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Shaping the future of AIDS, TB and Malaria responses in Africa in the context of Post 2015 development agenda
Introduction

Africa continues to make significant strides in socio-economic and political development. The Africa Union Common Position on the Post 2015 Agenda and Strategic Plan (2014-2017) identifies structural economic transformation, human capital development, financing and partnerships, and technology and innovation as the priority areas for responding to Africa’s challenges in the post-2015 development agenda. These factors directly impact on Africa’s ability to address health and development challenges particularly AIDS, TB and malaria. Indeed, Health is a key contributor, consequence, and indicator of each of the dimensions of sustainable development hence the urgent need to reduce the huge African disease burden that poses a threat to Africa’s aspirations.

In fact while Africa accounts for only 13% of the global population it is home to 57% of global maternal and 50% of child deaths respectively. AIDS and malaria are the greatest contributors to the disease burden in Africa with 70% HIV cases and 90% of the deaths due to malaria occurring in the Continent. Of the 8.6 million people who developed TB globally in 2012, 27% were from Africa. HIV and TB co-infection are a priority concern with 75% of the estimated 1.1 million of all people with TB who are HIV-positive living in Africa. It is noteworthy that AIDS has been the fastest growing cause of disease burden globally in the last 20 years. Communicable and non-communicable diseases including neglected tropical diseases are also increasingly becoming prominent across the continent.

Both the African Union Common Position and the 2013 Abuja Declaration review and note the progress made on the health related MDGs in Africa and recommits Member States to the 2001 Abuja Call for universal and equitable access to quality healthcare and to reduce the incidence of communicable diseases including AIDS, TB and Malaria. The implementation of the African Union Roadmap provides the impetus that is required in the remaining two years to consolidate the progress achieved so far and to shift the paradigm of development cooperation to one that is African sourced and sustainable.

The overarching objective of this paper is to highlight important global discussions and evidence on HIV, TB and Malaria, and evaluate progress made in response to HIV/AIDS, TB and Malaria in Africa, in order to stimulate dialogue and shape forward looking thinking and strategic action in the Post-2015 scenario.

Finally, the report proposes key health thematic areas that arguably constitute future strategic focus in the domain of health in Africa after 2015.

Translating political commitments into action

At the Abuja 2001 Special Summit on AIDS, tuberculosis, malaria and other infectious diseases, eight Heads of State and Government joined hands together to create AIDS Watch Africa (AWA) to spearhead advocacy and resource mobilisation to the AIDS epidemic emergency. For over a decade AWA served as an African-led advocacy, resource mobilisation and accountability platform to press for the urgent acceleration of continental action to AIDS and ensured that the response remained high on the continental and global agenda.

Sustained commitment and ownership by African leaders has yielded results with the last decade being a defining moment for health and development, demonstrating a compelling vision for the future and strong political commitment to control the three diseases. Recognising that the successes of the last decade was predicated on the political will and commitment of Africa’s top leadership, a decision was taken by the 18th Session of the African Union Assembly in January 2012 to revitalise AWA in alignment with the continental and strategic directions. As a result, the mandate of AWA was broadened to cover the three diseases.

The experience in Africa in responding to the AIDS epidemic has shown the fundamental importance of collaboration by various players at global, continental and country levels. Joint efforts resulted in unprecedented mobilisation of resources with substantial global resources flowing in rapidly from contributions by donors. Through joint advocacy efforts by African leaders and various stakeholders the Global Fund to Fight AIDS, TB and Malaria (GFATM) was established in 2002. This initiative has now grown to be one of the most significant source of financing for programmes on AIDS, TB and malaria in most affected countries. The US Government also responded to global calls to address the AIDS epidemic through the President’s Emergency Plan for AIDS Relief (PEPFAR), which has also become one of the biggest contributors to the AIDS response.

In 2012 the African Heads of State and Government adopted the African Union Roadmap on Shared Responsibility and Global Solidarity on AIDS, TB and Malaria Response in Africa. The roadmap provides a blueprint for fast tracking implementation of the priority areas of the “Abuja Declarations and Abuja Call” following three action pillars which are health governance, diversified financing and access to medicines. The roadmap offers a set of practical and African-owned solutions to enhance sustainable responses to AIDS, tuberculosis and
malaria. In 2013 the African Union and partners released an update on the progress to implement the African Union Roadmap, which shows significant milestones in the implementation of the three pillars.

