AFRICAN UNION
الاتحاد الأفريقي

UNION AFRICAINE
UNIÃO AFRICANA

Addis Ababa, ETHIOPIA P. O. Box 3243 Telephone +251115- 517700 Fax : +251115- 517844
Website : www.africa-union.org

EXECUTIVE COUNCIL
Eleventh Ordinary Session
25 - 29 June 2007
Accra, GHANA

EX.CL/354 (XI)

REPORT OF THE THIRD ORDINARY SESSION OF THE AFRICAN UNION CONFERENCE OF MINISTERS OF HEALTH

REPORT OF THE THIRD ORDINARY SESSION OF THE AFRICAN UNION CONFERENCE OF MINISTERS OF HEALTH

EXECUTIVE SUMMARY

The 3rd Session of the AU Conference of Ministers of Health (CAMH3) took place from April 9-13, 2007 in Johannesburg, South Africa. The theme of the Conference was "***Health Systems Strengthening for Equity and Development."***

The first day of the Conference was dedicated to a meeting of Experts from Member States to finalize logistical arrangements.

The Ministerial session took place from April 10-13, 2007. During this conference a new Bureau for the AU Conference of Ministers of Health was elected as follows:

- Chairperson: Southern Africa (South Africa)
- 1st Vice Chairperson: Central Africa (Gabon)
- 2nd Vice Chairperson: Western Africa (Togo)
- 3rd Vice Chairperson: Northern Africa (Egypt)
- Rapporteur: Eastern Africa (Mauritius)

The main objective of the conference was to discuss health issues in general and strengthening of health systems in particular. At the end of the meeting the following documents were adopted:

1. The Africa Health Strategy
2. The Pharmaceutical Manufacturing Plan for Africa
3. The Plan of Action on Violence Prevention in Africa
4. The Monitoring and Reporting Mechanism Plan for the Outcomes of the May 2006 Abuja Special Summit on HIV/AIDS, TB and Malaria
5. The Johannesburg Declaration

AFRICAN UNION
الاتحاد الأفريقي

UNION AFRICAINE

UNIÃO AFRICANA

Addis Ababa, ETHIOPIA P. O. Box 3243 Telephone +251115- 517700 Fax : +251115- 517844
Website : www.africa-union.org

THIRD ORDINARY SESSION OF THE AFRICAN UNION CONFERENCE OF MINISTERS OF HEALTH
9 – 13 APRIL 2007
JOHANNESBURG, SOUTH AFRICA

CAMH/MIN/Rpt (III)

Theme: **"*Strengthening of Health Systems for Equity and Development in Africa*"**

REPORT OF THE MINISTERS' MEETING

REPORT OF THE MINISTERS' MEETING

I. INTRODUCTION

1. The 3rd Ordinary Session of the AU Conference of Ministers of Health was held at the Sandton Convention Centre, Johannesburg, South Africa, from 9 to 13 April, 2007. Its deliberations focused on the theme: "*Strengthening of Health Systems for Equity and Development*". The objective of the Conference was to share experiences and lessons from different countries and regions on how to strengthen health systems in order to improve the health situation in Africa.

2. The Meeting of Experts/Officials preceded the Ministerial Meeting and was held on 9 April 2007. Its objective was to finalise the technical, administrative and logistical preparations for the Ministerial Meeting. It was chaired by Ms. Batatu Tafa, Permanent Secretary at the Ministry of Health of Botswana. Briefings were provided on the preparations by representatives of the Department of Health of South Africa and the African Union Commission. The AU Commission also provided a brief background on each of the working documents.

3. During the ensuing discussions, the Senior Officials expressed the wish to have had the time to review the technical preparations, including documentation for the Conference. However, they were informed that Ministers had also expressed the need to discuss each substantive document in detail. The concern would, however, be rectified in future.

II. ATTENDANCE:

4. The Meeting was attended by delegations from the following AU Member States: Algeria, Angola, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Chad, Congo, Côte d'Ivôire, DRC, Egypt, Equatorial Guinea, Ethiopia, Gabon, Ghana, Guinea, Kenya, Lesotho, Liberia, Libya, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, SADR, Senegal, Sierra Leone, South Africa, Sudan, Swaziland, Tanzania, Togo, Tunisia, Uganda, Zambia, Zimbabwe.

5. It was also attended by Representatives of the following countries, International and Regional Organizations, Agencies, NGOs and CSOs: Canada, Peoples' Republic of China, Cuba, Japan, Romania, Serbia, USA, WHO, UNAIDS, International AIDS Vaccine Initiative, UNECA, UNIDO, IOM, UNICEF, FAO, WFP, UNHCP, UNFPA, UNDP, UNHCR, UNHCR, UNESCO, WORLD BANK, ADB, DPSA, ECOWAS, SADC, ICW/TAC, EU Commission, COMMONWEALTH SECRETARIAT, IPPF, National Population Council (South Africa), Medical Research Council (South Africa), OCEAC, OXFAM, NORAD, PANOS, GTZ, Pan-African Youth Organization against HIV/AIDS, Youth Against HIV/AIDS Cultural Organization, South African Youth Council, Netcare, Advocates International, Plan International, Center for Conflict Resolution, USAID, DFID (UK), CIDA (Canada), The Family Caucus, AGSC, APHA, SADTC, GHWA, Pharmaceutical Society of South Africa, Bongmusa, Ikhambi, Rentloile, Novartis,

Glaxosmithkline, South African Pharmacy Council, IKS Medical Research Council, University of Pretoria, RPM-DALBERG, DOE, AIDS Law Project, OSISA, AFRCASO, KHRAN, HENNT-AMREF, SPVC, ACD, Council of Medical Schemes, Board of Health Care Funders, Civil Society Charter Task Team, BEE Medscheme, Boneo of Healthcare Funders, Community Investment Holding, APHRC, IPAS, Ghanatta College of Art and Design, Monthly Asian Union, Cumulative Sunny NIG LTD, Prestige Academy, Kaneshie Anglican JSS, Health Professions Council of South Africa, ORACLE, ABMP, CHESTRAD, OAFLA.

6. The participants' list is annexed to this Report.

III. OPENING CEREMONY OF THE MINISTERIAL MEETING

A. OFFICIAL OPENING CEREMONY

7. The official opening ceremony for the Ministerial Session took place on April 10, 2007. The Deputy Minister of Health of South Africa, Ms. Nozizwe Madlala-Routledge, as Director of Programmes for the Opening Ceremony welcomed all participants to the Third Ordinary Session of the African Union Conference of Ministers of Health (CAMH3). This was followed by the anthems of the AU and the Republic of South Africa.

(i) Remarks by Prof. Sheila Tlou, Chairperson of the 2nd Session of the AU Conference of Ministers of Health

8. The Outgoing Chairperson of the AU Conference of Ministers of Health and Honourable Minister of Health of Botswana, Professor Sheila Tlou referred to the significant progress made since the second African Union Conference of Ministers of Health (CAMH2) held in Botswana in October 2005. However, she emphasized that Africa still faces severe challenges in achieving health and the Health Millennium Development Goals. She recognized that the theme of this Conference *"Strengthening of Health Systems for Equity and Development*" could not have come at a more opportune time, as health strengthening is central to achieving our common goal, which is to improve the health status of our people.

9. She concluded her remarks by expressing hope that the Africa Health Strategy which was expected to be the main outcome of the Conference would be adopted.

(ii) Statement by the Acting Minister of Health of the Republic of South Africa, Hon. Jeff Radebe

10. The Honourable Acting Minister of Health, Jeff Radebe, conveyed his best wishes for the speedy recovery to the Minister of Health of South Africa, Dr Manto Tshabala Msimang. He thanked the African Union for its leadership and all Ministers and Heads of Delegation for attending the Conference. He also highlighted the vision of an integrated and united Africa. He thanked Prof. Konaré and Advocate Gawanas of the AU Commission for their commitment and leadership.

11. While recognising that the disease burden in Africa continues to impede socio-economic development on the continent, Hon Radebe said that he was optimistic of the outcome of the conference. He expressed confidence that the Africa Health Strategy would help to address the health problems in Africa. He called for increased investment in health and emphasized the importance of human resources in strengthening health systems.

12. The Hon. Minister finally pointed out that it was his conviction that the conference would not be in vain but would present the people of Africa with an Africa Health Strategy which they have been yearning for.

(iii) Statement by Dr. Luis Sambo, Regional Director, WHO-AFRO

13. The Regional Director of the World Health Organisation Africa Region conveyed greetings from the Director General of the World Health Organisation, Dr Margaret Chan. He informed the delegates that Dr. Chan would very much have liked to attend the meeting in person but was unable to do so due to prior commitments. He then conveyed her sincere apologies. He informed the meeting that Dr. Chan is committed to putting Africa and women at the centre of the work of WHO. In this regard Dr. Sambo said that WHO would focus on the areas of health and development, health and security, health systems, health information and improving performance.

14. He added that health and poverty are related and that inequalities in health care must be addressed through policies and equitable health systems. With respect to HIV/AIDS, TB and Malaria, Dr. Sambo said that these diseases are still pervasive in Africa and pointed out that a lot had to be done in these areas if MDGs are to be achieved. He said that multi-drug resistant TB is a serious concern in Africa.

15. While acknowledging that Infant Mortality Rate (IMR) is going down due to public health interventions, Dr Sambo said that he was still concerned that Maternal Mortality Rate (MMR) was still high although there is a roadmap for the reduction of maternal mortality.

16. He then made reference to epidemics like cholera, rift valley fever in East Africa, cerebral spinal meningitis in West Africa for which a vaccine is being tested, and chronic diseases such as cardiopathy and diabetes which he said must be addressed within the health system although he contended that the health systems are already overburdened. He also reported that Africa has managed to lower measles morbidity and mortality.

17. According to Dr. Sambo, making National Health Systems capable is an absolute necessity and welcomed the theme of this Conference. He informed the delegates that WHO is committed to revitalising Primary Health Care according to the principles adopted at Alma Ata in 1978. He called for greater priority to health research by countries. He reported on commitments by UN agencies to improve co-ordination in their support for countries.

18. Dr Sambo announced that there will be a Health Systems and Primary Health Care (PHC) Conference in 2008 and Global Conference on Health in Mali also in 2008 and solicited the support of the African Union. He also announced that WHO now has a Deputy Director General from Ghana, Dr. Asamoa Ba.

(iv) Keynote Address by H.E. the Chairperson of the African Union Commission, Alpha Omar Konaré

19. Prof. Konaré greeted Hon. Jeff Radebe as Acting Ministers of Health of South Africa and wished him success. While thanking the government of South Africa for hosting the meeting, he wished Hon. Dr Manto Tshabala Msimang a quick recovery. He acknowledged the presence of the WHO-AFRO Regional Director at the meeting and expressed the appreciation of the AU for the commitment of Dr. Margaret Chan, the WHO Director-General to put Africa and women high on the agenda of WHO.

20. He recalled that health was a major preoccupation right from the inception of the Organization of African Unity in 1963 and also at the founding of the AU and its NEPAD Programme. Health is, indeed, a basic human right and therefore access to an integrated and affordable health system should be ensured throughout. This is in line with the theme of this Conference and is fundamental to Africa in view of the overwhelming disease burden on the Continent.

21. Prof. Konaré stated that although the millennium project refers to 50% access to health care, Africa is striving for universal access. The Millennium Development Goals will not be attained if things continue as they have been during the first five years of this century. He emphasized the call of the Heads of State for the Pharmaceutical Action Plan and local production that is to be discussed at this Conference, and a monitoring plan to assess access to drugs. He called for the effective implementation of the Abuja Summit Decision of 2005 [Assembly/AU/Dec.55 (IV)] on the major causes of the disease burden and stressed that access to drugs was in line with the spirit of the Bamako Initiative.

22. Prof. Konaré also referred to the Abuja Special Summit in May 2006 which ushered in the Abuja Call that urges for the acceleration of the Implementation of the Abuja Declarations of 2000 and 2001. The Implementation Plan for the Abuja Call would also be considered by this Conference. He cautioned that even with cheaper Anti-retroviral (ART), the fight against AIDS must continue. He also mentioned that HIV/AIDS should not overshadow other important diseases like malaria and Tuberculosis. In this regard, he stated that the AU would re-launch the malaria campaign in Africa. He called on partners to support an agenda defined by African governments rather than imposing their own and cautioned against dumping drugs that are unwanted elsewhere.

23. Prof. Konaré recalled the slogan *Health for All by the year 2000* which was never attained. On African Traditional Medicine, he reminded the Ministers that they had requested for a Mid-Term Review (MTR) of the Decade of African Traditional Medicine (ATM). He also referred to the Declaration of 2005 as the Year of Violence Prevention in Africa and informed the Ministers that a Draft Plan of Action on Violence Prevention

would be presented for consideration. He emphasized that all of these initiatives must be achieved within an overall Health Strategy for Africa, based on good governance and an effective human resources policy. He commended the Health Ministers for their initiative in creating an African common policy and called on UN agencies and partners to support it. He also expressed concern about the adverse effect of illicit drugs, tobacco and some newly introduced foods on peoples' health.

24. Finally, Prof. Konaré requested the Health Ministers to assist actively in fighting drugs in sports, stressing the importance of ensuring a clean 2010 World Cup which South Africa will be hosting on behalf of the Continent.

25. The Chairperson of the AU Commission concluded his intervention by appealing for the acceleration of the processes that would lead to a United States of Africa.

B. LAUNCH OF THE MALARIA ELIMINATION CAMPAIGN

26. The Commissioner for Social Affairs, Advocate Bience Gawanas, in her capacity as Director of Programmes of the Launching Ceremony, explained that it had been decided to launch this campaign in line with the various commitments made by the Heads of State and Government at the continental level, including the 2000 and 2006 Abuja Declarations. She added that it was an advocacy campaign mounted by the AU in order to move from control to elimination and indeed to the complete eradication of malaria. She then invited the distinguished personalities to address the gathering.

27. The UNICEF Regional Spokesperson for the fight against malaria in Africa, Ms Yvonne Chaka Chaka took up the slogans of the campaign that malaria can be prevented, diagnosed and cured and that no more should anyone die of Malaria in Africa. She then entertained the gathering and delivered an advocacy message through a song about malaria and children.

28. The Representative for AMBP (Africa Media Broadcasting Partnership against HIV/AIDS), Mr Solly Mokoetle, then explained that his Organization consisted of 35 press agencies in 25 countries dealing with HIV/AIDS issues while planning to address tuberculosis and malaria in the near future. He made a special appeal to the Ministers to use AMBP to transmit their messages. He stressed that his group would like to be involved as an active partner in all phases of development of continental advocacy campaigns. He concluded that the very fact that he had been invited to address the meeting proved that the importance of the media was widely recognized.

29. After a brief musical interlude, the Regional Director of the WHO, Dr Luis Sambo, also congratulated the African Union Commission on the launch of this campaign. He emphasized that the main victims of malaria were children and pregnant women and that the strategies and tools to overcome this scourge were known. He congratulated the previous speakers on the role that they had played and continued to play in the prevention of various diseases in Africa. He concluded that the WHO was willing to provide the AU and other partners with all the assistance required in the fight against malaria.

30. The Acting Minister of Health of South Africa, Hon. Jeffrey Radebe, expressed his satisfaction with the launch of this continental campaign and referred to his country's experience. He mentioned the impact of his country's interventions which had led to the marked drop in the malaria mortality rate. He stressed that this approach, consisting of spraying DDT and cooperating closely with the neighbouring countries, was first decried, but that the WHO was now backing the operation. In conclusion, he offered his country's assistance to the AU Commission with the objective of achieving similar results in other regions of the continent. He further announced his country's commitment to pursue its efforts to eliminate malaria in the southern African region.

31. The Chairperson of the African Union Commission, Professor Alpha Oumar Konaré, had the honour of officially launching the Malaria Elimination Campaign. In his address, he stressed that this disease was preventable and that ways and means of overcoming it once and for all were known to us. He identified access to insecticide-treated mosquito nets, DDT and other medicines as the real challenge to be met. He underscored the importance of informing, educating and mobilizing the public. He referred to the 25th of April, Malaria Control Day, as a great opportunity to give concrete expression to our determination.

32. After recalling the theme *"Leadership and Partnerships for Concrete Results"*, especially the slogan *"Rid Africa of Malaria NOW!",* he reminded the meeting that this would only be possible through the leadership of the African Heads of State and Government as well as the mobilization of all stakeholders, including artists, sportsmen and -women, and the media. He added that he had no doubt about support from such partners as the WHO, UNICEF and other development partners for this great mobilization campaign. In conclusion, he assured the meeting of his conviction that by 2010 malaria would be overcome thanks to the determination of all concerned to win this battle.

33. Prof. Konaré then proceeded to hand out mosquito nets to the members of the outgoing Bureau of the Conference of African Ministers of Health representing the five regions of Africa, to Ghana as the Current Chair of the African Union and to South Africa as the Host Country. The Chairperson recommended that the recipients of the nets ensure a wide distribution of these tools in their respective regions.

34. The ceremony ended with the signing of a Malaria Scroll by the Chairperson of the AU Commission, and with another musical performance by Ms Yvonne Chaka Chaka and other Artists.

IV. PROCEDURAL MATTERS

a) Election of the Bureau;

35. The Representative of the Office of the Legal Counsel informed the Meeting on the Rules of Procedure of the AU Conference of Ministers of Health as well as the pertinent decision of the AU Executive Council (EX.CL/Dec. 298 (X) adopted in January

2007. After due consultations and on the basis of the established Rules, the Conference elected the following Bureau Members:

- Chairperson: Southern Africa (South Africa)
- 1st Vice Chairperson: Central Africa (Gabon)
- 2nd Vice Chairperson: Western Africa (Togo)
- 3rd Vice Chairperson: Northern Africa (Egypt)
- Rapporteur: Eastern Africa (Mauritius)

b) Adoption of the Agenda;

36. The Conference discussed the Provisional Agenda and adopted it. However, it was agreed that under the Item "Any Other Business" the following issues would be discussed:

(i) The principle of rotation of the post of WHO Director General among the world regions,
(ii) A brief on health and health workers in Palestine.

c) Organization of Work

37. The Programme of work was adopted as proposed.

V. SUMMARY OF PROCEEDINGS

Item 3: Report of the Outgoing Chairperson – Doc. CAMH/MIN/2 (III)

38. In her report, the outgoing Chairperson of CAMH3, Prof. Sheila Tlou, recalled the 2005 Session of Health Ministers that was hosted by Botswana. She acknowledged the modest achievements that have been registered in the area of health. She thanked the Acting Minister of Health of South Africa for hosting the Conference and wished him success in his tenure of office as new Chairperson of the AU Conference of Ministers of Health. She further wished the substantive Health Minister of South Africa quick recovery.

