collaborate with UNITAID, the Global Drug Facility (GDF) of the Stop TB Partnership, the Green Light Committee (GLC), and the GFATM. Innovative market interventions enhanced the efficiency of TB control programmes in Africa. As a result of discounts stemming from an up-front, bulk purchase of the Xpert MDR/ RIF technology, unit prices for this critical diagnostic tool fell from US$ 17 to US$

10 in one year. In 2012, the Global Drug Facility provided access to TB diagnostic technologies to 11 countries in Africa.

7.8.3 Access to malaria treatment and commodities

Several initiatives emerged in Africa in recent years to improve access to affordable malaria treatment. Supported by the AU, Member States committed to increasing production of generic drugs, with concrete initiatives having been launched in Cameroon, Nigeria, South Africa and Tanzania. Other measures taken by countries to facilitate access to quality antimalarial medicines at affordable costs include eliminating taxes on treatment and establishing a strict pre-qualification process for producers managed by WHO.

The Affordable Medicines Facility for Malaria Fund (AMFm), established and managed by the GFATM with the support of UNITAID, the United Kingdom Department for International Development and other donors, aims to reduce the cost of ACT through subsidies. It also aims to contribute to efforts to gradually phase out mono-therapies to avoid the development of resistance. Following an initial successful pilot project of this approach in East Africa, eight African countries[44] namely Ghana, Kenya, Madagascar, Niger, Nigeria, Uganda, Madagascar and Tanzania submitted successful proposals to the GFATM to implement this approach. The approach has been demonstrated to be successful since 2010. An assessment carried out in 2012 indicates that AMFm subsidised nearly 320 million doses of ACT that helped to drive prices down[45].

In further recognition of the need for affordable commodities to combat malaria 74% of AU Member States waived taxes on anti-malarials. About 64% removed taxes or introduced waivers on ITNs while half waived taxes and tariffs on bed nets, netting materials and insecticides. In 2008, 42 of the 43 malaria-endemic countries in Africa were distributing ACT for treatment of Malaria. In 23 of these countries, ACT was free of charge for children under five. The GFATM working closely with many African countries and manufacturers, moved to a system of voluntary pooled procurement of commodities to reduce unit prices and enhance access to commodities. Accessibility was previously hampered by inefficient procurement and supply chain management systems. In 2013 ECOWAS announced that Côte d'Ivoire, Ghana and Nigeria will host new major factories for the production of biolarvicides used in the Malaria control programmes.

7.8 RESEARCH AND DEVELOPMENT

The Abuja Call committed AU Member States to promote ethical research and development of evidence-informed prevention, diagnosis, treatment and surveillance programmes for AIDS, TB and malaria. It also provided a framework for monitoring drug resistance. Although developing countries bear 90 percent of the global disease burden only 10% of all health research funding is used to address these diseases. Bridging this gap to deliver diagnostics for HIV and TB, drugs such as new fixed-dose combinations, paediatric formulations and more affordable second and third-line HIV treatments and possible vaccines to meet Africa's public health needs is critical to meeting the health related MDGs.

[44] Ghana, Kenya, Madagascar, Niger, Nigeria, Rwanda, Tanzania and Uganda
[45] www.essentialdrugs.org

To meet the access and innovation for health products that are needed stakeholders are re-examining current models and recommending alternatives. These include patent pools, public-private partnerships, prize funds, research incentives, tax breaks for some activities and tax levies for others, new donor relationships and strategies. Another important focus is a global binding treaty to prioritise and ensure funding for research and development. The AU Commission will co-operate closely with (i) WHO Public Health, Innovation and Intellectual Property (PHI) Team and (ii) WHO Consultative Expert Working Group on innovative financing mechanisms for research and development.

7.8.1 Research and development in the AIDS Response

Recent studies proved the efficacy of voluntary medical male circumcision on HIV for at least 42 months. Three randomised 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% and generalised heterosexual HIV epidemics with low rates of male circumcision should consider urgently scaling up access to male circumcision services. As a result, all 13-priority countries are implementing these recommendations.

An important partnership initiative was the 2010 launch of the African Network for Drugs and Diagnostics (ANDI), initiated by the WHO's Department for Tropical Disease Research (TDR). ANDI seeks to create partnerships amongst African institutions to strengthen national capacity for research and development for affordable new tools, including those based on traditional medicines, to address local health needs[46]. Significant research findings for HIV prevention between 2010 and 2012 included confirmation of the preventive possibilities of ARVs, making the prospect of a microbicide containing an antiretroviral drug an increasing reality for women in Africa.

Important findings for the treatment of mothers and children included a secondary analysis of the Kisumu Breastfeeding Study in Kenya showing that HIV-positive babies develop resistance to antiretroviral drugs through breastfeeding. A randomised study in Botswana showing that among pregnant women with HIV found that ART including a protease inhibitor increases the risk of preterm delivery compared to treatment containing only nucleoside analogues. In addition, there was increasing evidence that social protection especially cash transfers for young women and girls, perhaps linked to keeping them in school, can help bring down incidence. Similarly PrEP can play a role in very high incidence settings[47].

Since 2001, national HIV surveys were conducted in 31 high-prevalence countries in Africa. Eight of these countries conducted these surveys more than once. Household surveys that included a component to assess HIV prevalence were conducted in 28 African countries, 9 of them in 2007 and 2008.[48] While these surveys vary considerably in quality, they provided more representative population-based estimates of HIV

[46] "Developing ANDI: A Novel Approach to Health Product R&D in Africa", PLoS Med 7(6), e1000293. doi:10.1371/journal.pmed.1000293, Available at www.plosmedicine.org
[47] UNAIDS, New Global Prevention Targets for post-2015, Karl Dehne, Chief Prevention Department, 2015 (Ppt presentation)
[48] "AIDS Epidemic Update", UNAIDS; November, 2009.

prevalence than was possible with previous extrapolations from sentinel surveillance of women attending antenatal clinics.

7.8.2 Research and development in Tuberculosis

The development of a preventive TB vaccine for adults, improved diagnostics and treatment of MDR and XDR-TB as well as monitoring of drug resistance remain key priorities. The acute lack of funding for research and development in the field of TB remains a huge challenge. The development of a vaccine for malaria is an ongoing challenge, particularly given the various forms of the plasmodium parasite.

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

Four countries in East and Southern Africa undertook 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 were also earmarked to benefit from an expanded programme to introduce this technology through a collaborative project between WHO and UNITAID.[49]

Efforts to develop new TB diagnostics, drugs, and vaccines intensified during the past decade[50]. However, considerable progress and investment is still needed. Increased and sustained investment in new TB diagnostics remains essential for the development of an accurate, easy- to-use, affordable point-of-care assay for the rapid and early diagnosis of TB. There is significant industry interest in TB diagnostics, with more than 50 companies involved in assay development. However, although many new diagnostic technologies are under development or are available on the market, funding for accelerated field evaluation of diagnostic accuracy and robustness of these assays is insufficient.

To facilitate the development of new diagnostic tests, four priority target product profiles have been developed. This was developed through a consensus-building approach among stakeholders to define optimal and minimal characteristics of the four priority tests and help manufacturers understand their market potential. There are 10 new or repurposed anti-TB drugs currently in late phases of clinical development.

There were 15 vaccine candidates in clinical trials in 2014. Most are designed for prevention of TB. They work through the prevention of infection or prevention of progression to disease in infected persons. Several of these vaccines are currently in or will shortly enter Phase II and IIb trials and will be tested in further Phase III trials. Research and development is one of the three pillars of the WHO post-2015 global TB strategy. It will play a crucial role in accelerating the reductions in TB incidence and mortality required to reach post-2015 global TB targets and beyond.

[49] Feuer, Cindra. "Tuberculosis Research and Development: A Critical Analysis", The Treatment Action Group; October 2006.
[50] TB World Report 2014

Research to develop a test to diagnose TB and MDR-TB at the point of care is continuing and further diagnostic testing will soon be available. Innovative regimens to treat drug-susceptible TB and MDR-TB and shorten the duration of treatment have shown promising results in clinical trials. Research linking malaria and economic development in the western region of Ghana may help to strengthen the integration of the diseases in development strategies. The US National Institute of Allergy and Infectious Diseases has furthermore supported the establishment of international centres of excellence in research on malaria in endemic regions, especially in parts of Africa.

7.8.3 Malaria

Development of a vaccine for malaria is an on-going challenge, particularly given the various forms of the plasmodium parasite. 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 (MVI), Medicines for Malaria Venture (MMV), Innovative Vector Control Consortium (IVCC) and FIND for diagnostics.

The Bill and Melinda Gates Foundation supports these initiatives in order 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. There is also on-going research aimed at improving access to malaria diagnostic tests and ensuring that effective treatment using ACT is accessible at community level.[51] 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).

Insecticide resistance in Malaria vectors has been reported in 49 out of 63 reporting countries around the world since 2010. Of these 39 have reported resistance to two or more insecticide classes. The most commonly reported resistance is to pyrethroids, the most frequently used insecticide in malaria vector control. WHO has established a system to track insecticide resistance globally and recommends annual monitoring. In 2013, some 82 countries reported undertaking insecticide resistance monitoring. However only 42 of these countries provided WHO with resistance data for 2013, suggesting that many countries do not monitor insecticide resistance annually.

7.9 IMPLEMENTATION

In accordance with commitments made by States under the Abuja Call, AU Member States committed to strengthen and support the implementation of generalized strategic programs against HIV and AIDS, tuberculosis and Malaria at country and regional levels. Across all three disease areas, improvements in policies to promote better preventive measures, deliver more-effective medicines, and increase access to

51 "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.