In 2013 African Heads of State and Government reaffirmed their commitment to the AIDS response at the Abuja+12 Summit. The Declaration of the Special Summit of the African Union on HIV and AIDS, Tuberculosis and Malaria committed among other key actions to accelerate the implementation of the earlier “Abuja Commitments”, step up the mobilisation of domestic resources to strengthen the health system; ensure that strategies are in place for diversified, balanced and sustainable financing for health, in particular AIDS, TB and Malaria, accelerate access to Anti-Retroviral (ARV) treatment within the continuum of care and targeted poverty elimination strategies and social protection programmes that integrate HIV/AIDS, TB and Malaria for all, particularly the vulnerable populations. However, many Member States of the African Union are not on track to achieve the health MDGs – particularly MDG 4 and MDG 5. In fact, the failure to meet the set targets of the MDGs is not due to the paucity of adequate policy prescriptions, ideas, decisions, declarations and frameworks. Quite on the contrary, countries in Africa have had enough of them and these have never been in short supply. What countries have perhaps lacked has been the impetus to ensure more action on the ground and to implement policies into action. What we need now is to turn the commitments into people-centred, country-led actions and translate guidelines and policies into tangible health service delivery outcomes.

**Over a decade of progress in the fight against AIDS, TB and malaria**

While significant challenges remain unprecedented progress has been made in responding to AIDS, TB and malaria. In less than a decade, access to HIV treatment in Africa increased more than 100-fold and approximately 7.6 million people are on treatment. New HIV infections in Sub Saharan Africa declined by 40% between 2001 to 2012 and between 2005 and 2012, AIDS-related deaths in sub-Saharan Africa declined by 30%.iii

Similarly increased political commitment and expanded funding have helped to reduce malaria incidence by 31% in Africa. Between 2001 and 2012, an estimated 337 million malaria cases and 3 million deaths were averted in the African Region.iv The intensification of efforts already undertaken to prevent malaria, including universal coverage of bed nets, is estimated to save the lives of up to three million African children by 2015 hence the importance of continuing efforts and mobilising more resources for the fight against malaria.

The malaria response has an immediate gap of US $3.6 billion through 2015 in Africa alone that threatens to unravel the gains made against this preventable and treatable disease. Malaria causes out-of-pocket expenditure for households and loss of productivity to the economy resulting in massive losses to economic growth, with an estimated cost of US$ 12 billion each year lost to productivity in Africa.v

The picture of the TB epidemic is shifting positively with Africa’s TB treatment success rate reaching 82% in 2012. The previously increasing incidence of TB has been halted and a decline observed as a result of several years of intensive implementation of sustained efforts including TB/HIV collaborative activities. However Africa is the only region in the world which is not on track to achieve a 50% reduction in TB mortality by 2015. The continent still accounts for 27% of the world’s TB cases, and is home to nearly 80% of TB cases among people living with HIV. The high TB burden in Africa is linked to poverty, TB/HIV co-infection and multidrug-resistant TB.vi

While the world is closest than it has have ever been in defeating TB, the response faces a major funding crisis, which calls for both accelerated innovative domestic financing, global support and immediate action to integrate TB and HIV services in African countries. This will lead to substantial cost-savings and improved health and economic outcomes. In fact latest modelling shows that every US$ 1 spent on TB generates US$ 30 through improved health and increased productivity.

Fighting TB is a prerequisite for fostering economic growth, ending poverty and improving livelihoods. In fact the impressive progress achieved over the last five decades shows that TB can be stopped with strong political will and adequate financial resources. Additionally new tools are now available with which to accelerate progress. To reach everyone in need of treatment, care and cure we need to increase the domestic investments. Currently on average African governments contribute 30% of their national TB budgets, whereas in the rest of the world governments contribute 70%.

However it should be acknowledged that health funding in most countries remains below what is required to achieve a functional basic health system even if resources available were optimally used.

Notably in 2001, African Heads of State and Government pledged to increase their country’s funding for health to at least 15 percent of their annual budget. This was arguably a turning point in Africa’s history the most decisive
action taken by leaders to address AIDS, tuberculosis and malaria as major threats to Africa’s broad health and development agenda.

While achievement of the Abuja targets remains unfulfilled by most African countries, AU countries have, on average, increased the proportion of total government expenditures allocated to health from 9% to 11% between 2001 and 2011. Although per capita health spending arguably provides a better financial test of a strong health system, this is still an impressive achievement by African governments.

The unfinished business of the MDGs and Post-2015 development agenda

Notwithstanding the progress made, more needs to be done as the MDGs remain an unfinished business. Progress on the health-related MDGs such as child and maternal mortality, quality of health services, and access to sanitation is insufficient to achieve the targets by 2015 in many countries. Reducing inequity in access to basic social services remains a major challenge.