39. She recalled the Gaborone Declaration, the Africa Regional Nutrition Strategy (ARNS) and the Sexual and Reproductive Health Rights (SRHR) Policy Framework that were adopted in Gaborone and subsequently endorsed by the AU Summit. She also stated that in line with the recommendation of the Gaborone session, the Bureau organized the Special Session on SRHR in Maputo, Mozambique which ushered in the Maputo Plan of Action (September 2006) on SRHR which was also endorsed by the AU Summit in January 2007.

40. She also informed her colleagues that she had hosted the Human Resource for Health (HRH) Inter-Ministerial Consultation and that she would be presenting the outcome to her colleagues later. As part of the preparation for this Session, the Minister indicated that the Bureau spearheaded the preparation of the Draft Africa Health

Strategy which addressed, among others, issues of community participation, AIDS, TB and Malaria (ATM), partnerships and HRH.

41. She concluded by thanking all the Ministers, Members of the Bureau, the Chairperson of the AU Commission, the Commissioner for Social Affairs and all staff for their support.

Item 4: Report of the AU Commission Chairperson – Doc. CAMH/MIN/3 (III)

42. In presenting the Report, Adv. Bience Gawanas, AU Commissioner for Social Affairs highlighted the major health challenges faced by Africa, which included weak health systems, poor health infrastructure, and inadequate human resources for health. She outlined the various activities that had been undertaken by the AU Commission over the past two years as per the decisions of the Second Conference of AU Ministers of the Health (CAMH2) including elaboration and adoption of key policy instruments.

43. In the ensuing discussions, delegates commended the Commission for the work done, and raised some questions especially about when the draft Early Warning and Emergency Preparedness on Avian Human Influenza would be adopted. They also raised the issue of sharing experiences with some eastern countries, like China, on traditional medicines.

44. Regarding the 2006 Report of the AU/Africa AIDS Vaccine Partnership (AAVP) Meeting, the Commissioner informed the Meeting that Cameroon had offered to follow up on the issue and was expected to report back. Concerning the Action Plan on Avian Influenza, she noted the collaboration with the AU Inter-African Bureau for Animal Resources (IBAR)and WHO to facilitate the adoption of the Plan of Action. She added that the AU Commission would make the necessary follow up to ensure timely adoption of the Plan. On the issue of experience sharing on Traditional Medicine, the Commissioner noted that this would be discussed further when the agenda on the subject is considered in the course of the Conference.

45. At the end of the discussion, the Report was adopted.

Item 5: Overview of the theme: Strengthening of Health Systems for Equity and Development – Doc. CAMH/MIN/4 (III)

46. In presenting this item, the representative of the AU Commission while referring to the theme of the present Session, "*Strengthening of Health Systems for Equity and Development*", highlighted the key issues raised in the theme namely health systems strengthening, equity and development. Specifically, he underlined that the health system should be looked at in its broader sense including all actors, resources and actions whose primary intent is to meet the basic health care needs of the people. With respect to equity, the presenter observed that intra-country and cross country discrepancies in health indicators do not speak well of equity. He suggested that when addressing issues of equity in health systems development and strengthening, the

notion of fairness and equal treatment for equal needs should be guiding principle. The presenter concluded by acknowledging that health and development are inter-linked. He therefore stressed that improving the general well-being of a population requires addressing health issues and as such health should be at the centre of poverty reduction strategies.

47. The presentation on the Overview was then noted by the Conference.

Item 6: Presentation of the Draft Africa Health Strategy – Doc. CAMH/MIN/5 (III)

48. The Draft Africa Health Strategy was presented by a representative of the AU Commission who emphasized that disease burden continues to be a barrier to socio-economic development in Africa. He stated that the Africa Health Strategy provides an overarching framework for addressing health challenges in Africa. He indicated that the overall objective of the strategy is to strengthen health systems by, in particular, covering issues of governance, financing, community participation, social protection, human resources for health, health research and information and integration of African traditional medicine while taking into account its strengths and limitations. He finally provided the way forward envisaged in the Strategy, including the respective roles for the various stakeholders.

49. During the preliminary discussions, delegates welcomed the Draft Africa Health Strategy and shared some of their own country experiences which were also generally found to be in line with the Strategy. The delegates also suggested that proposed amendments be submitted to the AU Commission in writing for incorporation into the Strategy for further consideration by the Conference. Other concrete proposals included addressing the issue of gender, maternal and child health, collecting baseline data. Furthermore, there was need to clearly indicate in the Strategy that "Health creates Wealth". The delegates also suggested that the roles of AU and RECs be clarified as there seemed to be some duplication.

50. At the end of the discussion, the Commissioner for Social Affairs of the AU Commission thanked the Honourable Ministers for their comments which she said would be relevant when they discuss the Strategy section by section in the course of the meeting. She also indicated that the Strategy does not exclude ignore other existing strategies but agreed that the roles of the AU and RECs should be clearly delineated based on the principles of complementarity and subsidiarity. She further underlined the fact that RECs, as the pillars of the AU, needed to be greatly involved in this process.

Item 7: Consideration of the Status of African Traditional Medicine - Doc. CAMH/MIN/6 (III)

51. In his presentation, the Representative of the AU Commission gave background information to situate the paper entitled the Status of African Traditional Medicine and reviewing of progress made on the implementation of the Plan of Action on the African

Union Decade of Traditional Medicine (2001 – 2010), which constituted one of the working documents of the Conference.

52. He stated that the Conference of African Ministers of Health held in Gaborone, Botswana in October 2005 requested the AU Commission to conduct a mid-term review on the implementation of the Plan.

53. He pointed out that due to lack of accurate information at national level, the process of carrying out a mid-term review faced difficulties, hence the presentation concentrated on the achievements made by the five regions on the Plan of Action. In this respect, five priority areas were identified to gauge the progress.

54. The presenter talked of two options for the Ministers to consider: namely, the Member States to proceed with mid-term review on the status of traditional medicine and to encourage proactive implementation of the Plan of Action in view of limited time before the Decade expires (4 years) only.

55. During the discussions, Member States highlighted the importance of traditional medicine and the efforts expended in mainstreaming traditional medicine in their respective national health systems. Concern was expressed that there were still many challenges to be overcome, such as carrying out clinical trials, developing appropriate traditional medicine indicators and instituting regulatory frameworks to facilitate local production.

56. In conclusion, it was recommended that the mid-term review and the implementation of the Action Plan provisions should be undertaken at the same time, because the two options were not mutually exclusive.

INTER-MINISTERIAL CONSULTATION ON HUMAN RESOURCES FOR HEALTH

57. In introducing the session on Human Resources for Health Development, the Chairperson of the Session, Honourable Mrs. Missango Paulette, Minister of Health of Gabon, emphasised the central importance of Human Resources to strengthening health systems. She also emphasised the importance of remuneration and proposed that a political decision be made by Ministers for submission to the Heads of State and Government.

58. The Honourable Minister of Health of Botswana, Professor Sheila Tlou, reported on the High Level Inter-Ministerial Technical Consultation on Strengthening Political Support for Health Workers Development in Africa, held in Gaborone, Botswana from March 2-4, 2007. Senior representatives from Ministries of Education, Finance, Public Service and Health participated. She presented a series of recommendations for inter-ministerial action arising from the Consultation aimed at achieving improved performance and effective deployment, tackling migration, scaling up production, financing an expanded and sustainable health workforce, better intelligence for determining health workforce status and monitoring progress and enhancing governance, stewardship and partnership in support of HRH action.

59. Prof. Francis Omaswa, the Executive Director of the Global Health Workforce Alliance (GHWA) pointed out that the global health workforce crisis affects both developed and developing countries. It is estimated that the world is short of 4 million health workers, one million of whom are needed in Africa alone. In Africa, the crisis has worsened over the past several decades largely due to poor economic performance and under-investment, compounded by shortages of health professionals in developed countries. GHWA is a partnership that was launched in May 2006 as a focal point for a global response to the crisis.

60. Prof. Omaswa then informed Ministers about the strategy of GHWA and outlined some of its activities. He concluded by pointing out that GHWA anticipates increased visibility and awareness of the HRH crisis and solutions in the future, a number of countries implementing strategic plans, more resources flowing into the health sector with better working conditions, increased training of health workers and a more conducive national and global environment, including better managed migration.

61. Professor Eric Buch, Chairperson of the Steering Committee of the African Platform on Human Resources for Health, presented the Action Agenda of the Platform and made reference to the consultations in Abuja and Brazzaville in 2005 that advocated for the development of an African Platform on Human Resources for Health and a Health Workforce Observatory. Prof Buch informed delegates that a Secretariat is being established in Brazzaville, hosted by the WHO Regional Office for Africa (Afro) and that a Steering Committee, the majority of which are country representatives, has been established. The intention is to formally launch the African Platform once the consultation process is complete and a work plan established. Three regional consultative meetings have been held.

62. The African Health Workforce Observatory has been established, based at WHO Afro and a Health workforce database initiated. Support has been provided for national HRH observatories and country profiles. Other countries were invited to embark on this process. The African Platform is envisaged as a network that will provide for consensus building and catalytic and co-ordinated action, but not a controlling mechanism, nor a new conduit for funding. The Platform supports HRH funding going directly to countries. Overall, the Platform seeks to mobilise energy and action on the HRH crisis, fostering an enabling environment for technical work, sharing of experiences and best practices, collaboration and harmonisation and advocacy for HRH.

63. In the discussion that followed, the delegates generally appreciated and supported the issues raised and emphasized the need for producing mid-level health workers, health officers, nursing auxiliaries and community and village health workers, with appropriate functions and referral systems to professionals.

64. Delegates also requested the AU to push for the developed countries to train sufficient professionals and provide compensation to developing countries while adhering to a code of conduct. Delegates further recommended that there should also be protocols for recruitment within Africa, which should adhered to and a Diaspora database should be built-up.

65. The Ministers suggested that increased remuneration and other conditions of service, such as transport, housing, security, gloves, telemedicine, scholarships, postgraduate training, supplementary salaries and improvements in the health system could motivate health workers and their retention. Establishing a Health Service Commission was also considered as an option for a better selection of health personnel and for ensuring flexibility of salaries, instead of the usual Public Service Commission.

66. The Ministers observed that conflict and post-conflict countries need support as they face the added challenges of destroyed infrastructure, demotivated health workers and underserved rural areas.

67. The Commissioner for Social Affairs thanked the Honourable Minister of Health of Botswana for convening the Inter-ministerial Consultation and supported the role envisaged for the African Union. She proposed that the AU Commission and the WHO work together on the Work Plan for the proposals submitted. The Chairperson of the Session noted that there was wide support for the proposals from the Gaborone Meeting as well as the AU proposal.

Item 8: Review of the Draft African Pharmaceutical Manufacturing Plan for Africa – Doc. CAMH/MIN/7 (III)

68. This item was introduced by a representative of the AU Commission, who explained that the Draft Pharmaceutical Plan was developed in line with the AU Assembly Decision (Assembly/Dec.55 (IV), adopted in Abuja in January 2005 and the Gaborone Declaration. He added that countries in Africa still depend on imported affordable generic drugs. The fact that countries that were major suppliers of these generics were supposed to comply with patent laws by 2005 was seen as a major threat to access to affordable generics in Africa. He outlined some of the advantages of local production, which included saving foreign exchange, job creation, technology transfer, value addition for raw materials and self-sufficiency in drug supply.

69. With respect to production capacity, the presenter observed that with the WHO AFRO Region, 37 countries have local production although only one has limited primary production which means that local production in Africa relies on imported active ingredients. He indicated that national capacity for production has increased in Egypt and Tunisia to between 60% and 95% of their national requirements for essential medicines.

70. The presenter then highlighted that Africa needs to decide what to produce, how to produce, what regulatory systems are required and how to assess the required human and financial resources. He concluded by saying that local production was feasible in Africa although capacity is currently limited. He then recommended that a Technical Committee should be mandated to study detailed implications and come out with a concrete plan. He stressed the importance of regional representation in the composition of such a Committee and recommended the following membership:

North Africa (Egypt and Libya)

West Africa (Nigeria and Senegal)

Central Africa (Cameroon and Gabon)

East Africa (Kenya and Ethiopia)

Southern Africa (South Africa and Angola)

71. The Committee would submit a Report and Phase 2 Plan to the Ministers for consideration as soon as possible.

72. During the discussion that followed, the delegates generally welcomed the Pharmaceutical Manufacturing Plan for Africa and commended the AU Commission for coming up with a plan which was realistic. The Ministers approved the proposed composition of the Technical Committee and agreed that Ghana and Burundi should also be part of the Technical Committee. The Ministers however cautioned that the November 2007 deadline might be unrealistic. After these observations the Honourable Ministers adopted the Pharmaceutical Manufacturing Plan for Africa.

Item 9: Draft Plan of Action on Violence Prevention in Africa - Doc. CAMH/MIN/8 (III)

73. The Draft Plan was presented by the Representative of the AU Commission who noted that violence is one of the serious public health problems in Africa. It is caused by a number of factors – biological, social, psychological, cultural, economic, political, and others. However, the presenter emphasized that violence can be prevented but a concerted effort is needed to address the problem, which should begin with the acknowledgement of its existence. He further pointed out that the Plan of Action is meant to guide the elaboration and implementation of national plans and strategies to prevent violence. The Presenter concluded by stating the need for determining roles by different actors and stakeholders at national, sub-regional and continental levels.

74. In the ensuing discussions, a number of delegates took the floor and welcomed the AU Commission's initiative in developing the Plan of Action. They also confirmed that violence remains a formidable public health and development challenge. The delegates underlined that poverty, illiteracy, social and economic inequality between men, women and children, alcoholism, and a host of other factors contribute to violent behaviours. They further agreed that women and children, particularly those living under conflict situations, constitute the majority of the victims of violence although it is evident that there are many cases of violence against men too. The delegates further recognized the vicious cycle in which violence leads to negative health and ill-health, such as mental illness, often results in violent behaviour; hence the need to address both.

75. Finally, the delegates recommended the following measures to prevent violence and promote health for sustainable development to be undertaken by Member States and Partners :

- Address the root causes of violence including poverty, illiteracy and gender inequality;

- Identify lead agencies and ensure inter-sectoral cooperation among line Ministries, civil society organizations/NGOs and other stakeholders;

- Encourage community participation in the prevention of violence, as well as care and support to the victims;

- Develop specific interventions with timeframes for implementation and monitoring of progress;

- Give special attention to children since violence against children is a worldwide phenomenon; link up the plan on violence against children and the present plan;

- Educate women, children and the population about their rights; all Member States need to legislate against all forms of violence because no one has the right to inflict violence on another person;

- Establish a National Counseling Unit (for the treatment of both the victim and the offender); for the latter, Counseling could be part of the corrective measures;

- The notion of violence should be seen in a broader context and should not be limited to the concerns of women and children only and should not also be attributed to poverty alone;

- Each member of society has a duty and responsibility to prevent violence, educate the children and the youth to respect one another, remove stigma and discrimination against victims and survivors of violence, to educate peace, to improve health program and care related to violence and to ensure emergency medical services; discourage children from watching video and TV programs that have violent scenes;

- Develop an Early Warning and Emergency Preparedness plan to prevent violence before it takes place and address it as soon as it occurs;

- Address the issue of harmful traditional practices, including female genital mutilation and early marriage which often gives rise to Obstetric Fistulae, such as vesico-vaginal fistula;

- Address the issue of rape and related gender-based violence against women and children under conflict circumstances; victims of rape would require special medical services all of which should be provided under one roof;

- Recognize and address the inter-linkage between economic dependency and violence.

76. With the above recommendations, the Conference adopted the Plan of Action.

Item 10: Consideration of the Draft Implementation Plan for the Outcomes of the May 2006 Abuja Special Summit on HIV/AIDS, TB and Malaria – Doc. CAMH/MIN/9 (III)

77. The Representative of the African Union Commission briefly presented the broad outlines of the document. She recalled the conclusions of the Special Summit on HIV/AIDS, Tuberculosis and Malaria and explained that the implementation plan provided an operational framework that spelt out the role of each stakeholder in giving concrete expression to the commitments made.

78. She then highlighted the various obstacles to universal access to HIV/AIDS, tuberculosis and malaria services, citing among other things, the increase in, and triple burden of, the diseases, the difficulties in ensuring predictable and sustainable financing, as well as weak planning, evaluation and monitoring systems at national level. She also stated that the decision to prepare the implementation framework was taken at the Abuja Summit in 2006 by Heads of State and Government who collectively committed themselves and identified the programme areas to be addressed.

79. The African Union Representative explained that the document focused on identification of activities to be implemented by each stakeholder, benchmarks and monitoring and evaluation timelines.

80. She then went on to make a detailed presentation of the roles and activities as assigned in the document to the Commission and other organs of the African Union, Member States, and programmes devolving on the RECs and the International Community. She also referred to the emphasis made in the document regarding issues of resource mobilization, evaluation and monitoring.

81. She concluded by explaining that the plan was relatively long because it focused on the implementation of four documents dealing with three diseases.