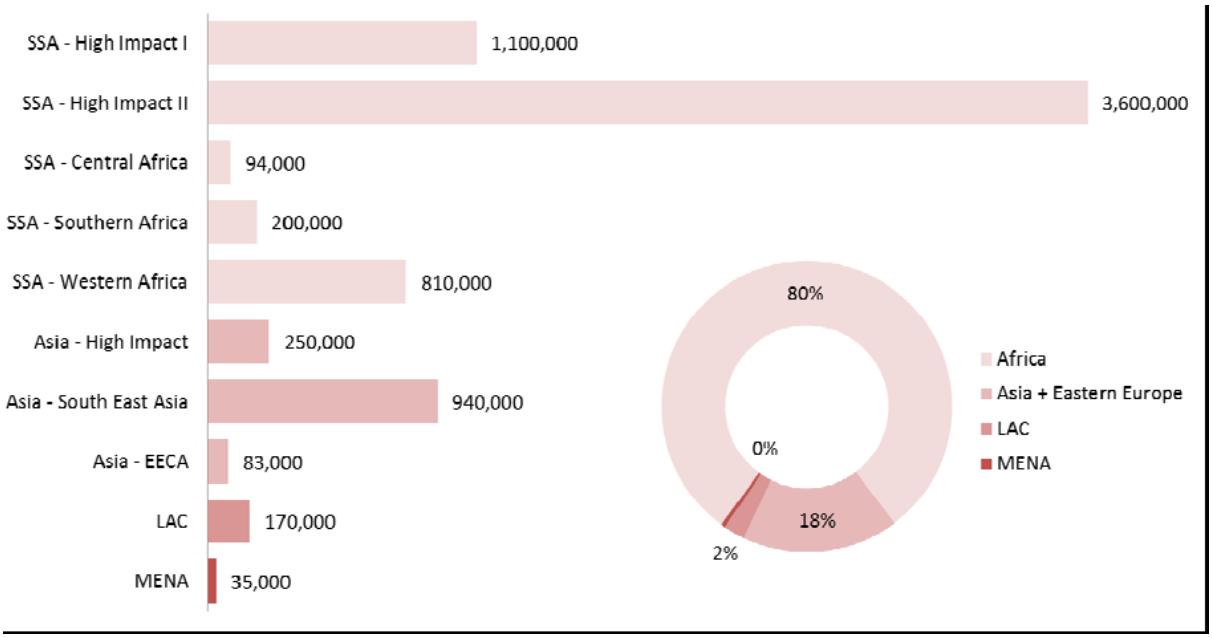
treatment and services has been significant. Progress in general in relation to HIV and AIDS, TB and malaria, including the development of national strategic plans on HIV, TB and malaria; the acceleration of Malaria control programmes and the prevention of MDR-TB, as well as the on-going challenges, were set out above in related sections of this report.

7.9.1 The AIDS response

National AIDS coordinating authorities are 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. Within Africa south of the Sahara 67% [65–68%] of men and 57% [55–60%] of women living with HIV are not receiving antiretroviral therapy. By 2012 ARV therapy reached more than seven million people in Africa, with five African countries achieving universal access to HIV treatment. Since 1995 ARV therapy has averted 7.6 million deaths globally, including 4.8 million deaths in Africa south of the Sahara.

The number of new HIV infections is falling in every country in the region except in Angola and Uganda where increases were recorded. South Africa is the country with the largest number of people living with HIV that recorded the largest declines in new infections in absolute numbers. It recorded a decline of 98 000 fewer new HIV infections than in 2010. Even as access to antiretroviral therapy expands in Africa south of the Sahara significant gaps remain. These include the fact that only 48% of people living with HIV know their HIV status, which underscores the need to increase HIV knowledge and expand testing.

Figure 6: ART Results by region[52]



[52] Global Fund Results Factsheet – December 2014

7.9.2 Tuberculosis

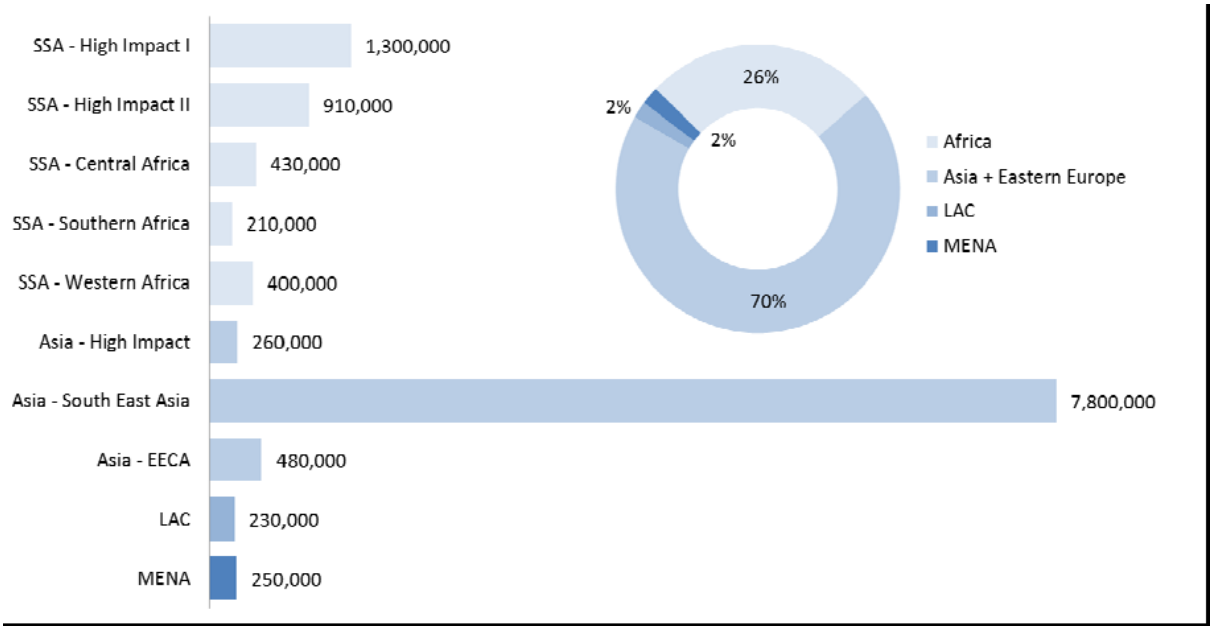
Since the Abuja Call, TB was declared a national emergency or targeted for special action in 26 of the 46 countries reporting.[53] Ministers of Health from across Africa gathered in September 2007 in Brazzaville, Congo where they jointly adopted a regional strategy to combat the dual TB/HIV epidemic. In September 2009 at the 59th session 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 TB control. Despite these repeated commitments and the development of regional strategies to fight tuberculosis, well-established national programmes 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 programmes to treat it.[54]

The case detection rate in Africa for TB is the lowest in the world. Countries with high HIV prevalence (48%) and low HIV prevalence (46%) were significantly behind the 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%). AU Member States with a low HIV prevalence fell short of their target by an average of 14%. The Directly Observed Treatment, Short-Course (DOTS) coverage now exceeds 90% in AU Member States with a high prevalence of HIV.

The treatment success rate has been sustained at above 81% in the African region in 2012 representing an improvement from 79% in 2011. In 2013, the case detection rate was relatively low in the African Region (best estimate 52%). The estimate for the African region is strongly influenced by the case detection rate in Nigeria, which was revised downwards (to a best estimate of 16% in 2013) in the latest series of estimates following the findings of the 2012 national TB prevalence survey. The treatment success rate in most of the 22 High Burden Countries (HBCs) was sustained at high levels for several years. In 2012, 16 of the 22 HBCs achieved a treatment success rate of over 85%. Improvements are still required in Uganda and Zimbabwe. The case detection rate was relatively low in Democratic Republic of Congo, Mozambique, Nigeria and Zimbabwe.

Figure 7: DOTS (New smear positive) results by region[55]

[53] "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.
[54] "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.
[55] Global Fund Results Factsheet – December 2014



7.9.3 Malaria

Since 2000 all malaria-endemic countries in Africa 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. Consequently all but two countries on the continent have adopted policies that introduce ACT as the first line treatment for malaria.[56]Country Strategic Plans (CSP) are all based on the four technical elements of Roll Back Malaria and the evidence-based interventions associated with them. These are 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 on-going health sector reforms. Linkages to existing initiatives such as Integrated Management of Childhood Illness and Making Pregnancy Safer are utilised 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.

Most AU Member States are moving towards universal access to malaria prevention and control among all populations at risk of malaria. There has been 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.

[56] "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.

7.10 PARTNERSHIPS

In the Abuja Call AU Member States committed to developing and supporting partnership mechanisms to coordinate the contributions of stakeholders, from public sector, private sector and civil society at regional and international levels. This was conceived as key in achieving universal access to prevention, treatment, care and support for AIDS, TB and malaria. Although there was limited updated information on partnerships at national level due to limited country reporting global and regional partnerships for all three diseases have been important to efforts to address the three epidemics. At the global level critical partnership mechanisms that helped to mobilise resources and accelerate progress in addressing AIDS, TB and malaria included GFATM and PEPFAR. Over the past decade, much was learned as the G8 and AU partnership evolved.

A Programme of the African Union, the New Partnership for Africa's Development (NEPAD), was established with the formal adoption of The NEPAD Strategic Framework at the 37th Summit of the Organisation for African Unity (OAU) in July 2001. In November 2012, a "consortium" to facilitate the implementation of the PMPA Business Plan was established and is currently coordinated by the AU Commission and United Nations Industrial Development Organisation (UNIDO). These organisations included but are not limited to UNIDO, UNAIDS, NEPAD, WHO, ANDI, FAPMA, UNDP and USP. The consortium includes representation from the private sector.

RECs and regional institutions are among the core implementers for the NEPAD programme as is the case with the AMRH programme. Among them are (i) the East African Community (EAC), (ii) the Southern African Development Community (SADC) through the Southern African Regional Programme on Access to Medicines and Diagnostics (SARPAM), a DFID funded regional Programme on improving access to medicines and diagnostics; (iii) the Economic Community of West African States (ECOWAS); (iv) the Economic and Monetary Community of Central Africa (CEMAC); (v) the Economic Community of Central African States (ECCAS); (vi) the Organization for the coordination of the fight against endemic diseases in central Africa (OCEAC); (vii) the Community of Sahel and Saharan States (CEN-SAD); (viii) the Arab Maghreb Union (AMU); (ix) the Common Market for Eastern and Southern Africa (COMESA), (x) the Intergovernmental Authority on Development (IGAD). The Pan African Parliament (PAP) and the Inter-Parliamentary Union (IPU) also play a critical role.