Investing in human capital is pivotal to achieving Africa’s transformation, and health financing in Africa has doubled over the last decade in actual fact. However, there are clear indications that in many countries, health results are still not proportional to the effort. There are wide disparities in the health outcomes of countries at similar levels of health spending, and household out-of-pocket health expenditures remains catastrophic in many Africans countries. Also, over-dependence on donors and international funding for the three diseases continue to be a major challenge, renders national responses vulnerable, and challenge the sustainability of effort.

One of the main challenges faced by governments and development partners in expanding services that will improve maternal and child health and reduce the burden of infectious and non-communicable diseases is the lack of an adequate health system.

Renewing their commitments in the 2013 Abuja Declaration the African leadership underscored the on-going work on the Post-2015 development agenda and the continued efforts to advocate for, and prioritise health as central to Africa’s development with a focus on elimination of HIV, tuberculosis and malaria and other neglected diseases. The Common Africa Position (CAP) on the Post-2015 development agenda that was adopted by the 22nd AU Ordinary Assembly provides a unique opportunity for Africa to reach consensus on common challenges, priorities and aspirations. The position paper advocates for the active participation of Africans in the global debate on how to provide a fresh impetus to the new development targets and to examine and devise strategies to address key emerging issues on the continent in the coming years.

Sustaining Africa’s development agenda: Addressing key priorities in health

The following ten areas are the key areas that should be at the core of the discussions on health in the post 2015 development discourse. The paper provides recommendations for future actions for each key area.

a) Universal health coverage and access

The goal of universal health coverage (UHC) is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them. Universal health coverage is thus a critical component of sustainable development and poverty reduction and a key element of any effort to reduce social inequities.

Universal coverage is the hallmark of a government’s commitment to improve the wellbeing of all its citizens. There are still many challenges in reaching Universal access and universal health coverage, particularly legal, cultural, gender and institutional barriers that hinder access to HIV prevention and treatment services especially for most-at-risk populations.

Stigma and discrimination remain key barriers to universal access to services in the region, and contribute to rights violations targeted at people living with HIV and AIDS and key populations at higher risk of HIV infection.

Today there are 18 million people living with HIV still awaiting access to treatment, while we have seen tremendous global solidarity and progress. There is also growing evidence that HIV and AIDS, TB and Malaria prevalence is strongly associated with economic and social inequality. TB and Malaria are definitively linked with poverty. While HIV may not fit the criteria for a “disease of poverty”, the comparative shortage of financial and human resources, as well as continuing stigma and discrimination and often legal barriers undoubtedly affect a

2 UNGA (2012). Global health and foreign policy
country’s ability to mount a strong and sustained response to the epidemic. Challenges and successes cited include the following:

- Countries commonly cited the lack of sufficient funding as a major obstacle to an effective response to these three diseases.
- Although financing for the AIDS TB and Malaria response has dramatically increased over the last decade, funding remains inadequate, jeopardizing efforts to achieve national targets.
- Some African countries are making tremendous efforts to reach Universal access. Ten countries with HIV and AIDS generalized epidemics, including three in Africa (Botswana, Namibia and Rwanda) have attained universal access to antiretroviral therapy and the number of AIDS related deaths has fallen by one third in the past six years with the number of people receiving antiretroviral treatment increasing by 59% in the past two years alone.xi

**Recommendations for future actions**

Re-energize commitment to Universal Access at all levels of leadership and strengthen mechanisms for coordination, decentralisation, monitoring and reporting by setting or revising HIV-targets;

i. Support and strengthen the capacity of national institutions, community systems and human resources for health to mount evidence-informed and rights-based responses;

ii. Design/adapt context-specific national health financing systems to promote Universal Health Coverage/Access;

iii. Strengthen multi-sectoral integrated collaboration in the implementation of UHC and improvement of Health Outcomes;

iv. Strategic private-public partnership to promote UHC;

v. Promote and implement social protection measures that include health insurance schemes to be able to reach the poor and the most in need;

vi. Promote high quality care that is client- and family-centred, addressing the needs and preferences of service users and the culture of their communities;

vii. Member states to adopt equitable people-centred policies that empower citizens through addressing poverty, marginalisation, internal displacement and forced migration which will result in increased access to health services.