82. In the ensuing discussion, the delegates commended the AU Commission for the document while underscoring the need to make the necessary corrections and improvement on the language. Several countries shared their experiences in the development and implementation of policies relating to HIV/AIDS, Tuberculosis and Malaria control activities, particularly the conclusions of the Abuja Special Summit. The discussion also focused on the following issues:

- The role of Development Partners and the need for national and continental ownership of the plan, as well as more in-depth multi-sectoral consultations at national, regional and continental levels, prior to the formal adoption of the document;

- That HIV/AIDS, Tuberculosis and Malaria are common causes of disease burden which should be taken on board in the African Health Strategy; The central and primordial nature of prevention was underscored, as well as the need to include Tuberculosis in the HIV/AIDS control strategies;

- Financing of the plan and use of flexible sources such as GAVI, taxation and creation of Specific National Funds;

- The need to place emphasis on vaccine and access to antiretroviral medicine, particularly for children, as well as meeting the legal protection needs of persons affected and those not yet affected by HIV/AIDS;

- The need for the AU to prepare clear indicators for monitoring and evaluating activities as contained in the plan and for the AU and the WHO to mount a research advocacy campaign in order to discover effective medicines to combat resistant micro-organisms;;

- As regards to malaria control, Members States were urged to use DDT, the WHO to advocate for the simplification of processes; a proposal was made to remove DDT from the Stockholm Convention so that it can be used by public health authorities. The difficulties encountered at national level in the implementation of intermittent treatment among pregnant women due to resistance to the medicines were noted;

- The need for all Member States and other stakeholders to support the capacity building efforts;

- The need to coordinate and harmonize the implementation of strategies in accordance with the “Three-Ones” Principles. In this regard, the AU was commended for organizing an inter-agency meeting between AU, RECs, CSOs and international partners;

- How to address the difficulties of equitable access by all to anti-malaria medicines and commodities through predictable international subventions as proposed by the partnership to “Roll Back Malaria”. This will lead to the promotion of access to free or highly subsidized treatment and commodities.

83. Following the various interventions, the AU Commissioner for Social Affairs took the floor to provide further clarifications to the concerns raised by delegates. She explained that the title of the document needed to be reviewed since the implementation of the continental commitments was the primary responsibility of Member States. Therefore, the document presented was only a Monitoring and Reporting Mechanism

designed to give an account of the implementation of the commitments in 2008 and 2010. Concluding, the Commissioner said that the document was aimed at harmonizing the various implementation frameworks and enabling Member States and other stakeholders to have easy access to the data required for the preparation of the report.

84. The document was subsequently adopted as amended.

Item 11: Consideration of the Draft African Health Strategy – Doc. CAMH/MIN/5 (III)

85. The AU Commissioner for Social Affairs recalled that the Draft Africa Health Strategy had already been introduced to the Ministers at the beginning of the Conference. What was required was that the Ministers make specific proposals and general comments and observations on the various sections of the Strategy.

86. The Ministers then considered the Draft Africa Health Strategy section by section and made a number of proposals to improve the document. These proposals were incorporated into the document. The Libyan delegation registered a reservation on paragraph 96 noting that there was no consensus on the issue of abortion. Delegates also requested the drafters to add a list of acronymns and number the bibliography. It was also recommended that paragraph 94 should acknowledge the role of older women in proving care. The Ministers also cautioned against the dumping of harmful materials in Africa. The Ministers finally adopted the Africa Health Strategy as the main outcome of the 3rd Session of the AU Conference of Ministers of Health.

X. ANY OTHER BUSINESS

87. The Hon. Minister of Health of Liberia informed his colleagues that WHO-AFRO and EMRO have never produced a WHO Director-General. He therefore requested the AU to make a proposal to the WHA that the position of WHO DG should be occupied on a rotational basis. The Ministers debated the issue and agreed that AU should take the issue of WHO DG rotation as its Common Position.

88. The Hon. Minister from Egypt informed his colleagues that there was need to get a report on the health situation in Palestine as he was of the view that people of Palestine are not getting the required health services. The Ministers took note of the issue raised by the Hon. Minister of Health of Egypt and subsequently requested Commissioner Gawanas to get the AU to take up this concern.

89. The Hon. Minister of Health from the Republic of Tchad requested the AU to develop an emergency plan for refugees. The Ministers took note of this request.

90. At the request of the Republic of Ghana, the Ambassador of Japan was invited to make a presentation on the Hideyo Noguchi Prize for Africa which will be presented to an African Researcher or Organization during the 2008 Tokyo International Conference on African Development (TICAD Conference). The Prize is worth 100 million Yen. The

selection will be done by WHO-AFRO and the Japan Society for the Promotion of Science (JSPS).

VII. DATE, VENUE AND THEME OF THE FOURTH ORDINARY SESSION OF THE AU CONFERENCE OF MINISTERS OF HEALTH

91. The Minister of Health of Zimbabwe offered to host the next Session in his country in 2009. The Ministers welcomed and thanked Zimbabwe for the offer to host the Fourth Ordinary Session of the AU Conference of Ministers of Health. They agreed that any proposals on the theme should be sent to the AU Commission, for subsequent discussion with the Bureau and that April could be maintained as the date of the next Session provided that it is not held over public holidays.

VIII. ADOPTION OF THE REPORT AND RECOMMENDATIONS OF THE 3RD SESSION OF THE AU CONFERENCE OF MINISTERS OF HEALTH

92. The AU Commission presented the Report of the Meeting as well as the outcome documents of the Conference namely: (i) the Africa Health Strategy and (ii) the Johannesburg Declaration on behalf of the Minister of Health of Mauritius.

93. On the Johannesburg Declaration, Ministers suggested that the preamble should recall the Abuja Declarations on HIV/AIDS, TB and Malaria and that i the AU should be requested to set up a Regional Plan for Human Resources for Health Development. The Ministers then adopted the Declaration.

94. During the debate the Ministers welcomed the report and suggested that the Plan of Action on Violence Prevention in Africa should also address the issue of post exposure prophylaxis for rape victims.

IX. CLOSING SESSION

95. The Commissioner for Social Affairs thanked all the Ministers of Health for their dedication and support. She also thanked Hon. Jeff Radebe the Acting Minister of Health of South Africa and, the Chairperson of AU Conference of Ministers of Health and host, for all the hospitality accorded to the delegations. She concluded her remarks by acknowledging that working with the Ministers of Health was a pleasant experience for her, and wished them safe journey back home.

96. Hon. Radebe, Ministers of Health of South Africa, host and Chair of the AU Conference of Ministers of Health informed the ministers that it was an honour for him and the Government of South Africa to host the Third Session of AU Conference of Ministers of Health. He also said that he was very happy that he had been given the privilege to Chair the AU Conference of Ministers of Health. He invited all Ministers and heads of delegations as well as all participants to stay on to sample the South African hospitality.

97. He concluded his closing remarks by thanking the Commissioner for Social Affairs and her staff and expressing his commitment to work with the AU Commission to ensure that the Africa Health Strategy is implemented during his tenure of office.

98. After the official closing, the Hon. Ministers of Health of the Republic of Kenya gave a Vote of Thanks. He thanked the host for all the hospitality and facilities that were put at the disposal of the delegates. He also thanked the Vice President of South Africa for sparing time from her busy schedule to come and address the delegates during the official Gala Dinner and President Konare for having travelled all the way from Addis Ababa to open the Conference.

99. The 3rd Session of the AU Conference of Ministers of Health then adjourned.

EX.CL/354 (XI)
Annex I

JOHANNESBURG DECLARATION OF THE 3RD ORDINARY SESSION OF THE AFRICAN UNION CONFERENCE OF MINISTERS OF HEALTH,

JOHANNESBURG DECLARATION OF THE 3RD ORDINARY SESSION OF THE AFRICAN UNION CONFERENCE OF MINISTERS OF HEALTH, JOHANNESBURG, SOUTH AFRICA

We, Ministers of Health of the African Union, meeting at the 3rd Ordinary Session of our Conference in Johannesburg, South Africa, 9 -13 April 2007 under the theme ***"Strengthening of Health Systems for Equity and Development"***;

DEEPLY CONCERNED by the multitude of public health challenges faced by our continent owing to, among others: weak health systems including inadequate social protection, rising levels of communicable and non-communicable diseases, shortage of human resources for health aggravated by brain-drain, widespread poverty and the impact of armed conflicts and violence;

ACKNOWLEDGING existing national, regional and continental policies, programmes and partnerships as key for the promotion of health;

COGNIZANT that Africa has to make great strides to meet the Millennium Development Goals by 2015;

ALSO COGNIZANT that the health sector is not merely a consumer of scarce resources, but a great source of national wealth; and that investment in people's health is vital to sustainable socio-economic development;

AWARE of the cross-cutting nature of health and the importance of inter-sectoral collaboration in the promotion of universal and equitable access to health services and reduction of the disease burden;

FURTHER AWARE of the need to scale up the integration of traditional medicine into national health systems, including broadening the skill base of traditional health practitioners;

TAKING NOTE of the recommendations of the Inter-Ministerial Consultation on Health Work Force Development in Africa, Gaborone, 2-4 March 2007;

RECALLING the Abuja Declarations on HIV/AIDS, Malaria, TB and Other Related Infectious Diseases;

WELCOMING the launch of the Campaign to Accelerate HIV Prevention (11 April 2006), and of the Malaria Elimination Campaign (10 April 2007).

WE HEREBY:

1. **COMMIT** ourselves, in collaboration with our partners, to implementing the decisions and recommendations of the 3rd Session of our Conference, particularly those aimed at strengthening our health systems; and to providing periodic reports on the status of implementation to the AU Commission;

2. **ALSO COMMIT** ourselves to developing social protection systems, particularly for the poor and vulnerable groups in society, aimed at promoting greater access to health care services and protecting families from debt traps due to health emergencies;

3. **FURTHER COMMIT** ourselves to implementing the Continental Africa Malaria Elimination Campaign and to launching similar campaigns at national level on 25th April 2007, on the occasion of Africa Malaria Control Day;

4. **FURTHER COMMIT** ourselves to implementing programmes aimed at combating childhood illnesses, promoting safe motherhood and women's health in general;

5. **URGE** Member States to facilitate inter-ministerial collaboration for an integrated, well-coordinated, harmonized and comprehensive response to the health challenges facing Africa. In this regard, **WE PLEDGE** to implement the Africa Health Strategy in collaboration with the AU, RECs, Regional Health Organizations, UN Agencies, Private Sector, Development Partners and other International and Civil Society Organizations;

6. **ENDORSE** the proposal for urgently establishing a Technical Committee to facilitate the implementation and monitoring of the Pharmaceutical Manufacturing Plan for Africa;

7. **RESOLVE** to develop mechanisms to effectively implement the Plan of Action on Prevention of Violence in Africa, including in situations of civil strife and armed conflicts;

8. **ALSO RESOLVE** to make the necessary efforts to utilize the Monitoring, Follow Up and Reporting Framework on the Commitments of the 2006 Abuja Special Summit on HIV/AIDS, Tuberculosis and Malaria, in line with scaling up towards universal access to health services;

9. **UNDERTAKE** to implement a comprehensive program of action to address all the elements of the health workforce crisis in Africa, including achieving improved performance and effective deployment, tackling migration, scaling up production, securing sustainable financing, enhancing governance, stewardship and partnership, among others;

10. **CALL UPON** UN Agencies, Private Sector, Development Partners and other International and Civil Society Organizations to continue to collaborate with the Continent and provide support to its development agenda, in a well-coordinated and harmonized approach;

11. **REQUEST** the AU Commission and RECs, in collaboration with all stakeholders, to coordinate the mid-term review on the implementation of the Plan of Action for the Decade of African Traditional Medicine (2001-2010);

12. **FINALLY REQUEST** the AU Commission and RECs to promote and coordinate international partnerships, as well as follow up and report on the implementation of the outcomes of this meeting, in particular the Africa Health Strategy, at our next Ordinary Session.

Done in Johannesburg, South Africa, on 13 April 2007

EX.CL/354 (XI)
Annex II

AFRICA HEALTH STRATEGY : 2007 – 20015

AFRICAN UNION | UNION AFRICAINE

الاتحاد الأفريقي | UNIÃO AFRICANA

Addis Ababa, ETHIOPIA P. O. Box 3243 Telephone 251115-517700 Fax: 251115-517844
Website: www.africa-union.org

THIRD SESSION OF THE AFRICAN UNION CONFERENCE OF MINISTERS OF HEALTH 9– 13 APRIL 2007 JOHANNESBURG, SOUTH AFRICA

CAMH/MIN/5(III)

Theme: **"*Strengthening of Health Systems for Equity and Development in Africa"***

AFRICA HEALTH STRATEGY: 2007 - 2015

AFRICA HEALTH STRATEGY: 2007–2015:
INDEX

LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ARVs	Anti-Retroviral
ATM	African Traditional Medicine
AU	African Union
CBOs	Community Based Organizations
FBOs	Faith Based Organizations
GAVI	Global AIDS Vaccine Initiative
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
ICT	Information, Communication and Technology
LLITNs	Long lasting insecticides impregnated bed nets
MDGs	Millennium Development Goals
M & E	Monitoring and Evaluation
NGOs	Non Governmental Organization
UN	United Nations
OECD	Organisation for Economic Co-operation and Development
PRS	Poverty Reduction Strategy
RECs	Regional Economic Communities
SAPs	Structural Adjustment Programmes
SWAPs	Sector Wide Approaches
TM	Traditional Medicine
UNFPA	United Nations Population Fund
WHO	World Health Organization

AFRICA HEALTH STRATEGY: 2007 - 2015

1. INTRODUCTION

1. Africa has made significant strides in certain areas of social and economic development but has the potential to achieve even more if it can overcome the large burden of disease which continues to be a barrier to faster development. This ever increasing disease burden, despite good plans and strategies, is cause for concern to the policy makers. This has prompted the African Union Ministers of Health to harmonize all the existing health strategies by drawing this Africa Health Strategy which Regional Economic Communities (RECs) and other regional entities and Member States can use to enrich their strategies, depending on their peculiar challenges. The Strategy neither competes with nor negates other health strategies but seeks to complement other specific and detailed strategies by adding value from the unique perspective of the African Union. It provides a strategic direction to Africa's efforts in creating better health for all.

2. The Strategy recognises that Member States and regions and indeed the continent have previously set health goals in addition to the Millennium Development Goals that they have committed to. It explores some challenges that militate against the continent decreasing the burden of disease and improving development and also draws on existing opportunities. It highlights strategic directions that can be helpful if approached in a multi-sectoral fashion, adequately resourced, implemented and monitored accordingly.

3. The African Union, member states and the RECs will use this Strategy as the inspirational framework within which they will fulfil their roles. The Strategy provides a focus for all health initiatives to converge around. Ministers of Health are calling on multilateral agencies, bilateral development partners and other partners in Africa's development to build their health contribution around this Strategy. Such a co-ordinated response is critical to ensure maximum benefit from the resources mobilised and to prevent fragmentation and duplication. This Strategy thus provides an overarching framework to enable coherence within and between countries, civil society and the international community.

4. The strategy proposes strengthening of health systems with the goal of reducing disease burden through improved resources, systems, policies and management. This will contribute to equity through a system that reaches the poor and those most in need of health care. Investment in health will impact on poverty reduction and overall economic development.

5. Health sector should be at the forefront of efforts to advance women's rights and equality as women not only bear the greatest disease burden but are also primary care givers.

2. Situation Analysis

2.1 Disease Burden

6. The evidence of the impact of good investments and effective interventions on burden of disease and on economic indicators is becoming stronger. Nonetheless, the reality remains that Africa's people face a huge burden of preventable and treatable health problems whose solutions are known, proportionately far beyond Africa's share of the world's population. The triple burden from communicable and non-communicable diseases and injury and trauma, including the social impact of these, has adversely affected development in Africa. Africa is still not on track to meet the health Millennium Declaration targets and the prevailing population trends could undermine progress made. The maternal mortality rate will need to drop from between 500 and 1500 to 228 per 100 000 and Under 5 mortality from 171 to 61 per 1000 to reach their respective Millennium Development Goals. Life expectancy on the continent, already low, has been reduced further to an average of 52 years by many factors including structural adjustment programmes (SAPs) and the AIDS epidemic. Women and children carry a disproportionate share of Africa's heavy disease burden, with 4.8 million children dying annually, mostly from preventable diseases. Women carry the major responsibility for care and poor education may add to their oppressed position.

7. AIDS, tuberculosis and malaria pose the greatest challenges. However, they should not overshadow the severe burden of other communicable diseases including pneumonia, diarrhoea and measles in children and other diseases that severely debilitate communities affected by them. These include Onchocerciasis, Trypanosomiasis, Schistosomiasis, Dracunculiasis (Guinea Worm) and Filariasis. Cholera, Meningitis, Ebola and Marburg outbreaks continue, while intermittent cases of Human Avian Influenza remind the continent of the pandemic threat that mutation poses.

8. The alarming rate of growth of the burden of both death and disability from non-communicable diseases in Africa is ever more recognised, with chronic diseases becoming ever more prevalent, linked to demographic, behavioral and social changes and urbanisation. Hypertension, stroke, diabetes, chronic respiratory disease and the consequences of tobacco use, alcohol abuse and illicit drugs, are growing as serious public health challenges. Injuries from violence, wars, traffic accidents and other mostly preventable causes result in widespread death and physical disability, while the impact of mental ill-health has previously been underestimated. Sickle Cell Disease is the most prominent genetic disorder, while the prevalence of specific cancers is extremely high in some parts of the continent.

9. Worsening protein energy and micronutrient malnutrition in many countries continues to contribute to elevated mortality, while dietary change and inactivity are factors driving the emergence of chronic diseases and obesity. Micronutrient deficiency including iron, zinc, iodine and vitamin A is widespread. About 60% of under-five mortality in some parts of Africa is attributable to malnutrition, which remains a major challenge to development and child survival in Africa.