7.10.1 The AIDS response

Several continental and global partnerships are noteworthy. These include PEPFAR, WHO and UNAIDS at state level to look at the integration of HIV and TB responses and UNITAID to increase access to affordable medicines for developing countries. Important sub-regional and national partnerships were established in different countries such as the Esther Programme and the Clinton Health Access Initiative. AWA also fostered partnerships between African political leaders, CSOs, academics and development agencies through a high-level meeting in 2012 on the side-lines of the UNGASS meeting.

Key partners in the AIDS response included groups and networks of PLWHA, AIDS service organisations, harm reduction networks, people who use drugs, key

populations, organisations of young people, women, health professionals and scientists, sports entities, national and international NGOs, faith-based organisations, humanitarian organisations, human rights organisations and academia. PLWHA played a pivotal role in the response to AIDS.

Based on existing human rights frameworks PLWHA had increased access to appropriate services, gender equality, self-determination and participation in decisions affecting their quality of life. The Greater Involvement of PLWHA (GIPA) was therefore critical for the implementation of effective programmes with a high degree of acceptability and service uptake. In 2012, national AIDS coordinating bodies included representation of people living with HIV in 47 AU Member States.

Africa recognised and responded to the critical importance of a working partnership with civil society. As of December 2012, 48 countries ensured full involvement and participation of civil society in the development of their national strategy on AIDS, with an additional three reporting moderate involvement. In 47 countries, a mechanism existed to promote interaction between government, civil society organisations and the private sector for implementing HIV strategies and programmes.

The private sector was an important, even if under-utilized, partner. Private sector representatives participate on many national AIDS councils and in country coordinating mechanisms of the Global Fund, which served as critical vehicles for engaging a broad array of stakeholders in national AIDS, TB and malaria efforts.

In many countries, national AIDS Business Councils also provided a platform for private sector engagement and the sharing of best practices in HIV workplace policies and programmes. Various networks, such as the African Broadcast Media Partnership against AIDS facilitated the active engagement and leadership of different components of the private sector in the AIDS responses. As the AU and G8 partnership itself illustrated, many critical partnerships in the AIDS response occur at the global and regional levels. The Global Fund served as a vital instrument for engaging OECD countries beyond the G8, as well as emerging economies.

7.10.2 Tuberculosis

The Stop TB Partnership, established in 2001 to co-ordinate country responses to TB, continues to be an important partnership in the response to TB. UNITAID and the Global Drug Facility of the Stop TB Partnership, the Green Light Committee and the GFATM continued to support Member States to improve global responses to TB. More than 1000 organizations—including non-governmental organizations, private sector entities, academic institutions, national and local governments, and consumer alliances— participated in the Stop TB Partnership, which is leading global efforts to meet TB targets[57].

7.10.3 Malaria

The RBM Partnership is a global partnership initiated by WHO, UNDP, UNICEF and the World Bank in 1998. It provides a cooperative framework for collaboration between the governments of countries where malaria is endemic with donor countries,

[57] TB World Report 2013

multilateral development partners, CSOs, the private sector, foundations, research and academia to reduce the human and socio-economic costs of malaria. African countries with endemic malaria furthermore established national partnerships to support universal access. The US PMI is another important initiative to reduce malaria mortality by 50% in 15 countries heavily affected by malaria. Since the Abuja Declaration on Roll Back Malaria (RBM) in 2000, all endemic countries in Africa south of the Sahara established country-based RBM partnerships.

The Malaria Elimination Group (MEG) catalysed a Southern Africa Partnership known as the "E8", focussing on regional Malaria elimination targets. The Intergovernmental Agency for Development incorporated in its regional HIV/AIDS partnership programme malaria prevention, diagnosis and treatment. This was primarily to address the needs of highly mobile cross border and internally displaced populations, refugees as well as for populations living in high transmission areas for HIV.

The African Leaders Malaria Alliance (ALMA) is a ground breaking coalition of 49 African Heads of state and government working across country and regional borders to achieve "near zero Malaria deaths in Africa by 2015". Promoting transparency and accountability, ALMA publishes scorecards of key elements of malaria control, including policies, financing, commodity procurement, implementation, and the impact on maternal and child health. ALMA supported the "SADC Malaria elimination eight (E8) scorecard project".

The AU Commission continues to engage in strategic discussions with international stakeholders at various international and continental fora and platforms such as China-Africa co-operation, India- Africa, USA-Africa, European Union - Africa co-operation, G8, and the EU. With the support of its partners, the AU Commission plans to continue to coordinate and mobilise support for implementation of agreed actions and commitments of the AU Member States in accordance with the objectives of the PMPA while fast tracking progress of specific initiatives at both regional and national level.

7.11 MONITORING, EVALUATION AND REPORTING

AU Member States committed to strengthening monitoring, evaluation and reporting of the three diseases. Subsequently a monitoring and reporting mechanism with target indicators was developed for reporting on the implementation of the Abuja Call. Accountability systems are critical to ensure implementation of AIDS, TB and malaria commitments and monitoring the achievement of results. Comprehensive and timely Monitoring and Evaluation (M&E) data is crucial to optimise the use of limited resources, to ensure effective programmes and to strengthen accountability.

Robust monitoring systems play a critical role in building and sustaining political support and provide country programmes with three key elements: (i) surveillance data to assess changes in disease burden (including incidence, prevalence, mortality rates and drug resistance), (ii) monitoring and evaluation of interventions and programmes, (iii) and operational research. These three components provide vital information that drives the development of new strategies and policies, resource mobilisation and interventions. Strategic information systems also provide proof that investments are making a difference in people's lives. Furthermore it promotes key values of the African rebirth, including transparency, accountability and good governance.

7.11. 2 Monitoring, evaluating and reporting on the AIDS response

National AIDS M&E systems were rapidly scaled up and strengthened with considerable technical and financial support from UNAIDS. These M&E support was extended to sub-national levels. Civil society partners were trained as part of a capacity building package to promote their contribution to functional health information systems at both national and sub-national levels in several countries. As one indicator of increased commitment to accountability and ownership, the rate of countries reporting to the United Nations on progress in implementing the 2001 Declaration of Commitment is among the highest for any development issue.

Forty-four countries in Africa reported having national monitoring and evaluation plans in place. 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 through the WHO-recommended methodology. Over 90% of high-prevalence countries and 50% of North African countries reported on progress towards implementation of the 2001 Declaration of Commitment to HIV and AIDS, up from 80% and 20% respectively[58].

The reporting framework developed for the 2001 Declaration of Commitment on HIV/AIDS has been cited as a model for the development of accountability mechanisms for other diseases. The international HIV reporting system was renewed at both the 2006 and the 2011 High-Level Meetings on AIDS. Under the HIV reporting framework, countries submit biennial reports to the UNAIDS Secretariat. The report describes the progress against a set of core indicators that are published at least 12 months in advance of the reporting deadline. Indicators are reviewed after each reporting period to assess their continued validity, although efforts are made to avoid changes to indicators in order to preserve the ability to monitor trends.

Extensive technical support is provided in the recommended process for report preparation. A national consultation meeting that includes both civil society and national governments reviews and validates data before its submission to UNAIDS. The report is in two parts, one of which is developed by government and the other by partners (including civil society and external partners). Results of each round of reporting are presented to the United Nations General Assembly by the Secretary-General, disseminated in UNAIDS reports, and made publicly available on an interactive database (AIDS Info).

In 2007, 39 of the 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 harmonising the efforts of major stakeholders in the response. In 2005, 19 of the 31 reporting AU Member States (61%) reported the existence of one harmonised M&E plan, increasing to 33 of the 44

[58] "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.

reporting countries (75%) in 2007. Civil society involvement in the development of these M&E plans remains high, with all 37 reports indicating civil society involvement.

7.11.3 Monitoring, evaluating and reporting on the Tuberculosis

TB surveillance systems tend to be much weaker than those developed for AIDS. Monitoring TB trends is frequently undermined by considerable discrepancies between diverse reporting channels in the same countries, reducing the ability of public health agencies to reliably report key strategic information. Due to the weakness in national reporting systems and the insufficient collaboration on reporting between HIV and TB systems, WHO uses various methods to estimate TB-related outcomes for people living with HIV.

The existence of a monitoring mechanism for TB in 94% of countries is encouraging. However other information is less widely available. Information on HIV prevalence among TB patients as well as the proportion of TB patients who receive HIV testing and counselling is available in almost 60% of countries. Thirteen countries provide the detection rate of TB cases and six countries provided information on DOTS coverage.

Significant progress has been made in the estimation of TB incidence, prevalence and mortality across Africa. However 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.[59]

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[60].

7.11.4 Malaria

Malaria surveillance and reporting have not experienced M&E gains commensurate with those reported in the case of HIV. As previously noted, it is impossible to estimate trends in Malaria incidence in nearly half of Malaria -endemic countries in Africa. This is due to the weakness of national surveillance systems. Countries do report annually to WHO on malaria control outcomes, but the quality of country reports varies. While improvements are needed in M&E systems, improvements are being made, in part through the collective efforts of the African Leaders Malaria Alliance (ALMA).

Monitoring and evaluation of Malaria has not progressed as well as in past years. Many countries are still struggling to measure various indicators related to malaria. This is reflected in the non-availability of information in a number of countries in 2012. Although 87% of countries are able to provide information on national malaria

[59] "Global Tuberculosis Control", World Health Organization; 2009.
[60] "The Global Plan to Stop TB 2006-2015: Progress Report 2006 2008", Stop TB Partnership of the World Health Organization; 2009

incidence rates, 46 countries provided information on malaria death rates. About 72% were able to provide data on children under 5 years who had slept under a treated mosquito net the previous night. There is less available information on other indicators such as the number of children under 5 years with fevers receiving treatment and the proportion of pregnant women receiving IPTp.