**b) Equitable access to health: Case of Women and girls in conflict and post-conflict settings**

Women and children have been disproportionately affected by conflict as casualties of violence, as internally displaced persons and as refugees. Violence against women and children in conflict harms families; impoverishes communities and reinforces other forms of inequality. In addition, women and girls experience direct violations of their physical integrity, for example through sexual violence and rape that often culminate, in addition to physical and mental trauma, in unintended and often forced pregnancies. Most recent conflicts have been rife with epidemic rates of sexual and gender-based violence, combined with high levels of gender-based human rights violations. The reality is that sexual violence has often been dismissed as an unfortunate consequence of conflict, resulting in widespread impunity for these crimes and general tolerance of gender based violence in post-conflict societies.4 Conflicts may actually help to create the social, political, and economic conditions in which the adverse health conditions such as epidemics thrive, creating a vicious cycle.

It was in recognition of this pervasive problem that the African Union Commission decided in 2010 to examine how best to develop targeted action to mitigate violence against women and children in armed conflict, building on the already existing normative frameworks. In October 2000, the UN Security Council adopted Resolution 1325 on Women, Peace and Security. In January 2007, UNFPA held a conference in Hammamet, Tunisia, to review challenges and good practices in support of women and girls in conflict and post-conflict situations, review progress on implementation of UN Security Council Resolution 1325 as well as to make recommendations for the way forward. In 2011 the United Nations Security Council resolution 1983 (2011) called for increased efforts by UN Member States to address HIV in peacekeeping missions. It also calls for HIV prevention efforts among uniformed services to be aligned with efforts to end sexual violence in conflict and post-conflict settings.

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4 Desk Review of women and girls, HIV/AIDS and conflict: Situation analysis of eleven selected conflict and post conflict countries in Africa.
The African Union Commission Second Desk Review on Women and Girls, HIV/AIDS and Conflicts: Situation Analysis of 11 Selected Conflict and Post-conflict Countries in (2013) provides concrete recommendations and strategic actions on addressing violence against women in conflicts and post conflict areas, in an effort to reduce their risk of exposure to HIV and curbing the vertical transmission of HIV from mother to child in conflict and post conflict situations. The Key strategic actions were shared with the Peace and Security Department, so that they can incorporate and mainstream these in their own plans.

**Recommendations for future actions**

i. Establish a strong AU institutional framework that addresses the intersecting dynamics of gender, peace and security and health, with particular focus on conflict and post-conflict settings.

ii. Establish and deploy mobile population specific equitable health care interventions in conflict and post-conflict settings.

iii. Provide guidance on the implementation of programmes addressing violence against women.

c) **Strengthen health systems**

Health systems strengthening remain a fundamental pillar of the health sector. The delivery of healthcare requires more than just medicines. For a country to deliver basic health care to its people, it requires a fully functional health system. There are many constituent parts that make up a functional health system, including human resources for health, transport, ICT, facilities and medicines and supplies. Numerous reports place high importance and recognise that unless existing health systems are sustained and improved, health goals in Africa can be hard to attain.

The inadequate service delivery is mainly due to the insufficiency of human resources, poor infrastructure, equipment, medicines and technology. The under-investment in health and infrastructure is also an important cause that is leading to the failure of health systems in many countries. National health systems continue to be plagued by various factors, such as drug stock-outs, discontinuity of care, insufficient quality control, inadequate collaboration between Tuberculosis and HIV services and the overall lack of comprehensive health and support services.

Through the renewed Abuja Declaration (2013), the African leadership declared the urgency of speeding up actions to strengthen health systems to provide comprehensive and integrated health care services and improve access to essential services; financing of health research; partnerships with relevant stakeholders; and a multi-sectoral and integrated approach to disease control.

**Recommendations for future actions**

i. Promote home-grown and creative solutions in governance of health systems as well as science, technology and economic policies.

ii. Ensure systematic involvement of all the key development sectors whose actions have a bearing on health, at the highest level of government – “health in all” policies – as well as the alignment of donor funds to country priorities.

iii. Commit to improve health systems including ensuring availability of well-equipped health facilities, increased health financing and strong information management.

iv. Ensure skilled and motivated human resources in adequate numbers and ensure wide geographic coverage.

v. Integrate auxiliary health workers (community health workers, volunteers etc.) into national health systems, and support and supervise them.

vi. Adapt and implement guidelines/standards of practice to implement task shifting at national level.

d) **Domestic & innovative financing for Health, Ownership & Accountability**

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.

The biggest challenge the health sector now faces is funding. Overseas development assistance (ODA) is still important – it remains a critical component of global solidarity for AIDS, global health and development.
Many of the countries with the heaviest disease burdens are unable to fund their responses to AIDS, TB and malaria without international support. However, country ownership and shared responsibility is the future and is critical to promote sustainability and predictability of the AIDS response.