2.2 Root causes

10. The economic growth in many Africa countries, decline in conflicts and important strides towards democracy and good governance are all contributing to health. Other wide ranging interventions are being implemented and important progress is being made in addressing the root causes of the disease burden in Africa. However, although the balance of reasons varies from country to country, the high disease burden continues because:

a. Health systems are too weak and services too under-resourced to support targeted reduction in disease burden and achieve universal access
b. Health interventions often do not match the scale of the problem
c. People are not sufficiently empowered to improve their health nor adequately involved, while cultural factors play a role in health seeking behaviour.
d. The benefits of health services do not equitably reach those with the greatest disease burden
e. There is widespread poverty, marginalisation and displacement on the continent
f. Insufficient action on the intersectoral factors impacting on health.
g. Environmental factors and degradation are not sufficiently addressed

11. There have been commendable efforts towards addressing the inter-sectoral challenges affecting health, particularly since the advent of the African Union and its New Partnership for Africa's Development. Nonetheless, shortfalls in agriculture, low literacy and lack of safe water, adequate sanitation, electrification and infrastructure, and ongoing conflicts all drive up the disease burden. A vicious cycle remains in which poverty and its determinants drive up the burden of disease, while ill-health contributes to poverty. Investment in health could therefore contribute to economic development.

12. Health system factors that still undermine efforts to reduce the disease burden are:

a. Insufficient sustainable financial resources and the efficient allocation and use thereof;
b. Lack of social protection for the vulnerable groups especially those in catastrophic situations;
c. A shortage of appropriately trained and motivated health workers;
d. Poor commodity security and supply systems and unfair trade practices favouring the rich countries;
e. Weak health systems operations;
f. Marginalisation of African Traditional Medicine in national health systems;
g. Inadequate community involvement and empowerment;
h. Capacity of the private sector, including NGOs is not fully mobilised;
i. Paucity and inadequate use of available evidence and information to guide action including use of ICT;
j. Effective co-ordination with other sectors and harmony with partners not yet attained;
k. Lack of optimal intersectoral action and coordination;

l. Restrictive and disruptive global policies (e.g. structural adjustment programmes and unfair terms of trade), conditionalities and actions that adversely impact on Africa's health systems; and
m. Gaps in governance and effective leadership of the health sector.

13. The world is facing a global health work force crisis that is characterised by widespread shortages, mal-distribution between and within countries, poor working conditions and paucity of information and knowledge on best practice. Migration of health workers to rich nations is draining human resources for health in poor countries, which is exacerbated by insufficient training of adequate number of health workers. To compound this, Africa and the world face the emergence of new pandemics and resurgence of old diseases. While Africa has 10% of the world population, it bears 25% of the global disease burden and has only 3% of the global health work force. Of the four million estimated global shortage of health workers one million are immediately required in Africa. This crisis has developed as a result of long standing neglect, unfavourable international development policies and practices.

14. Subsequent to the Abuja Declarations, some countries have increased their health expenditure, while development partners have increased their development aid for health beyond US$10 billion per annum. However, health funding in most countries remains below what is required to achieve a functional basic health system, even if resources available were optimally used. Only two out of the 53 African countries have met the Abuja 2001 target of 15% of total government expenditure to be allocated to health.

2.3 Opportunities

15. At the same time as it faces challenges, Africa is at a time of unique opportunities to significantly impact on its disease burden, notably through ensuring adequate investments in health systems. There is increasing recognition that health creates wealth and advances GDP.

16. There is growing improvement in public sector performance including the health sector, with decentralization unfolding in many countries.

17. Pursuant to the Abuja Declaration, some countries have increased their budget allocation to health in real terms, now exceeding 10% of public budget, the vital importance of sufficient, motivated Human Resources for Health has been recognised by Africa's leaders.

18. There is progress in ensuring commodity supply, and the decision of the AU Heads of State at their Fourth Summit will enable Africa to realize the economic production at volume of quality generic medicines and other commodities (e.g. long lasting insecticides impregnated bed nets -LLITNs).

19. The African Union and its programmes provide an African-driven mechanism for ensuring a common platform and framework for avoiding duplication and fragmentation for countries / RECs and partners.

20. Development partners have increased their development aid for health in Africa beyond US$10 billion per annum and the move towards funding of core public health

budgets based on national plans, such as through Sector Wide Approaches (SWAPS) integrated intersectorally, offers a major opportunity to move away from fragmented and inefficient vertical projects and programmes, which is supported by the international commitment on aid effectiveness as agreed at the High Level Forum in Paris in 2005. The benefit is enabled by alignment of donor funding with nationally determined plans and priorities. Funding opportunities such as Global AIDS Vaccine Initiative (GAVI) could also be utilized.

21. Independent research from large scale programmes is also providing evidence of what works and what does not work, especially in resource poor settings. This kind of evidence could be used to provide direction on cost-effective, high impact and sustainable interventions.

3. Vision and Mission, Principles, Goals and Objectives

22. Africa knows what its disease burden is and its consequences, Africa also knows that it is possible to and can change this legacy as well as the interventions required. Its Health Ministers are committed to leading and coordinating a committed effort to enhance the health of Africa.

3.1 Vision and Mission

23. The **vision** is an integrated and prosperous Africa free of its heavy burden of disease, disability and premature death.

24. The **mission** is to build an effective, African driven response to reduce the burden of disease and disability, through strengthened health systems, scaled-up health interventions, inter sectoral action and empowered communities.

3.2 Principles

25. This Strategy is underpinned by a set of **principles**:

- Health is a human right
- Health is a developmental concern requiring a multi-sectoral response
- Equity in health care is a foundation for all health systems
- Effectiveness and efficiency is central to realising the maximum benefits from available resources
- Evidence is the basis for sound public health policy and practice
- New initiatives will endeavour to set standards that go beyond those set previously
- Solidarity is a means of facilitating access for the poor
- Respect for culture and overcoming barriers to accessing services
- Prevention is the most cost-effective way to reduce the burden of disease
- Health is a productive sector
- Diseases know no borders and cross border cooperation in disease management and control is required.

3.3 Goals and Objectives

26. The **goal** of this Africa Health Strategy is to contribute to Africa's socio-economic development by improving the health of its people and by ensuring access to essential health care for all Africans, especially the poorest and most marginalised, by 2015.

27. The overall objective of this strategy is to strengthen health systems in order to reduce ill-health and accelerate progress towards attainment of the Millennium Development Goals in Africa; More specifically:

a. To facilitate the development of initiatives to strengthen national health systems in member states by 2009
b. To facilitate stronger collaboration between the health and other sectors to improve the socio-economic and political environment for improving health
c. To facilitate the scaling up of health interventions in member states including through regional and intergovernmental bodies.

4. Strategic Approaches

28. This Strategy presents an approach for addressing avoidable disease, disability and death in Africa and for strengthening Health Systems for equity and development, especially for the poorest, most marginalised and displaced people.

29. To achieve the goals of this Strategy, a number of strategic interventions need to be concurrently implemented towards achieving an effective and sustainable health sector, synchronised with an integrated focus on the major health burdens and vulnerable groups. The intention is to incorporate best practices for promotion, prevention, care and rehabilitation into country health plans in line with national circumstances. There should be special attention to post-conflict countries and those caring for refugees and internally displaced persons. The Strategy must apply the life-cycle approach for cost-effective disease prevention.

4.1 Health Systems

30. For a country to deliver basic health care to its people, it requires a fully functional health system. There are many ingredients that make up a functional health system, including human resources for health, transport, ICT, facilities and medicines and supplies.

4.1.1 Governance

31. Health is a human right that is increasingly being recognised as enforceable. Governments have a responsibility for guaranteeing health care for all their citizens in an equitable manner and with clean and efficient governance, while using resources accountably. Governance includes providing stewardship, including vision and direction and providing transparent leadership.

32. There should be committed intersectoral action for health involving other ministries and levels of government. The Health Ministry's stewardship role goes beyond the Ministry of Health's leadership in the health sector (stewardship in health)

and the strategic management of the health system (stewardship of health) to addressing the inter-sectoral, socio-political environment within which the health system operates (stewardship for health).

33. The move towards supporting one national plan, one governing framework and one monitoring and evaluation system should be accelerated.

4.1.1a Policies and legislation

34. Health policies will be reviewed regularly to ensure that they are an up to date reflection of government's vision and priorities, reflect best practice and take into account the realities and socio-cultural circumstances of the country. Policies should be geared towards guiding and supporting effective implementation and monitoring of programmes.

35. Legislation and consequent regulation are key tools in giving effect to policy. Countries should review their health legislation and promulgate new legislation and regulations as needed to ensure that their policy intent is supported and that legislative gaps are filled, creating an environment for effective delivery of affordable, appropriate, equitable, and accessible quality care for the entire population.

4.1.1b Organization and Management

36. This Strategy seeks to advocate and promote a coherent organisational framework that enhances efficiency and effectiveness through:

- Proper and adequate planning
- Strengthening and revitalizing a primary health care approach
- Reducing bureaucracy and enabling appropriately skilled and motivated management
- Increasing cost-effectiveness and evidence based decision making
- Improving efficiency through reorganizing services
- Introducing cost-effective, quality improvement programmes and services
- Allocating resources to effectively and equitably address health needs
- Determining the minimum package of core primary health care interventions that all citizens can access
- Decentralizing operational management of the health system
- Applying an effective multi-sectoral approach
- Providing an accessible, affordable and acceptable health care services.

37. Decentralisation provide for effective and transparent management. The basic unit of a well organised health system is the district, which needs to be strengthened and adequately resourced, in a balanced manner with the higher levels of health care. The essential features are the active involvement of local communities and stakeholders and flexibly adapting programmes to local circumstances. District managers should, within national guidelines and delegations, be able to allocate resources and modify approaches and introduce innovations. Each country should develop one or more learning sites to explore what it takes to develop an effective basic health system and to offer a demonstration opportunity to the country and even the region.

38. Integration of related and complementary programmes will be used to improve cost-effectiveness of the health system and convenience to the consumer, overcoming the problems of a vertical and fragmented approach.

4.1.1c Performance

39. Countries are committed to enhancing the performance of their health system to achieve the best value with the resources available. Each country will update and cost their national health plan, following a gap analysis between existing plans and this Strategy and other commitments, taking into account an agreed minimum package of core interventions. These National Health Plans will be the centre of health development in the country, and the basis for strengthening the health system, its implementation continuously monitored and its content regularly reviewed and updated.

40. National health care systems need to respond adequately to the expectations of their population and the changing health needs and there should be a clear mechanism for disseminating the expectations, enhancing community responsiveness and ownership and for improving performance and caring of health workers. There should be a commitment to transparency, accountability and reporting.

41. Countries should consider three possible resource availability scenarios; one at current or low growth levels, a second anticipating greater national commitment and delivery of international promises and the third for the resources required to make the impact desired – and then set targets commensurate with these resources. At the same time countries must constantly ask if the health outcomes justify the inputs, if resources are being optimally utilised and if health system improvements will achieve sustained positive change. These plans must include ways of bridging any possible resource gaps in the short, medium and long term.

42. Incorporating the new opportunities offered by advances in technology and developing and retaining human resources are critical to health systems performance and all elements should receive priority attention. Strategic interventions should value, motivate, proportionately compensate and equip all cadres of health workers.

Countries will update their National Health strategies and plans in line with this Africa Health Strategy and with the detailed commitments collectively made on specific issues by African Heads of State and Government and Ministers of Health. This will include a gap analysis and costing against different resource scenarios, taking into account the minimum package of core interventions.

Ministers of Health will drive efforts to strengthen health advocacy, governance and leadership, implement/strengthen the primary health care approach and make organisational changes to support efficiency, including strengthening of district health systems in line with the 1978 Alma Ata declaration.

4.1.2 Resources

43. Resources encompass key inputs such as fiscal provisions, human resources, physical capital, drugs and medical supplies and commodities. Ministries should

generate and apply these resources optimally towards strengthening health systems for equity and development.

4.1.2a Financing, **Resource Allocation and Purchasing of Health Services**

44. Governments alone cannot assure the health of its population. 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.

45. Countries are encouraged to target the US$34-40 per capita required to provide the essential package of health services.

46. Member states are urged to review current public and private health expenditure with a view to increasing the per capita expenditure so that a greater proportion of the population has access to the essential package of health services, with vulnerable sections of the population, especially women and children. This should focus on the major health challenges by using cost-effective measures, with adequate financing for primary health care.

47. Strategies that may be considered by Member States to increase the pool of funding available to the health sector include:

(a) Increasing the efficiency of the public and private health care sector;
(b) Advocating for greater donor support in line with the Paris Declaration;
(c) Advocating for investment in health in line with the Commission of Macroeconomics and Health;
(d) Exploring alternative sources of additional revenue for both public and private sector; including health insurance systems, while avoiding conflict of interest;
(e) Elaborating national health accounts for better management of health expenditure;
(f) Promoting public-private partnerships

48. Financing for health systems needs to be treated as an exceptional case. If basic essential health care is to be achieved then budget caps will need to be lifted, and time bound renewable employment contracts used. Development partners will need to move towards sector wide approaches to ensure absorptive capacity and reduce transaction costs. The health sector should receive suitable allocations from multi-donor budgetary support.

49. Member States are urged to allocate resources with due regard to redressing imbalances, including those between the rich and poor, the urban and rural communities and between men and women and children.

50. Member States must strengthen government's capacity and regularly review the practices and procedures to purchase health services, including tendering and contract management systems which must be accountable.

51. The African Union should engage global health initiatives to encourage them to fund the core health system and human resources requirements needed for their programmes

Countries should steadily increase their budget allocation for health to at least the 15% target set by Heads of State and prioritise primary health care.

The African Union should engage development partners to match the commitments they have made in international forums, with longer cycles of predictable, dependable and harmonised aid.

Countries should explore the use of contract posts (with benefits) for staff in the public sector using basket-funded development aid, the posts being renewable with new funding cycles.

The African Union should engage global health initiatives to encourage them to integrate with national health systems and to fund the core health system and human resources requirements needed for their programmes.

In exploring additional sources of revenue countries should work towards a solidarity model within a framework of equity, seeking to implement pre-payment systems to avoid user fees at the time that care needs to be sought.

Procurement systems should be transparent.

4.1.2b Social Protection

52. Social safety nets at country and community level as well as national health plans need to be encouraged and enhanced in a manner that meets the needs of the vulnerable and that is compatible with traditional and cultural norms and practices of the society. Measures for identifying people who fall through the cracks need to be put in place in a participatory manner. All social protection mechanisms should be mobilised, including social health insurance. There should be a review of user fees with a view to abolishing them as this is important in social protection.

53. National solidarity mechanisms for social protection should be put in place.

54. Enhanced inter sectoral action should provide for a continuum of care and it should be delivered as such. But, there are certain areas which are clearly the responsibility of the health sector and these should be included in National Health Plans or in social pensions.

55. Poverty reduction strategies rather than mere social welfare should be at the core of social protection.

National Health Plans should include social protection for the vulnerable and a plan to protect families from the long term debt traps of catastrophic illness or injury.

There should be a review of user fees with a view to abolishing them.

4.1.2c Human Resources

56. Health sector reforms must promote all aspects of human resources for health development and retention, addressing policies, strategic plans, information, training, recruitment, deployment and retention, administration, working and living conditions and the health of staff. In this regard, in line with the AU Heads of State and Government decision, Governments should:

- Determine the categories of professional, auxiliary (mid-level) and community health workers that will provide an appropriate human resource mix for their needs.
- Develop costed national human resources development and deployment plans, including revised packages and incentives, especially for working in disadvantaged areas.
- Forward fund the establishment of the training capacity required to produce the desired number of health workers.
- Build a cadre of multi-purpose trained staff as the nucleus of health care delivery.

In addition, member states should:

- Collectively lobby for the lifting of expenditure ceilings imposed by partners in health and other social services
- Ensure that health workers trained are using public funds offer compulsory community service for a given time as a means of paying back to society
- Explore additional sources for funding the development of human resources for health in Africa and especially how to reduce migration of health workers out of the continent. An endowment fund can be a possible starting point.
- Advocate for western governments to also increase investments in the training of their own health care workers in order to address the gaps in their countries and thus reduce the pull factors in developed countries
- Address the push factors by putting in place mechanism that value, respect, motivate, adequately compensate, professionally develop and equip the health workforce.

57. The African Union needs work towards ensuring ethical recruitment within the continent and by developed countries, by insisting on agreements that take into account the investment made by African countries as well as the rights and freedoms of individuals. Countries should address the causes of migration and conduct migration and retention studies of health workers and should also improve the conditions under which health professionals and other health workers operate. African countries should work together to produce the health workers we need and to develop a common African curriculum.

58. The continent has to implement most effective ways of developing, retaining and enhancing the human resource capital. The most fundamental issue to be ensured is whether the training of health care workers is appropriate and aligned to the needs of the continent. The decision by Africa to train mid level and multi-skilled health workers needs to be followed up by reviewing training curricula and sharing

training resources and institutions of higher learning on the African continent. This must be coupled with updating personnel audits of various cadres of the health sector and determining causes of attrition, as well as reviews of career structures.

59. Countries policies and plans should provide for a balance of professional, auxiliary and community health workers to ensure suitable skills, continuous safety, cost-effectiveness and availability. Each country needs to have a comprehensive Training Needs Assessment, for basic and continuing education, supported by a plan of action. In scaling up training, one of the quickest measures is to increase the size and intake of existing institutions while bearing in mind the need to also increase the training and working environment infrastructure and appropriate staffing norms. Some may need upgrading of their facilities, all should have internet connectivity and curricula in some countries may need to be modernised to take account of the latest developments. As we scale up training, we should put in place mechanisms to absorb these staff into service. In this regard countries should support training needs assessment to help identify areas of most need for type, number and qualifications.

60. Countries should ensure effective management of human resources for health starting with updating their employment and deployment policies. Improvement in salaries and work conditions is a critical factor for success. To this should be added flexible career paths, supportive supervision and mentoring, continuing education, recognition of credit hours and continuing professional development and fostering motivation and retention strategies. Managers should demonstrate openly the value they place on their health workers and recognize their professional worth and the adverse circumstances under which many work. There should be effective registration and monitoring of health workers.

61. The severe rural – urban and formal – informal settlement imbalances require special attention. Financial and non-financial incentives e.g. housing, additional leave, further training opportunities should be used to entice/compensate staff. Community service (under supervision) is an important way for new graduates to offer something back to the society that has invested in affording them the opportunity to become a health professional.