Improvements were 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 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 35 countries were expected to conduct nationally representative household surveys in 2009 and 2010 to address malaria prevention and control issues. All Malaria endemic countries in Africa now have functional Health Information Systems (HIS). However interpretation of the trends in Malaria cases and resulting mortality is complicated due to incomplete and non-standardised reporting and on-going reliance on clinical diagnosis.[61]

Despite these advancements on-going 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 number of confirmed malaria cases, admissions for severe malaria, and malaria-associated deaths must be strengthened. Once malaria transmission is reduced, national programmes 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.

Overall the system of monitoring and evaluation and reporting in African countries requires strengthening and requires renewed commitment from African leaders, as well as technical and financial support from international institutions and organisations.

7.12 M&E systems in AU Member States

In numerous summits the AU pledged to provide reliable, timely reports about the progress towards AIDS, TB and malaria targets. Assessing progress in addressing the three priority diseases in Africa demands strong national and regional M&E mechanisms. The African Peer Review Mechanism (APRM), a mutually agreed policy diagnostic and self-monitoring instrument adopted by AU Member States in 2003. It represents a unique and innovative approach that monitors political, socio-economic and corporate governance values, codes and standards. APRM not only promotes

[61] www.afro.who.int

knowledge and experience sharing, but also the reinforcement and dissemination of best practices with respect to health care delivery. The APRM undertook reviews of strategies to address AIDS, TB and malaria in 17 countries to date.

The AU called for regular reporting on progress towards the Abuja targets. Most AU Member States however have failed to provide regular progress reports. In the most recent review (2010–2012) only nine countries submitted data to the AU Commission. Much remains to be done to strengthen accountability for health results in Africa. Health systems in Africa often continue to suffer from an absence of reliable, high-quality data, underscoring the need for further efforts to ensure the availability of timely, reliable, valid data to inform programme management and policy development.

8. AFRICAN UNION ROADMAP ON SHARED RESPONSIBILITY AND GLOBAL SOLIDARITY FOR HIV/AIDS, TB AND MALARIA

8.1 PROGRESS ON PILLAR 1: MORE DIVERSIFIED, BALANCED AND SUSTAINABLE FINANCING MODELS

Most African countries recognised the need to diversify and expand the sources of funding for health generally and for HIV responses specifically to reduce aid dependency. Measures that have been taken include quantifying the country-level funding gaps and identifying policy options to increase domestic resources. Additional measures include increased financial commitment by the private sector and inclusion of malaria and HIV services in different forms of health insurance and other health financing schemes. Selected examples of countries that began to implement innovative AIDS financing measures are detailed below. The African Union 2013 Progress Report and the UNAIDS Efficient and Sustainable HIV Responses: Case Studies on Country Progress provide comprehensive analyses of domestic financing measures across the continent.

In February 2013 representatives of African civil society platforms met with representatives of nine global health organisations to kick start work on harmonising efforts to increase domestic funding for health. This work includes non-governmental domestic financing initiatives. However while AU Member States are increasing their share of annual budgets dedicated to health this remains on average below the 15% target agreed in the 2001 Abuja Declaration.

Sustained commitment and ownership by African leaders has yielded results with the last decade being a defining moment for novel approaches in domestic financing for health. These African sourced solutions aim to enhance sustainable financing through shared responsibility while taking cognisance of global solidarity for AIDS, TB and malaria responses in Africa. The blossoming of Africa's economies has enabled dynamic cycles of domestic growth; generating strong domestic revenues and decreasing aid dependency. This offers opportunities for a new partnership paradigm of shared responsibility and global solidarity for health.

Significant progress has been made in Domestic Financing for Heath. Between 2006 and 2011 global domestic investment has doubled spending on AIDS, TB and malaria.

In the last four years, African countries have increased their domestic resources to fight AIDS by 150%. South Africa has contributed US$2 billion dollars per year of domestic funding toward the AIDS response—the second largest national investment in the world. South Africa has reformed its tender process to increase competition among suppliers and improve transparency. The new tender achieved a 53% overall reduction of ARV costs.

In 2013 Nigeria committed US$1 billion for investments in treatment, care and prevention for people affected by the diseases as part of the "Saving One Million Lives" campaign. For the first time in the history of global health, there is mobilisation of more domestic resources than foreign development assistance. In 2012, domestic spending for HIV from low- and middle-income countries represented 53% of all global HIV resources.

Zimbabwe is a pathfinder in domestic financing for health having been the first country on the continent to introduce an AIDS levy, known as the National Aids Trust Fund (NATF) in 1999. The 3% tax is levied on taxable income of institutions and individuals and earmarked for the AIDS response. The levy increased from 5.7 million in 2009 to 150 million in 2014. In 2011 Cameroon joined Congo, Madagascar, Benin, Mali, Mauritius and Niger in applying an airline levy with funds set aside for HIV programmes. Cape Verde, Comoros and other countries charge alcohol excise taxes with funds earmarked for HIV programmes.

Kenya established a High Level Steering Committee for Sustainable HIV Financing to pool additional public and private resources. The current proposal is for the allocation of 0.5% to 1% of government ordinary revenues to the Trust Fund. This will also be enhanced by additional strategies, such as an airline levy. The revenue in the Trust Fund has been calculated to fill 70% of the HIV funding gap between 2010 and 2020, and 159% of the gap between 2020 and 203070 71. Kenya is also considering the levy on mobile phone usage to further increase revenues.

Over the past year, Benin piloted a scheme for results-based financing in the context of plans to increase domestic resources for HIV treatment and prevention. Since 2010 the Government of Swaziland has relied exclusively on domestic resources for its ARV medicines. Domestic funding of the AIDS response has increased in Namibia from 50% to 60% between 2008 and 2011. Rwanda (24%), Liberia (19%), Malawi (19%), Zambia (16%), Togo (15%) and Madagascar (15%) have met the Abuja target of allocating 15% to health.

Rwanda and Uganda are charging levies on mobile phone usage. The governments of Benin, Congo, Madagascar, Mali, Mauritius and Niger charge airline levies. After a three year pilot programme over 90% of Rwandans enjoy health insurance. Ghana has set up a similar health insurance scheme. Over 90% of patients in both private and public facilities in Ghana are health insurance subscribers. Dedicated taxes, payroll contributions and general budgetary sources are pooled together to finance the scheme. Ghana recently increased the value-added tax (VAT) by 2.5% to contribute to the pool, with some funds earmarked for HIV treatment. Ethiopia committed 2% of the budget of each public sector body for HIV. In Swaziland, all public bodies are required to devote 2% of their budget to workplace policies for their

staff. Similarly, the Government of Malawi requires all ministries and departments to allocate a minimum of 2% recurrent costs budget to HIV-related activities.

The Gambian Government's contribution to its national response has increased from GMD 1.8 million per year in 2008-2011 to over GMD 5 million in 2012. In 2011 the Gabon Government increased the National Fund for HIV Prevention and Treatment by approximately 150%. The Tunisian government is also aiming to finance just over 70% of its HIV response domestically with almost universal treatment coverage – including coverage for non-nationals in need.

Gabon's tax on mobile phone companies is used to cover populations that are not economically capable of contributing to the national health insurance system. In 2009, Gabon collected $25 million with the levy of mobile phone companies. Large telecommunication companies are already engaging in philanthropic behaviour for development projects– such as Orange's Data for Development Project. If more governments framed these taxes as a way to directly benefit health and development, this could be another way for corporations to contribute by means of corporate social responsibility.

In its 2012 budget, the Government of Niger dedicated US$ 2.5 million for AIDS treatment and planned to double that amount in 2013. The Egyptian National Strategic Plan (2012-2016) is directed at high-impact interventions and the country now finances 50% of its response domestically. Working closely with partners, the South African Government was able to implement interventions that achieved price benchmarking, robust allocation of preference points, price stability, reliability of need estimates, and transparency of the process.

Similarly, Swaziland has increased its antiretroviral drugs tender efficiency by introducing ceiling prices, supplier performance data and more reliable quantification methods, resulting in internationally competitive prices and high-quality products. The revised tender process led to savings of US$ 12 million between January 2010 and March 2012, an overall cost reduction of 27%.

Malawi is currently evaluating alternative options in order to increase domestic funding. Three potential approaches have been identified: airline levy, telecommunications levy, and expanding public sector mainstreaming. Members of Parliament passed the Tanzania Commission for AIDS (TACAIDS) Amendment Bill, 2014 that among other things, creates a special fund to ensure that resources for fighting HIV/AIDS are readily available. This will work under the government of Tanzania and will draw funds from a government ring fenced budget. The government is expected to initially contribute about EUR150 million per year to the fund, which aims to reduce donor dependency by 40%. Currently, donor dependency stands at 97%. The government of Uganda is planning to follow the lead of the other countries with intentions to establish a US$1 billion-dollar HIV Trust Fund to finance local HIV programmes.

In February 2013, representatives of African civil society platforms met with representatives of nine global health organizations to kick start work on harmonizing efforts to increase domestic funding for health that would include non-governmental domestic financing initiatives.

Investments in health can also create jobs in more direct ways. According to an economic assessment in South Africa, when investments were made to scale-up HIV treatment, those investments returned three times as much economic activity. Given these evolving scenarios, beyond 2015, African needs to adopt and adapt successful models in innovative financing, take them to the next level and harness the power of numbers. It is also imperative to curtail illicit financial flows and fight corruption in a way that ensures the efficient and effective use of resources and domestic long-term financing, such as insurance, pension schemes and capital market instruments.

8.2 PROGRESS ON PILLAR 2: ACCESS TO MEDICINES THROUGH LOCAL PRODUCTION AND REGULATORY HARMONISATION

Considerable progress has been made to enable countries to scale up pharmaceutical manufacturing. The focus is especially on antiretroviral drugs and artemisinin-based combination therapies, as well as other malaria commodities such as insecticide-treated nets. The Pharmaceutical Manufacturing Plan for Africa Business Plan, an African-wide framework for increasing pharmaceutical capacity, was developed and approved and will be supported through a consortium that is now being set up.

In November 2012 a Consortium to facilitate the implementation of the PMPA Business Plan was established and is currently coordinated by the AUC and United Nations Industrial Development Organization (UNIDO). This consortium, which consists of selected organisations based on relevant expertise required to achieve overall objectives of the business plan, was set up as a strategic first step in delivering the set results. These include but are not limited to UNIDO, UNAID, NEPAD Planning and Coordinating Agency, WHO, African Network for Drugs and Diagnostics Innovation (ANDI), FAPMA, UNDP and United States Pharmacopoeia (USP).