It is heartening to note that significant progress has been made in Domestic Financing for health: 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. For the first time in the history of global health, we are mobilizing 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. This is the essence of what we call shared responsibility.

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.

**Recommendations for future actions**

i. Align continental policy frameworks with regional and national plans.

ii. Support country mapping and gap analysis in terms of funding and expenditure both domestic and international and establish an accessible database.

iii. Compile lessons learnt and best practices to share with countries in the continent on a range of innovative financing efforts that can be promoted domestically.

iv. Strengthen involvement of parliamentary organs for increased advocacy and oversight nationally, regionally and continentally.

v. Promote advocacy and monitoring of the implementation of continental policies.

vi. Engage with promoters of large capital projects to incorporate HIV, gender and social impacts in environment assessments and ensure that large capital projects in Africa set aside funding to promote health and provide for HIV, TB and malaria services in communities affected by large capital projects – during project implementation as well as after

### e) Development of local pharmaceutical industries and regulatory harmonisation

A continent of 1 billion people cannot continue to depend on external sources of medicines and health commodities. The Business Plan for the Operationalization of the Pharmaceutical Manufacturing Plan for Africa (PMPA) was articulated to improve access to Medicines on the continent, to improve public health ending unsustainable dependency, as well as to stimulate economic and industrial development.

Pursuant to this, the Heads of State and Government renewed commitments through the Abuja declaration (2013). The Declaration calls various stakeholders including the private sector, to support the already established pharmaceutical industries in Africa and the implementation of the Pharmaceutical Manufacturing Plan for Africa Business Plan (PMPA BP). The Business plan is premised on the inalienable human rights principle of access to quality assured, safe, efficacious essential medicines and promoting trade and industry in Africa.

The following challenges remain the main obstacles to the implementation of the PMPA:

i) The lack of access to sustainable financing mechanisms; the costs of inputs and services; and fragmented markets;

ii) The other challenges include the lack of technical and human resource capacities, including poor R&D;

iii) The inability of African nations to fully utilize TRIPS flexibilities enshrined in the Doha Declaration on the TRIPS Agreement and Public Health, and

iv) The international/WHO norms of good manufacturing practices (GMP) and quality assurance issues.
Achievement of universal access to lifesaving treatment and commodities will demand concerted efforts to ensure a long-term supply of affordable, high quality antiretroviral drugs in the region. In this respect shared or pooled procurement policies should be explored, and countries should take steps to remove tax and tariff barriers to lower prices and enable health goods to flow easily from country to country.\textsuperscript{5} Additionally, South-South collaboration and international partnerships should help to build the capacity of eligible countries to make appropriate use of TRIPS flexibilities and to engage with industry on intellectual property and licensing issues.

**Recommendations for future actions**

i. Promote and implement the PMPA with the understanding that the pharmaceutical industry is knowledge intensive and requires a workforce of highly skilled professionals. The skills are available but the continent needs to expand this talent pool and equip our pharmaceutical industry with the practical knowledge of how to produce medicines of international standards at a competitive cost.

ii. Pharmaceutical companies need to make significant investments and require access to capital with long term maturity at affordable rates.

iii. Demonstrable commitment from African leaders will increase the appetite for the sector amongst the investment community but there is a need to facilitate and support investment through initiatives such as context specific and time limited incentives.

iv. For local pharmaceutical companies to be able to invest, the duty on key ingredients to be imported need to be reduced to curb against unfair competition by the international companies, they need to be protected from the unfair competition of, sometimes sub-standard and even counterfeit products requiring greater oversight of the market place.

v. To assist our companies to develop and to mitigate risk to public health it is necessary to support the work spearheaded by the Africa Medicines Regulatory Harmonization (AMRH) initiative.

vi. Strengthen reviews of laws and measures to fully incorporate and utilise all public health related TRIPS flexibilities.

f) **Revolutionising prevention of HIV, TB and malaria**

**HIV Prevention:** There is empirical evidence that HIV prevention is feasible and effective on a large scale. For the 2.6 million people newly infected with HIV in 2010, it was science not being applied rather than science failing to some extent. HIV spread has reached a turning point following decades of increasing and sustained incidence. An effective vaccine has not been developed, but critical breakthroughs with prevention based on antiretroviral treatment are promising. The field of biomedical HIV prevention has undergone remarkable changes over the past 5 years.