62. Good performance of all health staff should be rewarded. Expertise in health management should be developed. All countries should establish National Health Workforce Observatories.

Countries should develop costed national human resources development and deployment plans, including revised packages and incentives, especially for working in disadvantaged areas and for clinical career paths.

Each country should determine the categories of professional, auxiliary (mid-level) and community health workers that will provide an appropriate human resource mix for their needs.

Countries should conduct migration and retention studies of health workers and explore the possibility of establishing networks for training health workers.

The African Union should facilitate a common African position on migration of health professionals and lead engagement with OECD countries to overcome the devastating impact this is having on Africa's health systems.

4.1.2d Commodity Security and Supply Systems

63. Important progress has been made globally and in Africa, but commodity security still lags behind in many countries. Increased resources need to be made available, national procurement systems need to be updated and other sources of commodities need to co-ordinate their efforts with those of government.

64. Universal access to essential health care must be supported with adequate supply of commodities including essential medicines, ARVs, contraceptives, condoms, vaccines and effective drugs and other supplies. They should be part of the Essential Health Package. Essential medicines and supplies should be exempt from taxes and a special dispensation provided for landlocked countries.

65. Supply systems and logistics and human resource capacity need to be strengthened to ensure appropriate ordering, storage and distribution. As such Governments should promote bulk purchasing and ensure that local facilities have specific protected budgets to access supplies. Member States should be supported in use of available tools like the WHO Integrated Health Technology Package and the UNFPA Commodity Security tools to track commodity needs. Strong backing must be provided by quality assurance laboratories and control systems.

66. Following the decision of AU Heads of State and Government to develop and promote Local Pharmaceutical Manufacturing of Drugs, vaccines and health commodities in Africa, the AU Member States need to embark on local production of pharmaceuticals and other health commodities. Adequate preparation of infrastructure, Human resources training, resource Mobilisation and strategic partnerships for technology transfer in order to embark on the implementation of the Pharmaceutical Manufacturing Plan for Africa are critical and urgent. The AU Health Ministers should agree on a timeframe, scope, distribution, marketing and types of drugs and commodities to be manufactured in the continent.

Support should be given to the Pharmaceutical Manufacturing Plan for Africa which is aimed at realising the economic production at volume of quality generic medicines and other commodities, with countries showing solidarity and removing the tariff and non-tariff barriers to its success. The focus of the plan should be on ensuring a sustainable supply of affordable medicines, local production of generic medicines being but one of a range of ways to secure supply of affordable medicines. In this regard Ministers of health should encourage competition in the market while ensuring transparency in pricing of medicines to ensure affordability and access. Ministers of Health need to put in place medicine control laws and regulations for registration, use and distribution of medicines to ensure safety, quality and efficacy.

The African Union should engage with international partners to enable effective integration of global commodity strategies and systems with countries health needs and with the pharmaceutical industry and other stakeholders for accelerated development of need new commodities.

Countries should advance their logistics and supply systems towards ensuring continuous availability of commodities at health facilities.

4.1.3 Health Systems Operations

67. To be functional all parts of the health system need to be operational, work synchronously and guarantee accessibility in terms of distance. Thus, all elements should be developed simultaneously, focussing on making services widely accessible in terms of distance, cost and time.

68. Health facilities require water, power and working equipment maintained by a locally effective maintenance and repair system. Reliable communication is essential. The advances in telecommunication mean that no clinic should any longer be isolated. Access to laboratory tests, radiography, a safe blood supply and a suitable record system should back up patient care. The referral system should work both ways and be set up to cope with emergencies. Patient transport should be complemented by an effective logistics and supply system that, amongst others, ensures that drugs and other essentials are not out of stock.

69. While building the national health system, countries should consider developing one or more learning sites, as a pathfinder for strengthening their health system. Such integrated development will offer a working demonstration for the country of an effective basic health system.

70. Ensuring trained managers who can effectively mobilise, motivate and innovate as well as plan, organise and budget, and who stay in a district for a meaningful period of time is a top priority. This should be complemented by a cadre of staff with public health training. Each country should determine the qualifications and training they aspire their district, health programme and other managers to have and develop a plan for its attainment.

4.1.4 African Traditional Medicine

71. In declaring a Decade of African Traditional Medicine in 2001, Governments have recognized the wide use and hence importance of integrating traditional medicine into their national health systems and creating an enabling environment for optimising its contribution. The latter includes mobilizing and connecting all stakeholders. It is essential to strengthen structures of traditional medicine through analysis of the prevailing systems and with the involvement of traditional health practitioners and communities, focussing on strengthening the best practices of traditional medicine. Organizational requirements include the establishment of a national multidisciplinary body responsible for the coordination of traditional medicine; formulation of a policy and legal framework; allocation of adequate resources; development of regulations for the local production and rational use of traditional medicines and protection of intellectual property rights.

72. African Union Member States should consider establishing coordinating mechanisms at national and regional levels to facilitate the implementation of the Traditional Medicine Plan of Action. Research in Traditional Medicine should be promoted and funded to identify efficacious and safe traditional medicines and assist Traditional Health Practitioners patent their products.

73. In countries where ATM does not exist, other systems of TM should be considered.

Countries should integrate African Traditional Medicine or, where applicable, other forms of Traditional medicine into their health systems, recognising its strengths and limitations.

4.1.5 Participation

4.1.5a Community Participation and Empowerment

74. Community members are often perceived as consumers and yet are a potential resource that could be tapped into so as to strengthen health systems. Countries and the regions need to have strategies of empowering and involving communities to ensure ownership and sustainability of programmes. Community participation should not be limited to cost sharing only but should also include other aspects like report problems in the health systems.

75. Realising the full potential of community involvement is often a challenge. In scaling up community involvement there is a commitment to mobilize energy and voluntarism in a manner that is difficult for formal health services to match, and to achieve results in groups that formal services struggle to reach. Health ministries will therefore need to create an enabling environment for responsible and constructive community involvement, facilitate the emergence of local NGOs and CBOs and provide funding to initiate and facilitate efforts in underserved areas. However, such support should not detract from the independence and vibrancy of community involvement and there should be space for advocacy, which might coincide with or confront government efforts and also challenge other sectors to be supportive.

76. Innovative concepts on how buy-in by communities can be enhanced need to be employed. An example of this could be selling a stake of the health system, by outsourcing an income generating and self sustaining part of the system to communities, such that this results in a mutually beneficial relationship between the health system and the community it serves. Support and ancillary services in a health system lend themselves particularly well to this concept. The private sector has an important contribution to make through enabling the health of their labour force.

77. Countries should design and implement a plan for achieving health literacy, especially for women and girls, and community empowerment to realise the full benefit that this offers for health. The media have an important role to play in enhancing health and in reflecting community experience.

78. As situations vary from country to country, there is no single way of enabling community involvement. Each country should consider their local situation and incorporate a deliverable approach to community involvement in their counties health plan. The details may be different, but the aim is common to all countries: to reach all sectors of society, especially the poorest and most marginalized, in a sustained programme of social mobilization in support of health.

Each country should plan their framework for community participation in the health system and create an enabling environment for this to take place.

Countries should design and implement a plan for achieving health literacy and community empowerment to realise the full benefit that this offers for health.

4.1.5b Strengthening Partnerships

79. There is generally unsystematic and uncoordinated partnership between donor and recipient countries resulting in conflicting focus in programme implementation. Countries need to adhere to the 3 ones principle and to establish organisational structures that ensure a single entry and review point for engaging with development partners. Successful implementation of the Africa Health Strategy will take more than defining the role and responsibilities of all contributors. Equally, for continent wide partnerships the AU should develop procedures for engagement with Africa.

80. Relationships based on government stewardship and mutual respect between government and its partners must be strengthened to ensure coordinated action aimed at strengthening health systems.

81. Ministries of Health must facilitate an environment that will deepen partnerships in health. Regional economic communities should build partnerships between countries and others.

82. As part of the global community, because they add value and because Africa does not have the fiscal space and is short of capacity in some areas, Multilaterals, Development partners and Global Health Initiatives offer valuable support. However, Health Ministers should ensure and facilitate consultation, establishment of donor forums and ensuring good corporate governance including longer term dependable funding systems. Foundations should continue to play a strategic role, moving rapidly

and creatively to inspire new initiatives and learning. Multinational consulting and technical institutions should ensure that they are committed to building African capacity and not maintaining dependency. Countries should work with partners to assess the actions on commitments of both partners.

83. Multilaterals, which are predominantly in the United Nations system, play an important normative, developmental and technical role. Their expert views should continue to inform developments. All should be cognisant that that they are using funds which might otherwise have gone to countries and look carefully at their responsive to country accountability and the proportion of funds that are expended downstream.

84. The AU and its organs as well as RECs are urged to:

a. strengthen collaboration within Africa;
b. strengthen and expand south-south and North-South collaboration;
c. north-south collaboration;
d. work with donor partners to ensure that resources are mobilized to contribute to the attainment of the goals of this Strategy.

Innovative and effective partnerships are envisaged between government and health development stakeholders, anchored on mutual respect, leading to a harmonised and co-ordinated effort and a seamless health service for clients. Ministries of Health will provide an enabling framework for development partners to play their role.

4.1.6 Health Management Information and Research

85. Countries have been developing their essential national health research plans and their health information systems. Too often the latter is unsettled by the pressures to separately collect data on specific health challenges leading to a fragmented system. These need to be merged to in order to have an appropriate health information system made up of locally generated and collected accurate data suitable to monitor progress, inform decision making and assure quality in the delivery of health care. The systems need to be readily accessible, user friendly and capable of synthesising data for use at any level of the health system (policy, planning, implementation, monitoring and evaluation), an imperative for running an effective and efficient health system. The information system should be simple and efficient so as to flow smoothly with the provision of care and be suitable for informed decision making. Government should publish official statistics on health.

86. Health information systems should be strengthened to guide and support decision-making at all levels. A standard package of information reflecting gender and age and based on a minimum package of interventions should be collected to monitor and evaluate health system performance. The district or hospital information systems should provide a framework of information for monitoring progress, identifying where interventions are required and evaluating success. The routine data will need to be supplemented by other information, such as from surveys.

87. Health Research provides the evidence for policy- and decision-makers at all levels to make efficient and effective decisions. This was reinforced and detailed

direction on Health Research provided in the reports of the Abuja and Accra High Level Ministerial Meetings on Health Research. The content of research is critical and needs to go beyond determining prevalence to explore what social and psychological factors are behind health choices, and what factors lead to success of interventions. A continental position paper on health research in Africa should be developed.

88. The African continent must have locally driven and financed research which generates information to inform policy and plans. Empowerment of local researchers and resource allocation for research are critical factors for development of innovative approaches and interventions, which are sensitive to the peculiarities of Africa. Research in general, and operational health systems research specifically, is a necessity for improving health system performance. In consequence, countries should build research capacity and allocate at least 2% of national health expenditure and 5% of project and programme aid for research. They should prepare legislation governing research and establish or strengthen national health research systems and establish platforms for research to be presented so that it can indeed influence health policy and practice.

89. Multi-country collaborations will help to determine whether factors are specific to a country or locality or are broader predictors and determinants for a region or the continent. Countries should share their research findings among themselves and with the AU Commission. Clinical trials and research by international organisations should be regulated and be ethical.

.

Countries should develop a simple, timely health information system that is suitable to monitor progress, inform decision making and assure quality in the delivery of health care.

Countries should allocate at least 2% of national health expenditure and 5% of project and programme aid for research. They should determine what their essential national health research needs are and establish platforms for such research to flourish.

4.1.6a Surveillance, Emergency Preparedness and Response

90. Member States and regional economic communities need to formulate, strengthen and periodically review their Surveillance and Emergency Preparedness plans for health disasters as well as natural disasters which have health consequences. Countries should prepare to implement the International Health Regulations.

91. Each country should have a community based, clinic and district hospital mechanism of monitoring and rapid reporting in place, which will ensure that outbreaks are identified and acted upon up the line as appropriate at the district, regional and national and continental levels. The response should be based on clinical suspicion followed by laboratory confirmation as quickly as possible. Countries should promptly call in expert support and pooled supplies, but their response should already be activated based on a national plan that incorporates operational details.

Ongoing surveillance of both diseases and vectors will be the basis of a high level of vigilance for outbreaks so that they are identified and acted upon early within a national plan, responses being based initially on clinical suspicion followed rapidly by laboratory confirmation.

4.2. Integrated Approach and Linkages

92. Each country, based on its specific circumstances, needs to define, cost and implement a basic health care package that address the major part of its disease burden through appropriate interventions using an integrated approach. The interventions would take care of the priority health problems both communicable and non-communicable disease and conditions, including neglected diseases, injuries and trauma. Joint planning with other sectors like water, education, agriculture, environment, social welfare and justice should be undertaken. National policies and plans should address the needs of the elderly, the disabled, women, children in school and other vulnerable groups. There should be a strong emphasis on behaviour change.

93. The interventions should be comprehensive addressing promotion, prevention, treatment and care, support and rehabilitation as may be required. The health sector needs to strengthen inter-sectoral collaboration to address other determinants of health.

94. AU Member States should fast track the implementation of the declarations, plans of action, strategies and policy frameworks that have already been adopted by the African Union in order to accelerate progress towards the attainment of MDGs. In line with the Charter of the Rights of Children countries need to strengthen or develop programmes to combat childhood illnesses, with particular emphasis on orphans and vulnerable children and their carers who in the case of orphans and vulnerable children are mainly older women caregivers.

95. The health system should prioritise actions to address maternal mortality, emphasise gender into health policy and seek elimination by law of all forms of violence against women. It should promote helpful traditional practices and by legislation, eliminate harmful traditional practices which are linked to Vesico Vaginal Fistulas, and female genital mutilation.

96. A broader women's health programme should be institutionalised including family planning repositioned into wider reproductive health programmes. There should be programmes to take care of sexually transmitted infections, and screening and treatment of reproductive cancers - including human papilloma virus vaccination, for managing infertility and for menopause. Recognising the morbidity and mortality from unsafe abortions especially for the poor, safe termination of pregnancy and post-abortion services should be included as far as country's law allow. The right of women to manage their own health and health seeking behaviour should be advocated. This should be built on a gender and sexuality education programme and youth and women friendly services, with a specific focus on reducing teenage pregnancies and sexually related disease as well as ensuring access to post

exposure prophylaxis for victims of rape. The role of men, both as supporters and recipients of SRH services is imperative to develop.

97. With up to 40% of under-five deaths occurring in the first month of life and about 26% in the first week alone, reducing mortality and morbidity starts here. Efforts should be integrated with safer motherhood, which should have a specific neonatal care component to them.

98. The small number of major causes of under-5 mortality offers opportunities to make a major impact through focused efforts. However, experience has shown that single disease efforts can be costly and lead to alternate mortality, making the case for integrated programmes, delivered at the family and community level by community health workers, scheduled interventions requiring auxiliary staff and clinical services requiring permanently available professional (ideally) staff. The package of interventions includes breast and child feeding including micronutrient supplementation, immunisation including the introduction of new vaccines such as pneumococcal and rotavirus, prevention of mother to child transmission of HIV and care of HIV, use of insecticide treated nets and intermittent presumptive treatment of malaria and management of common childhood illnesses within the strategy of Integrated Management of Childhood Illnesses. Countries may wish to implement these in packages of growing complexity and cost, but should maintain the link to wider health system strengthening and be cautious of cost estimates that emphasise only the marginal costs of the drugs and supplies and do not sufficiently take into account the costs such as human resources, logistics and management.

99. Immunisation remains the most cost-effective public health intervention. Poliomyelitis has a special place in immunisation programmes. , not because it is still a cause of morbidity, but because of the potential of global eradication. At the same time experience has shown that diminishing the concentrated effort has resulted in importation of the polio virus to some areas.

There must be a focus on the key health challenges faced, but delivered within an integrated health system. A summary of the best practices for promotion, prevention, care and rehabilitation for each of these challenge, as elucidated in summary in this Strategy will be incorporated into country health plans in response to local circumstances. Universal access is the rallying point of the response to all health challenges.

4.3 Socio-economic and political context of health

100. Measures that reduce poverty, particularly for the poorest and most marginalised people of Africa, must be at the forefront of health interventions, while health interventions must be at the forefront of any poverty reduction strategy (PRS).

101. As health is influenced by interventions in many other sectors, a multi-sectoral approach is a cornerstone of any Health Strategy. Thus, the African Health Strategy recognizes and supports African commitments to address broader issues that are undermining health, including poverty, HIV/AIDS, marginalisation and displacement, poor governance, socio-political instability, economic underdevelopment, lack of infrastructure (energy, transport, water and sanitation), low educational levels,

agricultural vulnerability, environmental degradation and gender inequality. The health sector will continuously engage with these other sectors to encourage decisions and actions that give the best return for health.

102. The link between the environment and health was strongly emphasised at the World Summit on Sustainable Development. The responsibility for obviating environmental health risks lies in many sectors and the health sector should encourage health friendly environmental decisions and contribute its insights into them. Beyond this there is a unique contribution of the health system to offsetting environmental health hazards. The focus has shifted from inspection to environmental health promotion. Especially in rural areas, environmental health workers, working hand in glove with other community health workers and advocating appropriate technologies should make an important contribution, guided by mid level health workers and professionals. Water filtration and chlorination, ventilated improved privies, fly traps and mud stoves all reduce disease. For example mud stoves with chimneys obviating the indoor air pollution of open cooking and heating fires has the potential dramatically impact on the mortality from childhood pneumonia. Removal of pooled stagnant water used by mosquitoes for breeding, while avoiding soda bottle storage of paraffin reduces accidental ingestion. Appropriate handling of livestock has become even more important with the threat of avian influenza. Urban informal settlements require major environmental health attention. This includes food vendor education about avoiding food poisoning and community education about measures to avoid refuse-related risks and accidental fires. **Unlawful dumping of harmful substances in Africa should be addressed.**

Ministers of Health will seek to participate in their countries poverty reduction strategy and economic empowerment processes to encourage health promoting options and development for the poorest and most marginalised people and will engage with other sectors to promote decisions and actions that work in favour of health.