Inspired by the PMPA Business plan, regional economic communities such as the ECOWAS, EAC and SADC have developed/reviewed regional plans to promote the pharmaceutical manufacturing sector. The alignment of such regional plans with the PMPA Business plan is a strategic activity on the action plan of the consortium. n the East African Community activities to promote the pharma sector have primarily focussed on implementation of the EAC WTO-TRIPS Policy and Protocol, EAC Regional Pharmaceutical Manufacturing Plan of Action (RPMPoA), and the work of the Federation of East African Pharmaceutical Manufacturers (FEAPM).

The West African Health Organization of the ECOWAS composed of 15 countries is responsible for spearheading activities of promoting local production of medicines. The organization has been inspired by the PMPA Business plan and is currently at the final stages of developing a pharmaceutical manufacturing plan for the region. It aspires towards establishment of a regional certification scheme for pharmaceutical manufacturing, support to primary manufacturers of raw materials, intensively continue with the Medicines Registration Harmonisation processes, engage more partners to support the activities of the Medicines and vaccines programme and bulk purchase of raw material to reduce production cost.

The Southern African Development Community (SADC) is currently assessing implementation of and reviewing its Pharmaceutical Business Plan (2007-2013). The overall goal of the SADC Pharmaceutical Business Plan is to ensure availability of essential medicines including African Traditional Medicines to reduce disease burden in the region. Its main objective is to improve sustainable availability and access to affordable, quality, safe, efficacious essential medicines including African Traditional Medicines.

Under the leadership of the Government of Ghana the implementation of the Business Plan for Pharmaceutical Manufacturing Plan for Africa (BP-PMPA) is started in 2013. Government decided to provide a platform for joint and coordinated efforts by various government and private agencies. Involvement of the highest political level, through the presidency, in Ghana in the pharmaceutical sector development is a strong signal of government commitment and preparedness to lead, invest and coordinate efforts by its different agencies, the private sector and external development partners. This initiative is a major step forward and a concrete translation by a member state of the AU's major decisions and commitments including the Road Map on Shared Responsibility and Global solidarity for AIDS, Tuberculosis and Malaria response.

Other countries such as Ethiopia, Kenya, Rwanda, Nigeria, Uganda, Tanzania, have continued to promote their pharmaceutical sector and make significant progress through support received from multilateral agencies for example a regional bioequivalence centre was launched in 2013 in Addis Ababa, Ethiopia, Uganda's Quality Chemicals acquired WHO- Prequalification etc.

Some countries including Kenya, Nigeria, South Africa, Tunisia, Uganda and the United Republic of Tanzania negotiated public- private partnerships that will allow for more rapid prequalification by WHO of locally manufactured essential drugs and malaria commodities. Kenya, South Africa, Uganda and Zimbabwe now produce WHO pre-qualified ARVs. The South African state-owned company Pelchem is embarking on a joint venture with the Swiss Lonza Group to produce antiretroviral APIs by 2016. Nigeria is strengthening regulations in its pharmaceutical market, thereby increasing consumer confidence and decreasing illegal distribution networks. The Kenyan Government has identified pharmaceutical manufacturing as a key industrial sector for development.

Progress is also being made in improving regulatory harmonisation across the continent. The NEPAD Agency in 2012 began work on developing a model law for harmonising medicine regulation in Africa. The model law aims to address legislative gaps that hamper the harmonisation of medicine regulations and provide countries with a law comprehensive enough to be adopted by national legislative bodies. It will also ensure a systematic approach for developing harmonised legislation on medicine regulation in African countries.

The African Medicines Regulatory Harmonisation Programme (AMRH) is promoting the establishment of regional centres of regulatory excellence through the existing structures of regional economic communities. The initiative is being supported by the NEPAD Agency. In 2012, the AMRH approved funding for the East African Community project on harmonising medicine registration and is also supporting the Economic

Community of West African States, the Economic Community of Central African States and the Southern Africa Development Community to progress in a similar vein. This process will be rolled out to the country level during the next few years.

The African Medicines Regulatory Harmonization (AMRH) Programme works with Regional Economic Communities (RECs) to fulfil the vision of the Pharmaceutical Manufacturing Plan for Africa. The overall aim of the AMRH Programme is to support African countries to improve public health by increasing access to good quality, safe and effective medicines through harmonizing medicines regulations, and expediting registration of essential medicines.

Led by the NEPAD Planning and Coordinating Agency since 2009, the programme has supported regional economic communities to develop/adapt and adopts harmonised tools for undertaking various regulatory activities including medicines registrations, GMP inspections, etc. The programme has registered significant progress particularly in the East African Community (EAC) and the Economic Community of Western African States (ECOWAS) regions. Another key activity within the framework of the AMRH is the elaboration of the AU model law on medicines regulations, which is currently at its final stages of drafting and is being discussed among key stakeholders. The model law is expected to further strengthen the legislative environment for harmonization of medicines regulations in Africa.

The AMRH programme is currently partnering with various RECs in Africa that include EAC (Burundi, Kenya, Rwanda, Tanzania and Uganda); SADC/COMESA (Angola, Botswana, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Zambia, Zimbabwe); OCEAC/ECCAS (Cameroon, Central Africa Republic, Congo Brazzaville, Equatorial Guinea, Gabon, Chad, DR Congo, Angola, Sao Tome Principe); ECOWAS-WAHO/UEMOA (Benin, Burkina Faso, Cape Verde, Cote d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, Togo); CEN SAD/AMU (Algeria, Comoros, Egypt, Eritrea, Libya, Mauritania and Tunisia) and IGAD (Djibouti, Ethiopia, Somalia, Sudan).

The AUC, NEPAD and WHO are pursuing the creation of the African Medicines Agency (AMA) to harmonise regulatory frameworks. The agency was proposed in the PMPA Business plan as a key intervention to strengthen regulation of pharmaceuticals on the continent and to promote the expansion of potential markets for quality assured medicines. The first AUC-WHO joint meeting of Ministers of African ministers of health held in Angola in April 2014 considered the concept and endorsed the milestones towards the establishment of the AMA.

The milestones include decisions by the AU Summit of Heads of State and Government, designation of host institution/country, approval of the governing body, appointment of staff and allocation of resources and launch of the AMA. The Ministers of Health committed to prioritise investment for regulatory capacity development, pursue the efforts towards convergence and harmonisation of medical products regulation in Regional Economic Communities (RECs) and to allocate resources for the operationalisation of the AMA. The Ministers of Health also requested the AUC and WHO in collaboration with relevant stakeholders to establish a task team that will facilitate the implementation of the agreed milestones with due regard to regional representation and skills required to meet the mandate as noted.

AMA is intended to be an organ of the AU, legally mandated by Member States. It will provide a platform for coordination and strengthening of on-going initiatives to harmonize medicines regulation. It will also serve the purpose of pooling expertise and capacities and strengthening networking for optimal use of the limited resources available. AMA will therefore provide guidance and complement and enhance the efforts of the RECs towards harmonization of medical products regulation. By enhancing the regulatory environment, AMA will contribute to enhancing access to medical products.

Opportunities are available through the use of the flexibilities contained in the Trade-related Aspects of Intellectual Property Rights (TRIPS) agreement for further reducing prices and expanding access to medicines. A waiver that exempts least developed countries from complying with the provisions related to pharmaceutical patent protection was extended until 2021, ensuring the ability of least developed countries in Africa to access to affordable medicines.
Some African countries are leveraging on south-south cooperation for the development of pharmaceutical industries. For instance Mozambique's partnership with Brazil involves the development of a new pharmaceutical plant that will produce ARVs for people living with HIV in Mozambique and the region. Tunisia is taking active steps to make the technical capacity of its pharmaceutical industry available for the production of ARVs for Africa. It also plans to support countries in the Middle East and Africa south of the Sahara to improve AIDS responses, health integration, community mobilisation and support. The Tunisian government is also aiming to finance just over 70% of its HIV response domestically with almost universal treatment coverage – including coverage for non-nationals in need.

The realisation of the vision of the AU Assembly in the promotion of local production of pharmaceuticals as a key strategy both for the promotion of public health and economic/industrial development is on course. It requires a deep understanding of the various interconnected issues as well as an intricate knowledge of the pharmaceutical sector to realize. The broad but relevant skills and knowledge set provided through the consortium remains critical going forward, as is the leadership by national government and the coordination of strong intersectoral partnerships involving the private sector.

8.3 PROGRESS ON PILLAR 3: LEADERSHIP, GOVERNANCE AND OVERSIGHT

The African Union Commission, various organs of the African Union, Regional Economic Communities and Member States with the support of stakeholders including development partners have provided leadership for the implementation of the AU Roadmap. AIDS Watch Africa and the African Leaders Malaria Alliance are providing leadership for high-level advocacy and accountability on AIDS, TB and malaria responses. Member States are developing more robust, inclusive, results-focused national strategies and related investment cases. In addition they are working on streamlining disease coordination and governance with the support of the United Nations Development Programme and other partners to make the best use of limited national human and financial resources.

Various examples include Rwanda that merged disease programmes, including incorporating AIDS coordination in the Ministry of Health's Biomedical Centre. This was

a measure put in place to reduce the costs associated with multiple project management units. The integration also provided impetus for greater cross-fertilisation and multisectoral approaches across disease programmes. Burundi and Côte d'Ivoire integrated their ministries of HIV and AIDS into the Ministry of Health to better rationalise the resources available for health. South Africa placed the national AIDS council under the financial authority of the National Department of Health to ensure greater continuity and sustainability with staff funded by the Ministry budget. The government is integrating the national TB and HIV strategies for improved results.