The new prevention technologies will have to be combined with condoms and incorporated into the mixes of combination prevention approaches that are tailored to the local epidemic and context. Clinical trials have demonstrated efficacy with interventions such as voluntary medical male circumcision (VMMC), a topical vaginal microbicide, daily oral pre-exposure prophylaxis (PrEP), and the use of antiretroviral treatment (ART) to reduce the risk of HIV transmission in HIV-serodiscordant heterosexual exposure. To address the implementation gap, more political will and leadership will be needed to overcome the socio-cultural, legal or religious barriers to promotion. We have learned that the generation of demand for HIV prevention is not easy, as for health promotion in general.

If we collectively manage to develop common ground on combination prevention, customize programs to people’s needs and exercise technical and political leadership, our decade may indeed see the beginning of the end of the HIV epidemic, but eliminating HIV with the current tools seems unlikely.

**Challenges:** The variable capacity of the public sector, nongovernmental organizations and communities to implement prevention activities, as well as the limited involvement of people with strong management expertise to coordinate and manage the programs at national level, contribute to the implementation gap. Short funding cycles affect long-term programming and sustainability and finally, in the landscape of the ‘multisectoral’ response, the roles and responsibilities to coordinate the response and monitor progress have not always been clear.

**Malaria Prevention**

Intermittent preventive treatment of pregnant women (IPTp) is given at routine antenatal visits in areas with moderate-to-high malaria transmission in Africa. Intermittent preventive treatment of infants (IPTi) is recommended through immunisation services in the same areas. Coverage of IPTp remains a matter of concern in spite of the relatively good antenatal clinic attendance. Health worker training and simplified guidance and training of service providers are being used to improve IPTp coverage.

Bed nets: There is a need to increase ownership and use of bed nets in high prevalence regions.

According to the current statistics over half (US$2.8 billion) of the estimated annual global resource requirement is still unfunded which threatens to slow down progress as high-burden African countries are unable to replace expiring long-lasting insecticide treated nets (LLNs).

Tuberculosis

One of the major challenges has been the large proportion of estimated TB patients (40%) that remain undetected which contributes substantially to the continued mortality from this curable disease, and leads to continued transmission to others and development of drug resistant forms of tuberculosis. There is also slow progress in tackling multi-drug resistant TB (MDR-TB) and extensively drug-resistant TB (XDR-TB).

Recommendations for future actions

i. Continue to promote access to prevention services for HIV, TB and malaria.

ii. Expand, improve and integrate existing HIV, TB and malaria programmes.

iii. Maintain funding for, and uninterrupted supply of, life-saving malaria commodities to prevent resurgences of malaria that can occur rapidly with devastating loss of life.

iv. Engage the community more in increasing awareness and use of recommended interventions related to prevention.

v. Accelerate HIV prevention programmes using a combination of effective evidence-based prevention, particularly for young people, women, girls and other vulnerable populations.

vi. Strengthen the use of effective insecticides for control and elimination of malaria, including the use of dichlorodiphenyltrichloroethane (DDT), where it is suitable.

vii. Mobilise political leadership, civil society and champions from the AIDS, Malaria and TB-affected communities in order to mobilize resources, make progress and achieve the AIDS, TB and malaria-related targets in Africa.

viii. Strengthen mechanisms to increase coverage and access to services for detection and treatment of TB, Multi-Drug Resistant Tuberculosis (MDR-TB) and the involvement of communities in TB interventions.

Treatment as prevention strategy

The proponents of treatment as prevention led by UNAIDS note that scaling up HIV treatment is essential if the world has to achieve the targets required to end AIDS, TB and Malaria.

HIV treatment and other high-impact strategies have been rapidly brought to scale, resulting in sharp decline in AIDS-related deaths. Recent review of prevention interventions trials noted that among the biomedical prevention tools evaluated to date, effective antiretroviral therapy provides the greatest prevention effect.

Given its dual benefits, saving the lives of people living with HIV and sharply restricting the spread of HIV – antiretroviral therapy constitutes a cornerstone of an effective response. The world stands to benefit from this compelling evidence regarding investing in antiretroviral treatment as a catalytic action for ending AIDS.

Challenges:

Only 7 million people living with HIV are currently receiving ARV treatment. Although AIDS funding has increased from USD 260 million in 1996 to USD 15.9 billion in 2009, the costs of the ARVs remain unsustainable, as with the new WHO Guidelines, there will be a need of a huge increase in funds to be able to reach universal access to treatment in Africa.