5. Monitoring and Evaluation

103. Monitoring and evaluation of performance of the health system depends on the generation and use of sound data on health system inputs, processes, outputs and outcomes. The Health programmes must be responding to health problems. Countries must ensure that the data collected is accurate and timely as it will indicate both the performance of the system as well as the relevance of the programmes to health problems. The adequacy of a monitoring and evaluation system may be assessed by the regularity, completeness and quality of reports. Data should be disaggregated by gender and age to enable more focussed action. Community participation in monitoring health programmes should be encouraged.

104. While morbidity and mortality trends are important, the importance of health service operations monitoring should not be overlooked. Process and outcome data is particularly important. Surveys, including before and after intervention studies should be built in as part of the M&E system, as should qualitative perspectives, such as by community committees at clinics and hospitals and from focus group discussion. An ethos of using M&E to build a better health service, rather than a

perspective of it as a policing tool should be nurtured and is likely to enhance the results.

105. Periodic reviews should be held at the regional and continental levels. This will help to share best practices, more effectively address obstacles, strengthen a partnership approach and accelerate progress in the implementation of this Health Strategy.

106. Quality Assurance should be an integral part in health programme implementation at all levels.

107. The African continent must agree on what areas to monitor and evaluate to assess progress in health; thus common indicators must be agreed upon and developed, based on the minimum package for health interventions. For this to happen, common and standard data sets, disaggregated by gender and age will have to be designed. This will necessitate collection of common data sets, across the continent, using the same design and methodologies, in order for scientifically sound analyses and comparisons to be made. Efforts should be concentrated on the improvement of the vital statistics registration systems, epidemiological surveillance, morbidity and mortality registration and resource management information systems. Health workforce monitoring should be an integral part of the information system.

6. Way forward

108. The Commission will print and disseminate the Strategy widely to all Member States, partners and all stakeholders. RECs and Member States should build their capacity for implementation of this strategy, as they will have to review their Health Plans to incorporate the essential elements from the Africa Health Strategy. There will be need to enhance the financial and human resources of the AU Commission, especially in monitoring and evaluation to ensure that it plays its role in the success implementation of this Strategy.

Role of Stakeholders

(a) The African Union

109. The African Union will, among other things, undertake advocacy, resource mobilisation and dissemination of best practices at continental level in support of the implementation of this Strategy. The Commission will assist RECs and member states to develop their own costed implementation plans and monitoring and evaluation frameworks. The AU should organise a meeting of stakeholders to develop an action plan for the overall implementation of this Strategy

(b) Regional Economic Communities

110. Regional Economic Communities will, among other things, provide technical support to Member countries including training in the area of health systems strengthening, advocate for increased resources for health systems strengthening, harmonise the implementation of national Action Plans, monitor progress, identify and share best practices.

111. (c) Member States will review their Health Plans and will address issues of accountability within the health sector. They will also put in place advocacy, resource mobilisation and budgetary provision as a demonstration of ownership. They will also undertake monitoring and evaluation at country level and report to the RECs and AU Commission. They will also ensure participation of civil society and the private sector in the development and review of national health programs and create a conducive environment for this to happen. Member states will also harmonise their policies and strategies to ensure coherence.

Member States

(d) **Partners**

112. In line with the Paris principle multi-lateral and bi-lateral organizations, international and national civil society organizations and other development partners will align their financial and technical assistance and cooperation plans with national and regional needs and priorities for implementation of the Africa Health Strategy.

113. WHO, other UN agencies and International organizations should provide technical support for this Strategy

(e) Civil Society Organizations

114. These include NGOs, Faith Based Organizations (FBOs), CBOs, Traditional leaders and healers as well as media organizations. Civil society and the private sector must be included in national programs

7. Bibliography

7.1 African Union

1. Resolution of the Abuja Food Security Summit. Summit on Food Security in Africa. Summit on Food Security in Africa. Abuja, December 4-7, 2006.

2. African Union Plan of Action on Violence Prevention in Africa

3. Maputo Plan of Action on Sexual and Reproductive Health and Rights, 2007-2010. Special Session of the African Union Conference of Ministers of Health entitled "Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa". Maputo, 18-22 September 2006. *And*

4. Documents and Decisions of the Special Session of the African Union Conference of Ministers of Health, Maputo, 18-22 September 2006.

5. African Union State of the Africa Population Report 2006

6. African Union. 2005. African Common Position on the Progress on Implementation of the MDGs.

7. Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa. Special Summit of the African Union of HIV and AIDS, Tuberculosis and Malaria (ATM) entitled Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by a United Africa by 2010, Abuja, 2–4 May, 2006. *and*

8. Documents of the Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria Abuja, 2-4 May 2006.

9. Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Support in Africa by 2010, Brazzaville, 8 March 2006.

10. African Regional Nutrition Strategy 2005-2015

11. Gaborone Declaration on a Roadmap Towards Universal Access to Prevention, Treatment and Care 2nd Ordinary Session of the Conference of African Ministers of Health entitled Sustainable Access to Treatment and Care for the Achievement of the Millennium Development Goals, Gaborone, 10-14 October, 2005. *and*

12. Documents and decisions of the 2nd Ordinary Session of the Conference of African Ministers of Health, Gaborone, 10-14 October, 2005

13. Continental Policy Framework on Sexual and Reproductive Health and Rights. Adopted at the 2nd Ordinary Session of the Conference of African Ministers of Health, Gaborone, 10-14 October, 2005.

14. Sirte Declaration on Child Survival. Fifth Ordinary Session of the Assembly of the African Union, Sirte, 4-5 July 2005.

15. The AU Commission HIV/AIDS Strategic Plan 2005-2007 and AIDS Watch Africa Strategic Plan, Seventh Ordinary Session of the Executive Council of the African Union, Sirte, 28 June – 2 July 2005.

16. An Interim Situational Report on HIV/AIDS, Tuberculosis, Malaria, and Polio: Framework on Action to Accelerate Health Improvement in Africa, Fourth Ordinary Session of the Assembly of the African Union, Abuja, 30-31 January, 2005. *and*

17. Decision on the Interim Situational Report on HIV/AIDS, Tuberculosis, Malaria, and Polio: Assembly/AU/Dec.55 (IV) Fourth Ordinary Session of the Assembly of the African Union, Abuja, 30-31 January 2005.

18. The Fight against HIV/AIDS. Position of the NEPAD Steering Committee for the African Partnership Forum, Maputo, 16-17 April 2004.

19. Assembly of the African Union. Maputo Declaration on Malaria, HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, Maputo, 10-12 July 2003.

20. Comprehensive Africa Agriculture Development Programme (CAADP), adopted at the Assembly of the African Union, Maputo, 10-12 July 2003.

21. Documents and decisions of the Documents of the 1st Ordinary Session of the Conference of African Ministers of Health, Tripoli, 26-30 April 2003.

22. The NEPAD Health Strategy. Adopted at the Assembly of the African Union, July 2003.

23. Lusaka Decision on the African Union Decade for African Traditional Medicine, Lusaka, 2001 and its plan of action.

24. The Abuja Declaration on HIV/AIDS, Tuberculosis and other related infectious diseases adopted at The African Summit on HIV/AIDS, Tuberculosis and other related infectious diseases, Abuja, 26-27 April 2001.

25. The Abuja Declaration and Plan of Action, adopted at The African Summit on Roll Back Malaria, Abuja, 25 April 2000.

26. African Union Continental Plan of Action for the African Decade of Persons with Disabilities (1999-2009).

27. AU Policy Framework and Plan of Action on Ageing 2002

7.2 Recent global and continental sources

28. UNAIDS 2006 report on the Global AIDS Situation

29. UNAIDS 2006 AIDS Epidemic Update

30. Roll Back Malaria. World Malaria Report 2005

31. WHO Regional Office for Africa. The African Regional Health Report 2006

32. UNICEF, WHO, World Bank. A Strategic Framework for Researching the Millennium Development Goals on Child Survival in Africa. Unpublished, 2006

33. Documents of the 56th Session of the World Health Organisation Regional Committee for Africa, Addis Ababa, 28 August-1 September 2006.

34. Documents of the 55th Session of the World Health Organisation Regional Committee for Africa, Maputo, 22-26 August 2005.

35. Macroeconomics and Health: Investing in Health for Economic Development. Report of the Commission on Macroeconomics and Health, World Health Organisation, 2001.

EX.CL/354 (XI)
Annex III

PHARMACEUTICAL MANUFACTURING PLAN FOR AFRICA

AFRICAN UNION **UNION AFRICAINE**

الاتحاد الأفريقي **UNIÃO AFRICANA**

Addis Ababa, ETHIOPIA P. O. Box 3243 Telephone +251115-517700 Fax : +251115-517844
Website : www.africa-union.org

THIRD SESSION OF THE AFRICAN UNION CONFERENCE OF MINISTERS OF HEALTH 9– 13 APRIL 2007 JOHANNESBURG, SOUTH AFRICA

CAMH/MIN/7(III)

Theme: ***"Strengthening of Health Systems for Equity and Development in Africa"***

MINISTERS' MEETING
10-13 APRIL 2007

PHARMACEUTICAL MANUFACTURING PLAN FOR AFRICA

PHARMACEUTICAL MANUFACTURING PLAN FOR AFRICA

INTRODUCTION:

1. Pursuant to the AU Assembly decision 55 taken during the Abuja Summit in January 2005 which mandated the AU Commission to develop a Pharmaceutical Manufacturing Plan for Africa with the framework of NEPAD, the AU Conference of Ministers of Health undertook "to pursue, with the support of our partners, the local production of generic medicines on the continent and to making full use of the flexibilities within the Trade and Related Aspects of Intellectual Property Rights (TRIPS) and DOHA Declaration on TRIPS and Public Health {Gaborone Declaration Doc. CAMH/Decl.1(II) 3 (10 – 14 October 2005)}. They further requested the AU Commission to "accelerate development and facilitation of the implementation of a Pharmaceutical Manufacturing Plan for Africa" {CAMH/Decl.1 (II) 13(ii)}. The AU Commission conducted a drug production capacity mapping exercise in line with the Assembly decision on local drug production in the continent in collaboration with the World Health Organization.

2. At the WHO-AFRO 56th Regional Committee Meeting that was held in Maputo (AFR/RC55/10), discussions on strengthening local production of essential medicines emphasized that policy decisions about whether to import essential medicines from reputable sources or to promote local manufacturing should be based on careful situation analysis and realistic appraisal of the technical feasibility and financial viability underpinned by sound regulatory systems. A market size that would ensure sustainability as well as technical and financial viability was considered imperative. The WHO Regional Committee for Africa adopted resolutions AFR/RC/49/R5 and AFR/RC38/R19, which emphasize essential medicines, local production of essential medicines and African traditional medicines.

3. Pharmaceutical production occurs at three levels, primary, secondary and tertiary. The primary level includes the manufacture of active pharmaceutical ingredients and intermediates from basic chemical and biological substances. Secondary production includes the production of finished dosage forms from raw materials and excipients. The tertiary level is limited to packaging and labelling of finished products or repackaging of bulk finished products. (WHO AFRO, SADC).

4. A number of countries in the continent largely rely on India and China for imports of affordable generics and raw materials. The fact that India and China had to comply with both process and product patent laws by 2005 was seen as a potential threat to affordability and access essential drugs in Africa.

5. Unreliable medicine supply systems continue to hamper access. Some of the **perceived** benefits of local production include: -

i. Local production will save foreign exchange,
ii. Local production creates jobs, thus alleviating poverty and promoting social development,
iii. Local production facilitates technology transfer,
iv. Local production will stimulate exports,
v. Raw materials produced locally will be readily available and cheaper,

vi. Local production will improve/ enhance self-sufficiency in drug supply. [1]

6. The leadership of the African Union is committed to ensuring access to essential medicines for countries in need, irrespective of their level of technological development and manufacturing capacity.

SITUATIONAL ANALYSIS

7. Assessment of local production of medicines in some African countries (in the WHO African Region) indicated that out of 46 countries, 37 have pharmaceutical industries, 34 have secondary level production and 25 have tertiary production. Only **one** has limited primary production. Nine countries have no production ca pacity (WHO AFRO, Aug 2005). Self- reliance in local production seems to be a priority strategy in a number of Eastern Mediterranean countries. The national capacity for production has increased in Egypt, the Islamic Republic of Iran, Jordan, Morocco, Pakistan, Syrian Arab Republic and Tunisia to between 60% and 95% of their national requirements for essential medicines. [1] Though no one country, whatever its size and level of economic development, is entirely self-sufficient in pharmaceuticals, the negative trade balance of most countries in the continent is of concern.

ISSUES TO BE CONSIDERED

8. Pharmaceutical production is **capital**, **technology** and knowledge intensive/ driven. **Technical expertise** is absolutely critical, both in terms of sufficient numbers and appropriate skills. The continent will have to invest in the production of different skilled scientists (biology, chemistry, process engineering, medical engineers, biochemistry, bio-computer science, physics, medical engineers, clinicians, pharmaceutical scientists, technicians etc.). The critical factor is the ability of education system to produce sufficient numbers of skilled personnel in a sustainable manner. It will be necessary to form strong linkages with universities and funders to ensure a sustainable supply of required skills. **Academicians often have more interest in basic research compared with clinical research**, as the former is a faster route to promotions.[3] The balance between the two must be properly promoted and nurtured. Africans in the diaspora can probably assist in this regard. Incentives may have to be identified. At this moment there are very few technical experts with the appropriate qualification and experience to enable the Continent to go into large scale primary manufacturing.

9. At national and regional level, **the legislative framework** needs to be conducive to regionalised local production. This extends beyond legislation that ensures Good Manufacturing Practice (GMP), Good Distribution Practice (GDP), Good Laboratory Practice (GLP), Good clinical Practice (GCP) and other aspects of product regulation but also extends to legislation **regulating related duties on imported raw materials and intermediates and related taxes**. In - country procurement legislation and guidelines may also need to be amended. The continent is not homogeneous and has varying legislative frameworks and enforcement capacity.

1

10. Pricing policies and legislation linked to market size also have an impact on the extent to which local production can be expanded. **TRIPS flexibilities and national patent laws also have an impact.**

PROMOTION OF TECHNOLOGY TRANSFER

11. A strong link between academic and industrial research needs to be fostered. Technology transfer can meaningfully occur when there is a level of primary production. It is also highly dependant on the willingness of the technology owner, who may be losing a market in the process. Innovative manufacturing is in the hands of a few multinationals that have drastically reduced the number of manufacturing sites to a few niche areas around the globe, ideally located close to the more lucrative markets. Location is also influenced by favourable labour costs. **Would these innovators realistically be willing to transfer technology?** A few examples of technology transfer from the north have been for diseases of the developing world, and old technologies that are no longer profit-making eg. Treatment for Tuberculosis.

PHYSICAL INFRASTRUCTURE

12. Other than manufacturing plant and laboratory equipment, reliable, sustainable, reasonably priced **electricity and water** supplies, and modern IT and **telecommunication** technologies are critical. Reliable distribution networks are also important. Singapore has used some of these strategies to promote pharmaceutical production. [2]

PARTNERSHIPS

13. The assistance of development partners may be required in the following areas: -

i. The World Bank and DFID have done some economic analyses of pharmaceutical production in developing countries and these may be focused on the continent or used as a benchmark / comparators.
ii. WHO AFRO has also done a study on local production. WHO can be used to draw or source specific expertise as and when required.
iii. Other development partners can be used to support Research and Development, particularly in the areas of Indigenous knowledge systems and neglected diseases.
iv. Development partners may also be used to channel seed funding at the beginning.
v. Public private partnerships may need to be explored

14. Production in the continent is in the hands of the private sector. WHO advises that this may be the best arrangement so that governments concentrate on regulatory mechanisms.

[2] Footnote to be completed

TENSION BETWEEN HEALTH OBJECTIVES AND TRADE OBJECTIVES

15. There is tension between industrial policy and health policy. A manufacturer would decide to make a commodity if:-

i The desired quality is unavailable
ii Suppliers are unreliable,
iii There is desire to maintain intellectual property rights,
iv There is need to develop a local employment base
v There is need to reduce reliance on imports and manage foreign exchange flow
vi There is desire to produce for export
vii There is desire to increase technology transfer.[1]

16. On the other hand, health policy objectives' aim is to improve access to affordable medicines of good quality, without constraints like access to foreign currency, long lead times and inability to negotiate affordable prices. Some developing countries have embarked on pro-poor policies by capping prices for the domestic market, granting a range of incentives for local manufacturers etc. Some trade policies have encouraged investment by foreign innovative companies, with built-in safeguards for technology transfer to improve their global competitiveness. A balance has to be found to manage this tension. Both health and trade policies should be explicit and consistent with the overall development strategy.[3]

WHAT TO MANUFACTURE

17. The plan must investigate and suggest criteria for determining **what is to be produced**. Though the primary focus may understandably be on the diseases which contribute more to the burden of disease, like HIV and AIDS, TB and malaria, an investigation needs to be made whether concentrating only on these priority conditions will lead to sustainability. A decision needs to be made as to which medicines will be produced by whom. Essential Medicines Lists are not harmonised and there may be need to negotiation on which products to produce. Few medicines are however currently used to manage TB, malaria and AIDS.

18.

19. Criteria will need to be developed for deciding **which manufacturing plants will be eligible**. These may be linked to sustainable financing, compliance with GMP standards, sound regulatory systems, availability of appropriate human resources, reliable sources of electricity and water, technical feasibility and a viable market size.

20. Decisions also need to be made on intra-regional choice of **which country or group of countries will produce which commodity.**

21. Resources required need to be identified. Sources of funding will have to be identified up –front for both the producers and the purchasers. **Human resources** need special attention both at inception and to ensure continuous supply and sustainability.