8.3.1 Monitoring the implementation of the Roadmap

The AU Commission, in cooperation with UNAIDS, developed a guide to assist the AU Member States, African regional bodies, the AU Commission and other relevant stakeholders in implementing the Roadmap. The purpose of this guide is to provide practical ideas for how to take the agreed Roadmap agenda forward to achieve rapid results in both reducing the burden of these three diseases and in developing mechanisms to sustain national and regional programmes. Experts from AU Member States reviewed the guide in April 2013 and it received substantive contributions from a variety of key stakeholders. It was submitted to the Action Committee of AIDS Watch Africa for consideration during the African Union Summit in Addis Ababa, Ethiopia in May 2013.

9. CHALLENGES

The continental health system should prepare itself to face the triple burden of diseases (including other infectious diseases, for instance the Ebola outbreak), non-communicable diseases and injuries. The major challenges identified in implementing the "Abuja Call" and "AU Roadmap" are presented below:

9.1. Leadership

Coordination and harmonisation of partnerships at various levels remain inadequate. Insufficient policy planning and programming for addressing health in national development frameworks is reflected by the inadequate health system development, low coverage and access to services for the three diseases. The AU Commission is primarily a secretariat of the Union. To get things moving both faster and in the right direction, there is a need to add to this function / role a coordinating, oversight, regulation and standard setting role including allocating appropriate technical and financial support. Other key challenges relates to the limited integration of TB and Malaria control in health and development programmes at regional level. There is need create a framework that ensures translation of political declarations and decisions by Summits to concrete and measurable actions. This should be coupled with mechanisms to strengthen domestication and alignment between continental, regional (RECs) and country levels.

9.2 Resource Mobilisation

While there is a positive trajectory towards domestic financing for health diseases responses remain predominantly funded from international sources. Moreover,

disbursement of funds, access to 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. Although investment trends are generally encouraging, health spending in Africa remains low. Average government per capita expenditure on health in Africa is only $27, far below the $1,250 to $1,350 per capita expenditures that occur in Europe and the Americas. Further increases in health spending, combined with continued global assistance, will be needed to address the continent's health needs.

The global financial crisis and the challenge posed by climate change attracted greater attention at recent G8 summits. The summit in Camp David in 2012, for instance, did not mention AIDS, TB and Malaria at all. Forty-seven AU Member States have not reached the Abuja target of 15% public funding allocation for health while thirty-two invest less than US$ 29 per capita on health. Donor commitments and disbursements still have a high year-to-year variability, which negatively affect programme planning.

The lack of adequate funding for TB/ HIV prevention and treatment and the increased resources needed to achieve and maintain malaria targets are major challenges. The funding crisis that ensued from the cancellation of Round 11 of the Global Fund provides important lessons. The sustainability of health gains over the last decade are fragile and potentially jeopardised by the heavy dependence of many African countries on external financial support. In 26 of 33 of the African countries most affected by HIV, external partners account for more than half of current investments. Additionally partners contribute more than 95% of HIV spending in nine countries. Dependency on external resources remains high with respect to TB and malaria control as well.

The following are key learning points for other countries. Strong leadership leads to stronger political commitment and countries to achieve significant performance (South Africa, Rwanda, Botswana). There is need to strengthen domestic investments through innovative approaches in the context of shared responsibility, co-investment, ownership and accountability through focusing budget predictability. Countries can learn from numerous innovative financing solutions that have been documented in this review. Key questions that should be addressed include how to scale-up using the most successful cost-effective approaches; making smart investments for greater health returns through prioritising focus on interventions with the highest impact at the lowest cost. Countries need to reflect based on their context how they can ensure predictable and sustainable financing for HIV, TB and Malaria services including health services.

9.3 Protection of Human Rights

Many countries have not yet 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, people living with HIV and TB patients. However a significant number of African Member States demonstrated commitment towards reviewing punitive laws that criminalise HIV transmission in recent years. Currently at least 25 countries in Africa[62] still have existing policies or draft laws criminalising HIV transmission with the most recent enactment taking place in May

[62] [62] UNDP, A report on progress towards achieving law & human rights goals within the AU Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa (2012-2015)

2014. Such situations lead very often to stigma, discrimination and gender inequity and threaten to reverse the current gains in disease response.

The implementation and enforcement of protection at law for people affected by HIV and vulnerable populations such as women, remains a key challenge. There is limited provision in policy and restrictive laws targeting key populations at higher risk of exposure to HIV. There is a greater need to re-examine and adequately address the relationship between TB, malaria and human rights.

9.4 Poverty Reduction, Health and Development

The burden of poverty in African countries continues to constrain country efforts to provide access to adequate health services. Despite the recent and rapid economic growth over 45% of Africa's population, outside of North Africa, still lives in extreme poverty, surviving on less than US$1.25 per day. The MDG goal on poverty reduction will not be achieved by the end of 2015, even if it has accelerated relative to past trends. On the continent only 54% of those eligible for antiretroviral treatment have access. Only 10.9% of children under 5 years were reported to have received timely treatment according to national malaria treatment guidelines.

Tuberculosis is transmitted more readily in conditions of extreme poverty that includes 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. Poverty and low education are significant predictors of coverage gaps. Some of those without services live in the most endemic areas. There is an urgent need, for the AU Commission, to strengthen its work on cross-cutting issues such as ensuring that poverty, good nutrition and food security, mobility and migration.

9.5 Strengthening Health Systems

AU Member States face a huge human resources for health shortfall. Resolving this crisis would require African governments to more than double the size of their health workforce. The continent requires an estimated one million additional health workers to achieve the MDG targets. How to fill the gaps, stop the brain drain and widely implement "task shifting" approaches are the critical issues that need to be addressed.

Inadequate infrastructure and weak equipment including essential medicines / health commodities remain a major barrier to implementing disease prevention and control programmes. Vertical programmes and lack of integration lead to low effectiveness. To improve service delivery there is need to ensure early testing that will lead to early diagnosis and better health outcomes. There is thus a need to scale up testing and counselling services which remain very low. This should be complimented with scaling up treatment and integrated health services in order to achieve control and / or elimination of the three diseases by 2030.

The majority of people in most African countries do not have sustainable access to affordable essential drugs or to the provision of appropriate medical care. Increasing treatment and rights awareness to ensure that no one is left behind is thus a key priority. Programmes to sensitise and reduce stigma among service providers result in

increased satisfaction with services and improved outcomes. User fees create further barriers to access for poor populations. Efforts are needed to remove systemic barriers to access and putting in place measures to reduce stigma and discrimination.

Programmes to create and reinforce demand must be put in place. Despite impressive increases in intervention coverage, millions of people still do not receive the services they need. Gaps in service coverage were identified in all countries. To design programmes that can fill these gaps, it is important to have a good understanding of the factors responsible for low intervention coverage.

9.6 Prevention, Treatment, Care and Support

Disease prevention and control programmes to control AIDS, TB and malaria remain weak. There is thus a need to further strengthen treatment, care and support programmes and services if Africa is to meet the committed targets to end AIDS, TB and malaria by 2030. This includes the agenda for elimination of new HIV infections in children and keeping their mothers alive. The key issues that need to be addressed include how to move towards achieving set targets, ways to better address the co-epidemics of TB and HIV and how to prevent and address drug-resistant tuberculosis.

There is need to strengthen prevention programmes and services to avoid new cases. Prevention activities should include programmatic targets in addition to impact targets, better focus on key populations, intensify key interventions that include innovations and sustain prevention funding. Furthermore epidemiological surveillance (including pharmaco-vigilance and drug-resistance) should be strengthened. Monitoring and evaluation should also be further strengthened to provide the strategic information that is needed for policy and programming. The AU should expedite the process of the establishment of the African Centre for Disease Control and Prevention.

In addition programme management through robust governance mechanism and cost-effective mechanisms should be strengthened. To stem the tide of these epidemics there is need to increase the participation of young people, adolescent girls and key populations that are being left behind in programmes. The substantial access gap exists for male and female condoms and condom should be addressed as a key prevention technology.

9.7 Access to Affordable Medicines and Technologies

One of the key challenges that need to be addressed is to forecast the needs and timely flow of information of medical commodities from producers and suppliers to government bodies, implementing agencies and consumers. Unless these factors are addressed, there is a risk of shortage of essential medicines and other commodities. Member States should work on modalities for incorporating the TRIPS flexibilities in national laws, utilise the transitioning period provided under TRIPS and refrain from adopting laws or measures that limit their right to use these flexibilities to develop local pharmaceutical production.

This requires capacity to deal with the TRIPS flexibilities intellectual property framework that is sensitive to public health objectives and is a critical enabler to sustainable AIDS and tuberculosis responses. While significant efforts have been

made in reducing ARV prices, the average price paid for second-line regimens remains significantly higher. The continent continues to experience inadequate access to essential medicines, preventative commodities and technologies across much of the continent countries.

9.8 Research and Development

Due to the high disease burden due to AIDS, TB and malaria the AU Commission is paying special attention to research challenges. The focus areas include the use of ARVs for HIV prevention, pre-exposure prophylaxis and microbicides. There are on-going efforts to develop new TB diagnostics, drugs, and vaccines. Research to develop a test to diagnose TB and MDR-TB at the point of care and the development of a vaccine for Malaria are being conducted.

9.9 Implementation

The lack of evidence that investments are being done in high impact interventions at the lowest cost to ensure efficiency and effectiveness should be addressed.

9.10 Partnerships

Poor or inadequate coordination of regional and national and international partnerships needs to be addressed for effective responses. Public-private partnerships Africa remain underdeveloped. In addition there is inadequate involvement of civil society organisation in policy formulation and implementation.

9.11 Monitoring, Evaluation and Reporting

Monitoring and Evaluation (M&E) systems remain weak in many countries making reporting difficult. Monitoring of diseases interventions should include not only a report of progress to date, but also an assessment of where future gains are possible. The major challenge that has been experienced at the continental level is the collection of data from Member States on the Abuja Call. There African Union Commission and partners are working together on mechanisms to strengthen data collection. In addition challenges remain across the continent with regards to implementation of prevalence surveys.

The full extent of MDR-TB in Africa cannot be ascertained 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. How to prioritise interventions based on documented facts and scientific evidence remains a key challenge that Member States will need to address. Countries will need to look at how to utilise results-based management for improved programme effectiveness.