Therefore, countries with low revenues and limited resources, where the cost of each new infection is higher than the per capita GDP will continue to be challenged. As a result, the reduction of new infections through prevention will continue to remain a strategic investment.
Recommendations for future actions

i. Create demand for HIV testing and treatment with key advocacy actions by various constituencies working on responding to the HIV epidemic at various levels.

ii. Mobilise sustained investment, giving priority to innovation and using the available resources as strategically as possible.

iii. Ensure that health and community systems, infrastructure, enabling laws and policies are in place to deliver treatment to all eligible people living with HIV.

iv. Continue the investments in prevention of new infections as well as for responding to the current needs for treatment.

v. Be prepared to face forthcoming budgetary and sustainability challenges by planning for such exigencies.

g) Elimination of new HIV infections among children and keeping their mothers alive

Of the world’s 35 million people living with HIV, 25 million are in Sub-Saharan Africa. Ninety (90%) of all pregnant women living with HIV are in Sub-Saharan Africa and 60% of infections in Africa are among women. Without intervention, up to 40% of all these women would pass infection to their babies. Evidence has shown that it is possible to prevent new HIV infections among children and keep their mothers alive if pregnant women living with HIV have timely access to quality life-saving antiretroviral drugs for their own health or as prophylaxis during pregnancy, delivery and breastfeeding.

In Africa 7.6 million people are now receiving treatment, and 64% of pregnant women living with HIV, receive efficacious antiretroviral (ARVs) for prevention of mother to child transmission (PMTCT). In July 2010, the African Union Heads of States and Government recommitted to the elimination of mother-to-child transmission; as well as actions to attain the health-related Millennium Development Goals (MDGs). They also launched the Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA) whose purpose is to rally countries to take actions against maternal and child deaths including from HIV.

Recommendations for future actions

i. Accelerate implementation of action plans: The political will to address maternal, neonatal and child health exists. However, there is a need to accelerate the implementation of the action plans that have been developed to maintain the progress achieved so far. The African Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive provides a framework for joint continental action and effective coordination.

ii. Promote and support synergies and strategic integration between programmes for preventing HIV infection among children and programmes for maternal, new-born, child and reproductive health.

iii. Support partners and coalition building and reinforce support of integration of initiatives for eMTCT.

iv. African Union to ensure that countries’ targets are being effectively monitored to promote accountability in meeting eMTCT targets.

v. Rapidly accelerate roll-out of anti-retroviral treatment (ART) for children and adolescents and eliminate adult-child inequities.

vi. Promote South-to-South knowledge sharing including exchange of best practices and lessons learned at national, regional and continental levels.

h) Leadership and accountability

The Abuja Declaration commitments represent a turning point in terms of leadership and accountability in Africa especially in regards to HIV/AIDS, TB and Malaria. In 2012, AIDS Watch Africa (AWA) was revived as a platform for advocacy and accountability and through this initiative the Heads of State and Government (HoSG) adopted the AU Roadmap on Shared Responsibility and Global Solidarity. During the last AWA Action Committee of HOSG in May 2013, five countries were appointed as Regional Champions for AIDS, TB and Malaria Response.

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6 MDG Report 2013: Assessing Progress in Africa toward the Millennium Development Goals
in Africa, with one of them taking the role of the Vice-Chair. While Mozambique was appointed the Vice-Chair, the other Regional Champions were Cote d’Ivoire, Malawi, Tanzania and Tunisia.

Essential and multiple influences from the political sphere cannot be underplayed. The role of activism in driving political leadership cannot be underestimated. Undoubtedly, countries with successful responses to epidemics are often characterised by having very high-level political leadership that drives decision-making, partnerships brokering, resource allocation and oversight and tracking on health expenditure. Such political will gives impetus to accountability for local and external funding, bolsters programme implementation, including streamlining disease coordination and governance, to make the best use of limited national human and financial resources and stimulates formulation of laudable policy and legislative frameworks.

Countries that have had the greatest success have established ambitious targets for scaling up, with diverse national stakeholders holding each other accountable for results. Africa is therefore yearning for effective, accountable and participatory institutions and governance based on transparent laws and rules, effective public policy and services, strengthening the role of the state in development, enhancing the legitimacy of institutions and on building public trust.

**Recommendations for future actions**

i. Improve governance and coordination at all levels in order to ensure ownership and accountability for AIDS, TB and Malaria responses.

ii. Streamline disease coordination and governance to make best use of limited national human and financial resources (build on the concept of “Three Ones”).

iii. Heads of State and Government (HoSG) as well as other national, regional and continental leaders who are influential to actively champion the implementation of the AU Roadmap at the national, continental and global levels and oversee its implementation and reporting in their countries in collaboration with the main stakeholders.

iv. The HoSG are urged to maximise the opportunity presented by the AIDS Watch Africa platform to promote advocacy and accountability in the implementation of the African Union policy frameworks.