3

22. An honest appraisal of **when regulatory systems can be adequately** strengthened is a key milestone. Several models to strengthen regulatory systems may be explored. **Countries within a region may pool their resources together and form a regulatory system similar to the EU**. Countries with weaker regulatory systems would then eventually up-scale their regulatory skills within this umbrella. Post –marketing surveillance forms part of the regulatory system strengthening. The proliferation of counterfeits and substandard medicines in the market and the recent withdrawal of Cox2 inhibitors manufactured by reputable companies make this imperative. Regulation of clinical trials is equally important. Efficient and effective distribution systems are necessary to ensure that quality medicines reach the intended beneficiaries. It will be important to analyse whether mark-ups through the value chain do not compromise affordability, thus hampering access.

ADDITIONAL FACTORS TO BE CONSIDERED

POLITICAL

23. The plan must have safeguards against monopolistic tendencies by the approved centres. Tools to measure efficiency and fairness / competitiveness of prices must be developed, implemented and continuously monitored. A strategy needs to be developed for countries that do not have manufacturing capacity to share benefits and tasks from the plan, other than medicines. (Manufacturing packaging material, etc.)

24. Will the plants manufacture only medicines that address HIV and AIDS, malaria and TB only or will other medicines e.g. antibiotics, analgesics; OTC also form a basket of manufactured products? Viability will determine the model.

25. Will markets be segmented to cater for lower technology-driven and high-technology driven production? Where will centres of R&D be situated?

26. Will production be limited to generics or will an attempt be made to create space for development of innovative technologies including African Traditional Medicines and other indigenous knowledge systems. Will the plan include investigations of better medicine delivery systems more suitable to our climate and conditions?

27. A number of countries have recently entered into joint ventures with manufacturers from India to manufacture antiretrovirals. How will these plants be accommodated?

28. What strategies will be used to compete with China and India that historically have lower labour costs and bigger markets?

29. Acceptability of locally produced generics by both providers and consumers may be a challenge unless marketing is done.

30. As countries in the continent are at different levels of development, labour costs will not be the same and they will impact on the final price of commodities.

SOME SOBERING THOUGHTS

31. Local production may not save foreign currency at entry. Active pharmaceutical ingredients account for 60% or more of the final cost of the product. Until primary manufacturing becomes a reality, there will not be meaningful savings of foreign currency. Production equipment, laboratory equipment and reagents etc. will be paid for in foreign currency.

32. Manufacturing requires highly skilled scientists, engineers, technicians etc. Modern production is technology –driven and may not create many entry - level jobs. There are however possibilities of job creation across the value chain if we begin at research through development, production and distribution. Jobs can be created in public research organisations, small and medium biotech companies, upstream in engineering and downstream in public health services.[3]

33. Export markets can only be achieved with innovation, competitive prices and quality. Government – driven procurement often protects local products through preference margins in government tenders. This may distort the market, as local small companies may not even attempt to be competitive.

Raw materials and intermediates are manufactured by a few players and the quantities produced are not too large. An analysis would have to be made to establish whether manufacturing raw materials is cheaper than importing them. Patent and TRIPS issues also play a significant part in this area.

34. The response of big PhRMA (The Pharmaceutical Research and Manufacturers of America) and other similar structures to the plan and their geopolitical influence may need to be analysed, particularly with regard to the donor community.

CONCLUSION

35. Local production can be successfully done in the continent. However there is need for the African countries to reassess the realities, possibilities and the feasibility of the programme so that it moves from being a political slogan to a reality after good ground work .The time needed to do thorough scientific analyses in the continent , together with WHO and other bodies that can add value, is certainly longer than two years . An economic analysis however needs to be done to ensure appropriate planning.

36. It may be recommended for the African Union Conference of Ministers of Health to mandate a technical body well versed with manufacturing to do a “skill search” and appoint all the relevant expertise (taking care of all the regional groupings i.e. geographical, linguistic) to study the detailed implications and come out with a suggested plan to advise the ministers in the following areas:

- Capabilities of the regions ,
- Legislative reforms needed –TRIPS
- Products and level of Manufacturing (primary ,secondary and tertiary)
- Infrastructure, capital and market analysis

- Issues of equitable benefits for all countries per region
- Sustainability possibility of new inventions
- This group may be mandated to bring a firm proposal/informed advice to the Ministers on this highly technical issue within a few months

PLAN OF ACTION

This plan of action is being presented in phases to allow intense assessment of the feasibility and modality of local manufacturing of medicines in Africa.

PHASE I

It is recommended that Health Ministers are requested to appoint a committee of experts that will have regional and linguistic representation in the continent with the following expertise:-

i. Pharmaceutical production including technology transfer
ii. Health Economists
iii. Bio-engineers
iv. GMP Experts
v. Academia
vi. Epidemiologists
vii. Intellectual Property Rights and TRIPS
viii. Procurement
ix. African Traditional Medicine
x. Biotechnology
xi. Development partners in Health
xii. Legal

This group should be able to co-opt experts as and when necessary.

2. TERMS OF REFERENCE OF THE GROUP OF EXPERTS

1) Definition of regions
2) Mapping of pharmaceutical plants
3) Skills audit
4) Human resource needs identification
5) Infrastructure assessment
6) Identification of products to be manufactured by different regions
7) Level of manufacturing (primary, secondary, tertiary)
8) Market prospecting within the continent and beyond
9) Identify opportunities for new technological inventions
10) Financial resource needs.

3. The group should work with the support of AU Commission and present an informed plan of action to the Ministers of Health within six months.

TIME FRAME	April 2007 CAMH 3	May to October 2007	November 2007
ACTIVITIES	Appointment of group of experts with the following skills:- i. Pharmaceutical production including technology transfer ii. Health Economists iii. Bio-engineers iv. GMP Experts v. Academia vi. Epidemiologists vii. Intellectual Property Rights and TRIPS viii. Procurement ix. African Traditional Medicine x. Biotechnology xi. Development partners in Health xii. Legal	Group of experts does its work guided by (but not limited to) the following TORs 1. Definition of regions 2.Mapping of pharmaceutical plants 3.Skills audit 4.Human resource needs identification 5.Infrastructure assessment 6.Identification of products to be manufactured by different regions 7.Level of manufacturing (primary, secondary, tertiary) 8.Market prospecting within the continent and beyond 9.Identify opportunities for new technological inventions 10.Financial resource needs.	Report and submit informed plan of **Phase II** plan of action to Ministers.

REFERENCES

1. Kaplan, W. and Laing, R. Local Production of Pharmaceuticals: Industrial Policy and Access to Medicines – An overview of key concepts, issues and opportunities for future research. 2005, World Bank, HNP discussion paper, Human Development network.
2. Seiter, A., Pharmaceuticals: Local Manufacturing. 2005, World Bank, HNP#3 discussion paper. Human Development Network
3. AT Kearney Management Consultants Report, The Research-based Pharmaceutical Industry as a Chance for the Business Location Germany

EX.CL/354 (XI)
Annex IV

PLAN OF ACTION ON VIOLENCE PREVENTION IN AFRICA

AFRICAN UNION
الاتحاد الأفريقي

UNION AFRICAINE
UNIÃO AFRICANA

Addis Ababa, ETHIOPIA P. O. Box 3243 Telephone +251115-517700 Fax : +251115-517844
Website : www.africa-union.org

THIRD SESSION OF THE AFRICAN UNION CONFERENCE OF MINISTERS OF HEALTH 9– 13 APRIL 2007 JOHANNESBURG, SOUTH AFRICA

CAMH/MIN/8(III)

Theme: **"*Strengthening of Health Systems for Equity and Development in Africa"***

MINISTERS' MEETING
10-13 APRIL 2007

PLAN OF ACTION ON VIOLENCE PREVENTION IN AFRICA

PLAN OF ACTION ON VIOLENCE PREVENTION IN AFRICA

1.0 INTRODUCTION

1. Violence is an extremely complex phenomenon that has its roots in the interaction of many factors- biological, social, cultural, economic and political. Violence has been with us since time immemorial. War has made countries in Africa even more keenly aware of the importance of addressing the underlying causes of violence and ensuring that individuals, families, communities and societies are strengthened and supported in ways that will prevent all forms of violence. While there may be many different causes of violence one common feature of violence is the health effects it causes to millions of people in Africa. These effects include injuries, psychological and mental problems, disability and death.

2. It is now generally agreed that violence, especially one that results in physical and mental injuries, constitutes a human rights violation, and that it has the negative impact on the realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, as well as the enjoyment of other human rights as enshrined in the United Nations' Commission on Human Rights Resolution 2003. Among other things the Commission's Resolution highlighted the importance of enhancing the international community's response to violence by strengthening prevention efforts at the national level and through international cooperation and recommended that the General Assembly declare *2007 -The United Nations Year for Violence Prevention.* Similarly, the African Union has put prevention and reduction of violence among its top priorities as articulated in its Vision, Mission and Strategic Framework of 2004-2007. Moreover, earlier legal instrument such as the African Charter on Human and Peoples' Rights; the African Charter on the Rights and Welfare of the Child; and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa underline the need for addressing the issue of violence through appropriate policies and strategies.

3. Women and girls constitute the majority of the victims of violence. To address this particular social problem of women in Africa, Article 4, Sub-article 2 of "The Protocol to the African Charter on the Rights of Women in Africa (2003)"; urges Member States to:

a) enact and enforce laws to prohibit all forms of violence against women including unwanted or forced sex whether the violence takes place in private or public;

b) adopt such other legislative, administrative, social and economic measures as may be necessary to ensure the prevention, punishment and eradication of all forms of violence against women;

c) identify the causes and consequences of violence against women and take appropriate measures to prevent and eliminate such violence;

d) actively promote peace education through curricula and social communication in order to eradicate elements in traditional and cultural beliefs, practices and stereotypes which legitimize and exacerbate the persistence and tolerance of violence against women;

d) punish the perpetrators of violence against women and implement programmes for the rehabilitation of women victims;

f) establish mechanisms and accessible services for effective information, rehabilitation and reparation for victims of violence against women;

4. In order to prevent and limit violence there are, traditionally, religious, philosophical, legal and communal systems which have been put in place in almost every society. This demonstrates the society's conviction that violence can be prevented and its impact can be reduced. The factors that contribute to violent responses –whether they are factors of attitudes and behaviors or related to larger social, economic, political and cultural conditions –can be changed.

5. The public health approach to violence emphasizes collective action. Its cooperative efforts from such diverse sectors as health, education, social services, justice and policy are necessary to solve what are usually assumed to be purely medical problems. Each sector has an important role to play in addressing the problem of violence and collectively, the approaches taken by each have the potential to produce important reductions in violence. Investing in multi sectoral strategies for the prevention of interpersonal violence is not only a moral imperative but also makes sound scientific, economic, political and social sense, and that health sector leadership is both appropriate and essential given the clear public dimensions of the problem and its solutions.

1.1 DEFINITION OF VIOLENCE

6. **WHO** defines **violence** as "The intentional use of physical force or power, threatened or actual, against oneself, another person or group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation, excluded in the definition are unintentional injuries, such as Road traffic accidents and Burns." The nature of the violent acts can be physical, sexual, and psychological and may also involve deprivation and neglect.

7. As regards "Violence against women" the African Union Protocol to the African Charter on Human And Peoples' Rights on the Rights of Women in Africa defines the term "…all acts perpetrated against women which cause or could cause them physical, sexual, psychological, and economic harm, including the threat to take such acts; or to undertake the imposition of arbitrary restrictions on

or deprivation of fundamental freedoms in private or public life in peace time and during situations of armed conflicts or of war";

1.2 CAUSES OF VIOLENCE

8. As pointed out in the introductory paragraph, violence is an extremely complex phenomenon that has its roots in the interaction of many factors- biological, social, cultural, economic and political. Using the ecological model, the *World Report on Violence and Health*, tries to understand the multifaceted nature of violence. The model assists in examining factors that influence behavior or which increase the risk of committing or being a victim of violence- by dividing them into four levels.

- **Individual**- The first level identifies biological and personal history factors that influence how individuals behave and increase their likelihood of becoming a victim or perpetrator of violence. Factors that can be measured or traced include demographic characteristics (age, sex, education, income), psychological or personality disorders, substance abuse, victim of child maltreatment and a history of behaving aggressively or experiencing abuse.

- **Relationship**- The second level looks at close relationships such as those with family, friends, intimate partners and peers, and explores how these relationships increase the risk of being a victim or perpetrator of violence. Risk factors are poor parenting practices, marital discord, violent parental conflict, low socio economic status, and friends that engage in violence.

- **Community**- The third level explores the community contexts in which social relationships occur, such as schools, workplaces, and neighborhoods, and seek to identify the characteristics of these settings that increase the risk of violence. Factors such as poverty, high residential mobility, population density, high levels of unemployment or the existence of a local drug trade, high levels of crime, weak institutional policies and inadequate victims care services.

- **Societal** – the fourth level looks at the societal factors that help create a climate in which violence is encouraged or inhibited. These include the availability of weapons and social and cultural norms. Such norms that give priority to parental rights over child welfare, those that regard suicide as a matter of individual choice, those that entrench male dominance over women and children, those that support the use of excessive force by police against citizens and those that support political conflict. Larger societal factors also include the health, economic, educational and social policies that help to maintain economic or social inequalities between groups in society. So poverty, rapid social change, gender inequality, economic inequality, weak economic safety nets, high firearm availability, poor rule of the law, conflict and post conflict are important factors.

1.3 VIOLENCE AND HEALTH

10. The World Health Assembly resolution of 1996 (WHA49.25) recognized the increasing importance of violence as a leading worldwide public health problem and urged Member States to assess the problem within their own territory and communicate to WHO their information about this problem and requested the Director-General to initiate relevant public health activities to address the problem of violence.

11. Violence has many health effects which include injuries, psychological and mental problems, disability and death. There are four main areas where violence and HIV overlap:

- Forced sex may directly increase women's risk for HIV through physical trauma.
- Violence and threats of violence may limit women's ability to negotiate safe behavior.
- Sexual abuse as a child may lead to increased sexual risk taking as an adolescent/adult.
- Women who test for HIV and share the test results with partners may be at increased risk for violence.

1.4 AU COMMITMENTS

12. The First Session of African Union (AU) Conference of Ministers of Health, which took place in Tripoli, Libya in April 2003, considered the World Report on Violence and Health published by the World Health Organization in 2002 and made some recommendations to the Executive Council and Assembly in Maputo, Mozambique for adoption. The Executive Council endorsed the recommendations and requested AU Member States to declared **2005** as the "**African year of Prevention of Violence"**. The Executive Council further urged Member States to prioritize the development and implementation of multi-sectoral plans of action for the prevention of violence and enhanced systems for the collection of data on violence.

13. The AU has been a key partner in the continent and the AU Commission in collaboration with the WHO prepared a Draft Report on the Situation Analysis of Violence and Health in Africa which is yet to be finalized. The report analyzes the scope and magnitude of violence in the region and a reflection on what prevention initiatives exist. The report was also intended to provide the basis for a Continental Strategy for Violence Prevention and Control in Africa.

2.0 JUSTIFICATION

14. In addition to the positive benefits that effective violence prevention can have for the quality of individual, family, community and social life, the potential financial savings are also enormous. By establishing effective prevention measures, many aspects of life could be improved for populations from the money currently spent on treating the

consequences of violence. By improving care services for those who become victims of violence, much can be done to minimize the severity of their physical and psychological injuries and increase the likelihood that they can return to productive and fulfilling lives as true survivors.

3.0 OBJECTIVES

15. The overall goal of the Plan of Action is contribute to the improvement of health in Africa. Its objective is to enhance violence prevention and care of victims through raising awareness about the problem of violence in Africa, and to make the case that violence is preventable and that public health has a crucial role to play in addressing its causes and consequences. Strengthening the health care services system to deal with violence will also be a key component.

4.0 PREVENTION OF VIOLENCE

16.A major obstacle to violence prevention is simply an absence acknowledgment of the full extent of the violence problem. The idea that violence is a public health problem is new- and indeed rather contrary to the traditional belief that violence is not a crime punishable by law. The notion that violence is preventable is also new and may be questionable for some decision-makers. Not many decision-makers have seen the evidence that many forms of violence are preventable. Many of them feel that the traditional approaches of the criminal justice systems are the only ones that “work’. Such a view fails to acknowledge the range of violence in society. There is need for research to demonstrate that violence is preventable. Research can show that policy options for tackling violence exist.

17.Violence is an extremely emotional issue and many countries tend to be reluctant to take initiatives challenging long established attitudes or practices. It can take considerable political courage to try new approaches in areas such as policing and public security.

18.Whatever the case may be, there is a strong role to be played by government agencies, public health practitioners, academic institutions, nongovernmental organizations and international organizations, to help prevent violence and develop workable violence prevention strategies. Part of this role is advocacy, using education and evidence –based information. The other part is as a partner or consultant, helping to develop policies and design or implement interventions. Providing needed resources for the implementation of these interventions is still another area of consideration for concerned partners and stakeholders.

5. 0. CONFLICT PREVENTION

19. The effects of war on physical health are well documented, but the numbers of the dead and wounded is only the tip of the iceberg in as far as the impact of armed conflict on individuals is concerned. Wars lead to large-scale displacements, mainly involving the most vulnerable members of the population (women, children, the sick and

the elderly). It is also responsible for many forms of violence ranging from rape, body mutilations and destruction of essential infrastructure. Mortality rates for the displaced persons and refugees are 15 to 25 times higher than the corresponding rates in their places of origin.

20. A review of the available data on war and the health status in conflict and post-conflict situations reveal high maternal mortality, infant mortality, and malnutrition as major societal problems. In this context countries should endeavor to address the issue of conflict by, among other things, putting in place early warning systems and preparedness plans.

6. 0 MANAGEMENT AND CONTROL OF VIOLENCE

21. Strengthening the Health System to perform the following roles:

- **Minimizing harm**- when an act of violence cannot be prevented, high quality health services can minimize all forms of harm caused to the victim.

- **Victim Identification**-only when victims are known can comprehensive services be provide and harm mitigated. Harm will be reduced when the medical, psychological, social and legal needs are all met. This requires collaboration with other sectors.