10. OPPORTUNITIES

Since 2001 significant progress has been made by Member States towards universal access to health services broadly and for AIDS, tuberculosis and malaria in particular. High-level political engagement was noted to contribute significantly in stigma

reduction against people living with HIV including TB. Almost 90% of AU countries report that Heads of State and Government or other high officials have taken action in the past year that demonstrated leadership in the response to AIDS. While the commitment exists there is need to move from declarations to concrete actions.

Africa should take advantage of strong economic growth on the continent to increase investments in health. Africa has the second highest rate of economic growth in the world. The region's economy grew 5.1% in 2011 and growth was projected to accelerate to 5.8% in 2014.

Africa should take advantage of the reduction of prices of antiretroviral drugs as an opportunity to scale up treatment. In the past decade the annual price of first-line antiretroviral drugs plummeted from over US$ 10 000 per person in 2000 to less than US$ 116 in 2010 (for the lowest cost WHO- recommended regimen). This represents a reduction of nearly 99%.

The flexibilities contained in the Trade-related Aspects of Intellectual Property Rights Agreement—reaffirmed by the 2001 Doha Declaration—provide important opportunities for further reductions in prices of, and expanded access to, HIV medicines, viral load tests and other diagnostic equipment. Although there is limited updated information on partnerships at national level, due to limited country reporting; global and regional partnerships for all three diseases have provided important opportunities to to address AIDS, TB and malaria.

11. ABUJA CALL AND THE AU ROADMAP IN POST-2015: EMERGING ISSUES AND FUTURE CONSIDERATIONS

The following are the key issues that should be addressed by the new Africa Health Strategy.

11.1 Non Communicable Diseases (NCDs)

AU Commission needs to pay more attention to non-communicable diseases (NCDs) in the near future. NCDs, primarily cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, are responsible for 63% of all deaths worldwide (36 million out 57 million global deaths). 80% of NCDs deaths occur in low- and middle-income countries. NCDs are not only a health problem but a development challenge as well. Eliminating major risks could prevent most NCDs. If the major risk factors for NCDs were eliminated, at around three-quarters of heart disease, stroke and type 2 diabetes and 40% of cancer would be prevented.

11.2 The 2014 Ebola outbreak in West Africa

The Ebola outbreak in West Africa was first reported in March 2014, and rapidly become the deadliest occurrence of the disease since its discovery in 1976. In fact, the current epidemic sweeping across the region has killed more than all other known Ebola outbreaks combined. According to WHO, up to 25 January 2015; 8,810 people

had been reported as having died from the disease in six countries Liberia (3,686), Sierra Leone (3,199), Guinea (1,910) Nigeria (8), Mali (6) and USA (1). The total number of reported cases was more than 21 797.

The EVD outbreak continues to impact on the socio economic, political and cultural fabric of not just the affected countries but the entire continent. It has tested our resolve and resilience as Africans and as a continent. It has put to test our unity, solidarity and the integration project of the Union. Africa's young women and men rose to the occasion while Member States were hesitant and answered the call of the Commission for volunteers to go and help our brothers and sisters in Liberia, Sierra Leone and Guinea. These young people are performing heroic services on the frontline of Ebola. The Commission expresses its profound appreciation to these young people and invites the Assembly to do the same through a special declaration acknowledging the role of the young people of the continent in the fight against Ebola.

The Ebola outbreak has significantly impacted on the socio economic, political and cultural tapestry of not only the West Africa sub-region but indeed the development trajectory of the entire continent. Notwithstanding the significant progress made after international intervention including AU's ASEOWA and related actions, there is still need to further strengthen, coordinate, and focus all efforts on halting the spread of Ebola while forward planning is required to mitigate its impact. The EVD outbreak has exposed the fragile and weak health systems of many African countries and the need to be prepared for future threats to public health.

Thus building more resilient and sustainable health systems will remain at the core of AU's medium to long term post-Ebola plan and strategy. The Commission will continue to facilitate the strengthening of the capacity of Member States to effectively implement the International Health Regulations (2005) and establish the African Centres for Disease Control and Prevention for early detection and response to adequately prepared for future threats to public health.

11.3 Establishment of the African Centre for Disease Control and Prevention

The AU Heads of State and Government met in Abuja in July 2013 for the African Union Special Summit on AIDS, TB and Malaria (ATM) and directed the Commission to coordinate efforts for the speedy establishment of the African Centres for Disease Control and Prevention (African CDC). Subsequently during the 22nd Ordinary Session of the African Union (AU) Summit that was held in Addis Ababa, Ethiopia in January 2014, the Assembly of Heads of State and Government (under Assembly Decision/AU/Dec.499 (XXII)) stressed on the urgency of establishing an African Centres for Diseases Control and Prevention. The Assembly then extended the mandate of the African Union Commission to work out the modalities, financial and legal implications for the ACDC in collaboration with relevant partners.
Consequently the Health Ministers committed in April 2014 to accelerate the implementation of the Assembly Decision and agreed on the creation of multinational taskforce by May 2014 to define the modalities and to work on the roadmap for the establishment of the African CDC, including the legal, structural and financial implications relating to the Centre. The AU Commission, World Health Organization (WHO) and other identified relevant stakeholders were tasked to provide technical support towards the establishment of the African CDC.

At its 16th Extraordinary Session of the African Union Executive Council meeting on Ebola held on 8 September 2014, the Council decided to request the AU Commission to take all the necessary steps to ensure the functioning of the ACDC, together with the establishment of regional centres by mid-2015. Good governance will lead (i) to data-driven decision-making, (ii) to performance-based health management including community-based interventions, (iii) to find and fill the gaps.

11.4 Key issues for Africa in the post 2015 health development framework

The new African Union health frameworks will align with the new global health architecture that will sustain the post 2015 Sustainable Development Goal 3 that addresses health. The Common African Position (CAP) on the Post 2015 Development Agenda defines the key priorities for Africa in the new global development framework that will supersede the MDGs. It prescribes a new health framework that addresses various dimensions. According to the CAP to address the key health priorities for the continent the focus should be on improving the health status of people living in vulnerable situations such as mothers, new-borns, children, youth, the unemployed, the elderly and people with disabilities.

It highlights that this can be achieved through reducing the incidence of communicable diseases, non-communicable diseases and emerging diseases, ending the epidemics of AIDS, tuberculosis and malaria; reducing malnutrition and improving hygiene and sanitation.

At the centre of achieving these according to the Common African Position is to ensure universal and equitable access to quality healthcare, including universal access to comprehensive sexual reproductive health and reproductive rights (e.g. family planning); improving health systems and health financing, and medical infrastructure, the local manufacturing of health equipment, (e.g. commitment to the Abuja declaration); and setting up monitoring and evaluation, and quality assurance systems. This would also require strengthened governance in Africa to improve coordination, facilitate rapid dissemination of innovation, enhance local commitment and ownership and strengthen the region's voice on health issues with international partners and donors. These health goals will be fully incorporated in Africa's long-term strategy Agenda 2063. The overall objective of the Agenda 2063 is to develop a plan, which will chart Africa's development trajectory over the next 50 years. Agenda 2063 will clearly delineate the roles of each stakeholder such as RECs, Member States, Civil Society and private sector. At the global level the emerging issues and future considerations include the global agenda for the world to eliminate HIV and Malaria in 2030 and end TB in 2035. The African Union frameworks are aligned with these global targets.

11.5 Promoting innovation and making smarter investments for greater health returns

The AU Commission will leverage the newest technology and models of health service delivery to deliver the best possible care to the greatest number of people. Smart investment, innovation and evidence-driven flexibility can reduce unit costs for health services – and they can do so while improving health outcomes. Towards these ends, AU Member States should use investment tools to improve planning, overcome access

barriers and focus services on populations in greatest need. In particular, Member States should focus on improving maternal and child health.

In order to ensure the right choices are made for the highest long-term impact, AU will encourage Member States to use of investment frameworks to help prioritise spending on the most cost-effective interventions with the greatest health impact. Focused efforts will be needed to reduce unit costs while enhancing the performance of health systems to produce measurable health outcomes. Rigorous tracking of inputs, costs and health outcomes will be essential to promote greater efficiency. In recent years, less expensive delivery models have emerged that reduce front-line service costs. Rather than sacrificing quality, these new models should be utilised as they simplify and strengthen supply chain management, enhance programme oversight and extend limited human resources.

The growing demand for health-care services risks exacerbating the region's already acute human resource crisis. The AU Member States should take steps to significantly increase training capacity for health-care professionals, taking into account both the future demand for health-care services and the need to increase retention efforts. The AU should strongly support the sharing of knowledge, expertise and talent across AU Member States, helping to bridge current knowledge gaps and equipping local leaders with broader experiences and exposure.

To reduce incentives for out-migration of the limited number of trained health-care professionals, AU Member States should work to increase the number of local health-care jobs. This also includes improving the quality of these jobs and the retention of workers. New technologies can strengthen health systems and improve health outcomes. Innovative use of new technology is especially critical to efforts to enhance health-care services in rural areas (where technology offers new avenues to extend expertise in areas that have struggled with access). AU Member States should ensure funding for such initiatives and develop incentives to encourage entrepreneurs and institutions to expand use of innovative health and communications tools.

12. CONCLUSIONS

Since 2001 significant progress was made by Member States towards universal health access in general and AIDS, TB, and Malaria in particular. There is clear political will and commitment to achieve universal access and the unfinished business of health-related Millennium Development Goals by 2015 and beyond. The implementation of the AU Roadmap at various levels led to (i) sustainable financing models for AIDS, TB and Malaria; (ii) improved access to affordable and quality-assured medicines and health-related commodities and (iii) enhanced leadership, governance and oversight. However more effort is needed to strengthen and scale up the interventions undertaken.

Funding for the three diseases 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 the reduction of new cases. Significant progress was made in basic TB control especially DOTS coverage, case notification and improvement in treatment success rates. Investments in highly effective malaria 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.