**Partnerships for development**

The role of partnerships and networking clearly stand out in the successes in responding to global health and the response to AIDS, TB, and malaria has amply demonstrated this. Specifically, providing official development assistance (ODA) to developing countries has been an important source of finance for the MDG interventions and thus their progress. Partnerships practices gave birth to sector-wide approaches (SWAPs) and multi-sectoral approaches which galvanised relevant government departments, private sector, civil society and other stakeholders.

In the Abuja Call, AU Member States made the commitment to developing and supporting partnership mechanisms to coordinate the contributions of stakeholders, from the public sector, and from CSOs at regional and international levels, to achieve universal access to prevention, treatment, care and support for HIV/AIDS, TB and Malaria. Partnerships with communities, private sector, civil society organizations as well as development partners are essential to make an environment conducive to good health status as well as to deliver health services.

**Recommendations for future actions**

i. Advance strategic collaboration with international and national partners as well as civil society and private sector partners to improve efforts to address the three diseases.

ii. Uphold and advance broader aid effectiveness principles.

iii. Ensure that external partnerships are aligned with Africa’s transformation aspirations and health priorities.

**Research and development, strategic information, monitoring and evaluation and knowledge management**

Africa lags behind other regions of the world when it comes to innovations and knowledge creation. The shortage of researchers on the continent is exacerbated by the loss of skills to the developed world. Initiatives to close health research gaps particularly in low- and middle-income countries gives impetus to stimulate the research and development agenda. Efforts to strengthen research and data generation capacity and enhance the
research portfolio to meet the needs at a national level therefore remain critical in order to strengthen monitoring and evaluation.

AU Member States have also committed to strengthening monitoring and evaluation and reporting of the three diseases and a monitoring and reporting mechanism, including target indicators, has been developed for reporting in terms of the Abuja Call for Action.

However, monitoring and evaluation of programmes, especially for malaria has not progressed as well as in past years. Many countries are still struggling to measure various indicators related to malaria, reflected by the non-availability of information in a number of countries in 2012.

Overall, the system of monitoring and evaluation and reporting in African countries requires strengthening and renewed commitment from African leaders, as well as technical and financial support from international institutions and organizations. Vigorous data gathering, timely, reliable and compelling strategic information systems are more likely to culminate in a strategic response.

**Recommendations for future actions**

i. Carve a niche in the area of research and development with specific focus on biomedical, clinical and socio-cultural research in Africa.

ii. Document and share best practices on research and innovation on AIDS, TB and malaria across Africa and beyond.

iii. Strengthen national monitoring and evaluation systems in order to have robust data gathering.

iv. Improve the collection, analysis and use of data in AIDS, TB and malaria responses to improve monitoring and reporting.

v. Support resource mobilisation, partnerships, policy harmonisation and integration of efforts for the implementation of the African Plan.

vi. Develop resource and sustain mechanisms for coordinating the rapid provision of technical support and capacity development based on country needs.

vii. Strengthen national, regional and continental monitoring and evaluation system(s) for better implementation of commitments as well as for ownership and accountability.

**Conclusion**

- Africa’s strong economic growth is an encouraging trend in the continent’s broader story. Africa has the second highest rate of economic growth in the world. The region’s economy grew 5.1% in 2011, and growth is projected to accelerate to 5.8% in 2014. According to AfDB, 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. A stronger economy means more resources to combat diseases and improve the health of African peoples.

- As Africa becomes healthier, even more economic growth will be possible. More people will be pulled out of poverty, and health outcomes will rise accordingly.

- At this moment, Africa has the lowest life expectancy in the world: 54.4 years. As life expectancy rises, however, 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.

While millions of lives have been saved and the African continent has seen remarkable progress on the path of development there is a need to consolidate and sustain these foundations for the present generation as well as the future generation. With the existing science, our understanding of the epidemiology and our collective experience in combating the diseases, we now have an opportunity to control them. If we do not control these diseases now the long term-costs will be incalculable.

The balance between making the case for the importance of health in the Post-2015 agenda, and identifying which specific health targets or interests should be highlighted and carefully managed. In the Post-2015 context, efforts to generate evidence for programming and clinical interventions cannot be relegated to be a secondary priority but should take pre-eminence in the health domain. It will be critical in the Post-2015 development goals to ensure that the linkages between health and development are much clearer and more visible. This will serve
to clearly articulate and support the synergies between health and other sectors, and increase policy coherence, interdependence, and shared solutions to drive people-centred, inclusive, and sustainable development.

ENDNOTES & REFERENCES