In spite of the above, the progress made is still insufficient to attain the Abuja target of universal access to AIDS, TB and malaria services by 2015. The 'final push' towards universal access and ultimately ending the three epidemics should be advanced through the intensified implementation of national programmes with the support of the African Union Commission, African Union Organs, Regional Economic Communications, Regional Health Organisations, the UN system and other international partners. Greater emphasis should be placed on longer-term sustainable financing through efficiency gains and mobilising greater domestic resources.

Reducing the impact of the three diseases would significantly propel efforts to achieve the unfinished business of the Millennium Development Goals and those related to women and children's rights, education and the reduction of extreme poverty. Future efforts by the AU Member states and its partners to sustain and accelerate progress in the response to AIDS, TB and malaria should be grounded in human rights, gender equality and solidarity with marginalised populations.

13. RECOMMENDATIONS

With continued commitment and efforts spearheaded by the African Union Member States and the implementing countries, African Union Commission and its regional bodies, development partners, civil society and communities affected by these epidemics greater progress can be achieved towards universal access for all by 2015.

The increased commitment is also demonstrated by the steady availability of data since 2001 from a greater number of AU Member States. This has allowed policies to be effectively formulated/reviewed and the programmatic and policy gaps to be better understood. Based on the findings of this review the following recommendations are proffered:

13.1 Leadership and governance

Member States should further strengthen leadership and governance mechanisms through greater involvement of members of parliament, cities, and the private sector. There is greater need to reinforce harmonisation, integration and coordination at all levels in order to ensure greater ownership, stewardship and accountability including mechanisms for early warning systems. Member States should further harmonise national policies and strategies to ensure coherence with regional and continental policy instruments. This should be done through a multi-sectoral approach in order to better control the three diseases.

The African Union Commission and Member States should work on the modalities of ensuring that MPs receive information on Global Fund allocation (including other allocations) by country to help with monitoring. The AUC should further call for a merging of the Abuja Call and the AU Roadmap for a greater efficiency and effectiveness. The new framework should have an implementation plan that includes aspects of both the Abuja Call and the Roadmap.

To streamline coordination the AUC in close collaboration with PAP and the NEPAD Agency should organise an annual meeting of Ministries of Health, Finance and Economic Planning, Labour, Trade and Industry, Legal Affairs and MPs to facilitate dialogue on issues of common interest. The AUC, NEPAD Agency and PAP Secretariat should work jointly in putting together modalities for assisting MPs in ensuring ratification and domestication of AU policy frameworks and decisions.

The AUC should share AU policy frameworks, commitments and decisions to support MPs function in ratification processes, and facilitate collaboration between CSOs, (including PLWHA's networks), NGOs and the MPs in promoting accountability on continental commitments made by the AU. In addition CSOs & NGOs should mobilise communities to create demand for services (testing, treatment scale up etc.).

13.2 Resource Mobilisation

Member States should further strengthen advocacy and resource mobilisation for the three diseases including increased domestic resources with middle-income countries moving towards self-financing. Member States should promote global solidarity with increased donor funding directed towards low income countries. This should be aligned with efforts to increase value for money, efficiency and strategic investments as essential touchstones for success in the response through efficient implementation of high impact interventions in relevant populations and strengthening health systems.

Member States should establish innovative mechanisms for resource mobilisation at national level with a strong involvement of the private sector and CSOs to complement resources at international level. This includes taxation of tobacco and alcohol, and innovative taxation on manufacturing, imports, distribution, licensing and consumption as outlined by AU Roadmap. There is need to ensure predictable and sustainable long term financing for priority interventions such as responses to health, AIDS, TB, malaria and non-communicable diseases (NCDs).

Member States should ensure sound management of mobilised resources to maintain and/or gain the trust of technical and financial partners and put in place budgetary provision as a demonstration of ownership. RECs and RHOs should advocate for increased resources for the implementation of initiatives on the three diseases and health systems and community systems strengthening.

Partners should continue to advocate for mapping existing resources for health and identifying existing gaps. This will provide a solid foundation for advocating for increased innovative domestic financing measures and private sector investment including the development of financial sustainability plans for health at national, regional and continental levels. National investment cases for health should be developed based on the findings of the mapping and should take into account health and community systems strengthening and access to affordable medical products. In addition partners should align their financial and technical assistance and cooperation plans with national, regional and continental needs and priorities in a coordinated and efficient manner. This in line with Paris Declaration on aid effectiveness principles, Accra Plan of action and the Busan Partnership for Effective Development Co-operation that provides frameworks for good donorship and aid effectiveness.

13.3 Protection of Human Rights

Member States should promote and prioritise human rights-based responses to AIDS, TB, malaria and health through better access to justice and law and policies enforcement at national and regional level. This will ensure that the needs of vulnerable and key populations are taken into account in an adequate way. Member States should furthermore strengthen efforts to protect the rights of vulnerable and key populations at higher risk of HIV exposure. In addition Member States should increase efforts in research in structural drivers to address and better take into account challenging issues like stigma and its role in the spread of the three diseases.

AUC should work with Member States to assist them in ensuring that their laws, policies, and strategies are in compliance with continental instruments and that such laws, policies and strategies are enforced. MPs should continue to revise laws and policies that affect key populations and ensure that these are in compliance with regional and continental instruments that aim to secure equitable access to health services. Furthermore MPs should advocate for services to reach extremely vulnerable populations including pastoralists, refugees and internally displaced persons (IDPs). Similarly RECs and RHOs should intensify the implementation of rights-based and gender-inclusive inter-country and cross-border programmes.

13.4 Poverty Reduction, Health and Development

Member States should continue to promote the development and implementation of effective and targeted poverty reduction strategies. This includes social protection programmes to mitigate the impact of the three diseases particularly for the vulnerable groups. Furthermore this calls for governments to commit to 90% reduction in stigma and discrimination faced by PLWHA and key populations by 2030.

13.5 Strengthening Health and Community Systems

Member States should further strengthen health systems and community service delivery in order to make them more efficient with focus on integrated AIDS, TB and malaria services. Systems strengthening include effective integration, addressing inadequate human resources, weak laboratory and surveillance systems, procurement and supply management systems, primary health care and operational research. Focused efforts will be needed to reduce unit costs while enhancing the performance of health systems to produce measurable health outcomes.

Rigorous tracking of inputs, costs and health outcomes is essential to ensure greater efficiency. Member States should effectively train more health workers, create more health jobs, retain health workers and encourage south-to-south knowledge sharing. Member States and partners at various levels should leverage on the newest technology and models of health service delivery to deliver the best possible care to the greatest number of people. The AUC should continue with its expedited plans to establish the African CDC.

13.6 Prevention, Treatment, Care and Support

To provide a new framework to meet the new targets to end AIDS, TB and malaria by 2030 it is recommended that the Abuja Call and the AU Roadmap should be merged and extended for the period 2015-2030. Member States should expand access to high impact prevention interventions for each of the three diseases and set programmatic and impact targets. This should include better focus on key locations, intensifying key interventions and sustaining prevention funding while addressing human rights through improved focus (geographic and population focus).

This should start with high burden areas and interventions to economically empower young women and girls in high-prevalence settings. This includes cash transfers targeted at women. Member States should ensure timely access to appropriate, effective diagnosis, treatment care and support for the three diseases through improved focus (geographic and population focus), starting with high burden areas.

AUC to work with Member States to end AIDS by 2030 in line with the UNAIDS Fast-Track 90–90–90 targets as a concrete strategy for ending the AIDS epidemic. This includes strengthening implementation of the Global Plan for EMTCT as the first step of achieving an AIDS-free generation. Furthermore AUC should work with Member States towards the achievement of the Abuja +12 commitment to intensify efforts to end AIDS and TB and to eliminate malaria by 2030.

13.7 Access to Affordable Medicines and Technologies

Member States should accelerate the development and implementation of national action plans to ensure reliable access to affordable and quality-assured medicines and health-related commodities. The end goal should be to ensure that Member States provide uninterrupted availability of quality assured and affordable AIDS, TB and malaria medicines and commodities. This can be achieved through the promotion of local production of pharmaceuticals, harmonisation of regulatory standards and practices and measures to support the implementation of adequate procurement and supply-chain management. Therefore the recommendations of the Pharmaceutical Manufacturing Plan for Africa, its business plan and the AU Roadmap should be fully implemented.

This includes continued efforts to create an enabling legal and regulatory framework for access to medicines. RECs and RHOs play a critical role in coordinating the regional operationalisation of the Pharmaceutical Manufacturing Plan for Africa through harmonisation of medicine and commodity registrations and regulatory systems. RECs and RHOs should further promote harmonised efforts for affordable pricing of medicines and health commodities. This includes access to second line regimens, paediatric drugs, quality diagnostics and regionalisation of manufacturing, purchasing and regulation. In addition members of parliament should support the development of regional hubs for drugs production in Africa and universal treatment on the continent. This includes advocating for strengthening nascent regulatory systems to ensure access to affordable and quality assured drugs.

13.8 Research and Development

Member States should further strengthen capacity on biological, clinical and socio-cultural research, including traditional medicines, vaccines research and to generate evidence to improve and adapt policies and programmes. The AUC should further advocate for closer collaboration between governments, partners, private sector and research institutions to develop a cure for HIV and vaccines for HIV, TB and malaria. Members of Parliament should commit to promote continued investment in research on HIV vaccines and improvement of African research capacity and to facilitate promotion of local production.

13.9 Partnerships

The AUC and Member States should further diversify and strengthen partnerships with NGOs, CSOs, private sector and international community in the fight against the three diseases to advance the agenda of shared responsibility and global solidarity and create a conductive environment for this to happen.

13.10 Monitoring, Evaluation and Reporting

Member States should strengthen mechanisms and strategies to prevent, detect, and treat all confirmed cases of drug resistant tuberculosis, HIV and malaria including patients suffering from TB/HIV co-infection. Member States should strengthen monitoring and evaluation at country level and reporting to the RECs and AUC. The AUC should enhance monitoring and accountability mechanisms, evaluation and supervision of the implementation of the policy instruments at regional and national level. Furthermore the AUC should collect and share good practices and experiences on the responses to AIDS, TB and malaria for continental information sharing and exchange. This process can be supported by RECs, RHOs, Roll Back Malaria, Stop TB Partnership and UNAIDS WHO.