- Treatment and Care for Victims – it is not enough to identify victims of violence; it is also essential to provide timely treatment – physical, social, psychiatric, and emotional. They also need to receive care, support and rehabilitation services. Some of the victims, for example those affected by rape and sexual assault, may require long-term treatment and care.

- Maintaining a data base- it is also essential to a complete record of cases, principal causes of violence and actions taken actions taken to

7. 0 KEY STRATEGIC AREAS

22. Experience has shown that it is important to conduct early and ongoing consultations with religious and traditional leaders, lay groups and prominent figures in the community in order to prevent and mitigate violence.

7.1. Strengthening National Commitment and Action

23. This may include:

1. Promote Gender equality and women's human right's, in line with relevant international treaties and human rights mechanisms, including women's access to property and assets, and expanding educational opportunities for girls and young women.

2. Enlist social, political, religious and other leaders in speaking out against violence.
3. Enhance capacity and establish systems for data collection to monitor violence and the attitudes and beliefs that perpetuate the practice.

24. Although support and care services for victims are important in mitigating the physical and psychological consequences of interpersonal violence and reducing individual vulnerability, considerable attention needs to be given to preventing the development and perpetration of violent behaviour in the first place.

25. Promoting the primary prevention of interpersonal violence involves encouraging and supporting the development, implementation and evaluation of programmes explicitly designed to stop its perpetration.

7.2. Primary Prevention of Violence

26. Under this section consideration should be given to the following:

1. **Investing in early interventions-** Prevention programmes targeted at children or those who influence them during early development, have the potential to shape the attitudes, knowledge and behaviour of children while they are more open to positive influences, and to affect lifelong behaviours. Pre-school enrichment and home visitation programmes, and school-based social development programmes that teach children social and problem- solving skills have been found to be effective in reducing youth violence.

2. **Increasing family involvement**- Inadequate monitoring, supervision and parental involvement in the activities of children and adolescents are well established risk factors for youth violence. There is evidence that a warm, supportive relationship with parents or other adults is protective against antisocial behaviour.

3. **Strengthening Communities**- The community is the environment in which individuals and families interact, and the extent to which it condones or censures violence and its associated risk behaviors (for example drunkenness) will be an important consideration in prevention efforts. Interventions to reduce the availability of alcohol, through restrictions on marketing approaches aimed at increasing alcohol consumption. Increasing the availability and quality of childcare facilities may help to promote healthy development and facilitate success in school, while the creation of safe routes for children on their way to and from school and to other activities in the community can prevent victimization.

4. **Discouraging harmful social and cultural practices**- it is important to address norms that associate violent behaviour with masculinity. Cultural norms can be a source of protection against violence, as in the case of

long held traditions that promote equality for women or respect for the elderly.

5. **Reducing income inequality-** The juxtaposition of extreme poverty with extreme wealth appears to be universally associated with interpersonal and collective violence.

6. **Improving the criminal justice and social welfare systems**- maintaining a fair and efficient criminal justice system contributes to the general deterrence of violence. Social welfare institutions that provide basic support for individuals and families in dire economic circumstances may serve to mitigate the effects of income inequality.

7.3. Promote Primary Prevention Strategies:

27. Here recommended actions will include, among others:

1. Develop, implement and monitor programmes aimed at primary prevention of violence. These should include sustained public awareness activities aimed at changing the attitudes, beliefs and values that condone violence as normal and prevent it being challenged or talked about.

2. Give higher priority to combating sexual abuse of girls and boys in public health programmes, as well as responses by other sectors such as the judiciary, education, and social services.

3. Integrate responses to violence against women into existing programmes for the prevention of HIV and AIDS, and for the promotion of adolescent health.

4. Make physical environments safer for women and children, through measures, such as identifying places where violence often occurs, improving lighting and increasing police and other vigilance.

5. Make schools safer, by involving education systems in anti violence efforts, including eradicating teacher violence as well as engaging in broader anti-violence efforts.

6. Develop a comprehensive health sector response to the various impacts of violence and in particular address the barriers and stigma that prevent abused persons to seek help. This includes supporting mental health services to address violence against women and children as an important underlying factor in women's mental health problems.

7. Use reproductive health services as entry points for identifying and supporting women in abusive relationships and for delivering referral or support services.

8. Strengthening formal and informal support systems for women living with violence.

9. Sensitize legal and justice systems to the particular needs of women victims of violence.

10. Support and promote further research on the causes and consequences of violence against women and on effective prevention measures.

7.4 Promote Social and Gender Equality and Equity to Prevent Violence

28.Unequal power relations are the main cause of violence. Gender and social inequalities and inequities, are related to many of the risk factors themselves, particularly at the societal level of the ecological model. They can exacerbate other risk factors across the ecological levels to facilitate conditions in which violence can thrive. Conversely increased equality and equity can multiply the effects of protective factors to reduce the level of violence.

29.Policy development and implementation can make important contributions to achieving social and gender equality and equity. Policy can both provide legal protection from discrimination and improve the access of groups to opportunities and resources. Though positive policy measures are one key step towards equitable social conditions, it is important to remember that inequities are not the result of poor policies alone, but also of discriminatory attitudes and social norms. Changing policy will have some impact on social norms, but the involvement and commitment of leaders and policy makers, along with public awareness campaigns, social marketing and other communications strategies, are often required to bring about sustained efforts for social change.

30.Social policies are those policies that establish welfare and social protection programmes to safeguard the well being of citizens; and may be directed either at the general public or at certain groups(such as the young and the elderly).
Outcomes of social policy that are particularly relevant to violence prevention due to their bearing on cross cutting risk factors include:

- Increased access to and quality of early childhood education and care

- Improved access to primary and secondary education, including adequate resource allocation for education;

- Reduced unemployment rates;

- Stronger social- protection systems(for example, social security for the elderly and disabled, health insurance, child care, income and /or food supplementation, and unemployment benefits).

7.5 Develop/Implement Appropriate Gender & Youth Policies

31.In addition to being essential for fulfilling human rights, especially women's human rights, promoting gender equality and equity is a critical component of violence prevention. Discrimination based on gender and unfair distribution of opportunities, power and resources between and among men and women are underlying causes of interpersonal violence. Violence against women (VAW) cuts across all types of interpersonal violence and must be addressed as a component of gender inequality and inequity. VAW is not only a manifestation of unequal power relations between men and women; it is a mechanism for perpetuating inequality. The violence directed at women and girls, often because they are female, can prevent them from obtaining equal status and full enjoyment of their human rights. As stated in the Beijing Platform for Action, fear of this violence can function as a barrier that limits women's access to opportunities and resources. Specific measures to address and eliminate VAW should be incorporated into any strategy for the promotion of gender equality and equity.

7.6. Advocacy for Effective Social and Gender Policies

32.Promoting social and gender equality and equity through social and gender policy requires convincing decision makers to implement policies that may take years to bring about the desired results. Advocates need to understand what type of arguments and rationales motivate decision –makers responsible for these policy areas and to tailor their strategy accordingly with a mixture of human rights, health and cost/benefits arguments. To understand this, it is important to understand the local context within which policy is created, adopted and implemented by the government as well as the social and political environment.

7.7. Strengthening Support and Care Services for Victims

33. In addition to promoting the primary prevention approaches to interpersonal violence, providing quality support and care services to victims are an essential component of any response to interpersonal violence. Appropriate services for victims of non-fatal violence can prevent future fatalities, reduce the amount of short-term and long-term disability, and help those affected to cope with the impact of violence on their lives. The specific aims of strengthening such services are to:

- Treat injuries and minimize harm and suffering in both short-term and long-term;

- Reduce the likelihood of secondary victimization- both intentional and unintentional- by service providers;

- Facilitate redress through criminal justice system where possible;

- Reduce the likelihood that individuals will suffer repeat victimization in the future and the likelihood that victims themselves will become perpetrators.

7.8. Research and Information

34. It is extremely important to base policies and actions on solid evidence through:

- Conducting and disseminating public health oriented research into the extent, causes and consequences of violence and injuries;

- Encouraging research to identify, support and develop best practice examples for primary prevention and for victim support and care services;

- Building capacity among African researchers to address violence and injuries.

7.9. Monitoring and Evaluation

35. Appropriate monitoring and evaluation mechanisms and instruments should be put in place to track progress and status of implementation by Member States, development partners and all stakeholders.

8.0 ROLES OF DIFFERENT INSTITUTIONS

36. The complex nature of violence necessitates concerted efforts by various actors and stakeholder in its prevention, protection and reduction of the negative impacts of violence on health and overall social security.

8.1. Member States

- Member States have the responsibility to translate the plans into concrete actions and to reduce the impact of violence on public health;

- They need to put adequate resources for the prevention and elimination of causes of violence;

- Member States and civil society organizations should monitor and evaluate national level performances in the control of all forms of violence

8.2. Role of the African Union (AU) and Regional Economic Communities (RECS)

37. As umbrella continental organizations the AU and the RECs will continue to:

- the advocate for the adoption and implementation of the strategy for violence prevention

- monitor and evaluate progress

- compile and disseminate best practices and create forum for the sharing of experiences and best practices;

- mobilize political will and create enabling environment for the mobilization of needed resources;

8.3. Development Partners

- Development partners including WHO, UNFPA, ICRC, and other UN agencies can provide technical, financial and expertise assistance to Member States, RECs and other stakeholders.

- The necessary enabling conditions should be created in order for development partners to play supportive role.

ANNEX 1:

GUIDELINES FOR DEVELOPING A NATIONAL PLAN OF ACTION FOR VIOLENCE PREVENTION

A National plan of Action for preventing violence and improving care and support is the blueprint that provides the different sectors involved with a set of common goals, a shared time frame, a strategy for coordinating activities, and a framework for evaluation. Such a national plan is therefore the key to organizing national and community –level interventions that involve more than one objective and which depend upon the input of participants from different sectors.

In most countries health authorities carry the main responsibility of health promotion and diseases prevention. It is therefore desirable that wherever possible the health ministry should take the lead in developing a national plan of action, while at the same time facilitating multi-sectoral involvement with the other main stakeholders.

The content of a national plan of action refers to the precise activity areas and topics addressed and this must reflect local realities, as well as developments in the understanding and prevention of violence. It is important to consider the five recommendations of the World Report on Violence and Health as the potential activity areas. These recommendations are:

- Increasing the capacity for collecting data on violence;
- Researching violence-its causes, consequences, and prevention;
- Promoting the primary prevention of violence;
- Promoting Social and Gender equality and equity to prevent violence;
- Strengthening support and care services for victims.

A Plan of Action should specify goals for each of the activity areas above, objectives and strategies for achieving them, and measurable progress indicators. Any effective national plan of action is likely to be multi-sectoral, developing inter-sectoral leadership in violence prevention across all levels of the programme. To facilitate efficient and meaningful collaboration, the plan of action must clearly identify the roles and responsibilities of each stakeholder in each one of these activity areas. For instance, an inter-ministerial task force for the prevention of violence could be formally established through an agreement that obliges different ministries to collaborate in the prevention of violence under the overall leadership of the Ministry of Health.

ACTION STEPS IN DEVELOPING A NATIONAL PLAN OF ACTION

No matter which stage a country has reached on the violence prevention path, a national plan of action can be developed. The primary resource requirement is a small unit preferably with an influential individual within the Government (preferably within the Health Ministry) or a Government –contracted consultant specific terms of reference to implement the following Action Steps:

1. Identify and consult Key stakeholders
2. Draft a national situational analysis an violence and health
3. Convene a national consultative conference
4. Revise and finalize the plan of action
5. Obtain endorsement for the plan of action
6. Implement, monitor and report on the progress.

The important message is that both multi-sectoral involvement and clear leadership are essential to the success of national efforts to prevent violence. As with every new public health challenge, initially there will be resistance on the ground to implement the suggestions that might be made. It might be argued that they will cost too much and cannot be contemplated in the face of more important health priorities such as HIV/AIDS, Malaria or Tuberculosis.

EX.CL/354 (XI)
Annex V

THE MONITORING AND REPORTING MECHANISM FOR THE IMPLEMENTATION OF THE 2006 ABUJA COMMITMENTS ON HIV/AIDS, TUBERCULOSIS AND MALARIA (ATM) SERVICES

AFRICAN UNION **UNION AFRICAINE**

الاتحاد الأفريقي

UNIÃO AFRICANA

Addis Ababa, ETHIOPIA P. O. Box 3243 Telephone 251115-517700 Fax: 251115-517844
Website: www.africa-union.org

THIRD SESSION OF THE AFRICAN UNION CONFERENCE OF MINISTERS OF HEALTH JOHANNESBURG, SOUTH AFRICA 9– 13 APRIL 2007

CAMH/MIN/9 (III)

Theme: **"*Strengthening of Health Systems for Equity and Development in Africa"***

MINISTERS' MEETING 10-13 APRIL 2007

MONITORING AND REPORTING MECHANISM FOR THE IMPLEMENTATION OF THE 2006 ABUJA COMMITMENTS ON HIV/AIDS, TUBERCULOSIS AND MALARIA (ATM) SERVICES, (2007 – 2010)

List of Acronyms

ACT	Artemisenin-based combination therapy
ADB	African Development Bank
AFRO	African Regional Office
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
ATM	HIV/AIDS, Tuberculosis and Malaria
AU	African Union
AUC	African Union Commission
AWA	AIDS Watch Africa
CSOs	Civil Society Organizations
DOTS	Directly Observed Treatment, Short course
ECA	Economic Commission for Africa
EMRO	Eastern and Mediterranean Regional Office
GFATM	Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IPT	Intermittent prevention therapy
ITN	Insecticide Treated Nets
MAP	Multicountry AIDS Programmes
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
NEPAD	New Partnership for African Development
NGOs	Non Governmental Organizations
OAU	Organization of Africa Unity
ORID	Other Related Infectious Diseases
PEDA	Population, Environment, Development and Agriculture
PEPFAR	US President's Emergency Fund for HIV/AIDS Relief
PLWHA	People Living With HIV/AIDS
RBM	Roll Back Malaria
RECs	Regional Economic Communities
RHOs	Regional Health Organizations
TB	Tuberculosis
TRIPS	Trade Related aspects of Intellectual Property Rights
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
WFP	World Health Organization
WHO	World Health Organization
WTO	World Trade Organization

MONITORING AND REPORTING MECHANISM FOR THE IMPLEMENTATION OF THE 2006 ABUJA COMMITMENTS ON HIV/AIDS, TUBERCULOSIS AND MALARIA SERVICES, (2007-2010)

EXECUTIVE SUMMARY

This document provides the Monitoring and Reporting Mechanism for the African Union Assembly mandate on scaling up towards Universal Access to HIV/AIDS, TB and Malaria services in Africa by 2010 from the Abuja, Nigeria Special Summit on HIV/AIDS, Tuberculosis and Malaria, 2-4 May 2006. The theme of the Special Summit was "***Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by 2010***". The purpose of this Mechanism is to provide a design that would guide the role of Member States, the African Union Commission (AUC), Regional Economic Communities (RECs), Regional Health Organizations (RHOs), Development Partners (bilateral and multilateral organizations), and the Civil Society and the Private Sector in translating the decisions of the Heads of State and Government at the Abuja 2006 Special Summit into action; and then report back to the AU Assembly.

1. ***At the Special Summit, African Heads of State and Government adopted the following commitments:***

   (a) Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis and Malaria (ATM) Services in Africa.

   (b) Africa's Common Position to the June 2006 UN General Assembly Special Session on AIDS; together with the Brazzaville Commitment on Scaling up Towards Universal Access to HIV/AIDS Prevention, Treatment, Care and Support by 2010 (4-6 March 2006)

   (c) The Continental Framework for Harmonization of Approaches and Policies on Human Rights and People Infected and Affected by HIV/AIDS.

The Monitoring and Reporting Mechanism on the implementation of commitments on HIV/AIDS, Tuberculosis and Malaria provides a strategic operational framework for the Abuja 2006 Special Summit, identifies broad responsibilities for each stakeholder and provides outlines of implementation activities for program priorities established by the Heads of State and Government at the Abuja 2006Summit. This document also identifies agencies or organizations that will support Member States in implementation activities. This document also includes benchmarks and timelines that will guide the implementation of Abuja Commitments by Member States.

2. The document comprises six sections:

   Section 1 discusses an overview of HIV/AIDS, TB and Malaria in Africa, the operational framework and the cross-cutting implementation, monitoring and reporting issues that apply to all stakeholders in the quest for universal access to remedial services for the three diseases.
   Section Two briefly describes the continental monitoring and reporting mechanism of commitments on HIV/AIDS, TB and Malaria. **Section Three** describes the implementation, monitoring and reporting activities, responsibility centres for each program priority and benchmarks and time lines for the envisaged role of stakeholders, 2007 through 2010.
   Section Four outlines the special need for adequate resource mobilization at various levels.
   Section Five provides an operational framework for the technical role of the AU and its organs and programmes.
   Section Six includes annexes to this document and a list of selected bibliography.

3. Following the adoption of the Mechanism, stakeholders are urged to play their role and prepare progress reports accordingly, the first one in 2008 and the second at the end of 2009, in preparation for the comprehensive review of 2010.

MONITORING AND REPORTING MECHANISM FOR THE IMPLEMENTATION OF THE 2006 ABUJA COMMITMENTS ON HIV/AIDS, TUBERCULOSIS AND MALARIA SERVICES, (2007-2010)

SECTION 1: BACKGROUND

1.1 Purpose of This Document

1. This document provides the Mechanism for Monitoring and Reporting on the African Union Assembly mandate on HIV/AIDS, TB and Malaria Services in Africa by 2010; from the Abuja, Nigeria Special Summit on HIV/AIDS, Tuberculosis and Malaria, 2-4 May 2006. At this Special Summit, African Heads of State and Government adopted the following commitments:

a) Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis and Malaria (ATM) Services in Africa.;

b) Africa's Common Position to the June 2006 UN General Assembly Special Session on AIDS; together with the Brazzaville Commitment for Accelerated Action on Scaling up Towards Universal Access to HIV/AIDS Prevention, Treatment, Care and Support in Africa by 2010;

c) The Continental Framework for Harmonization of Approaches and Policies on Human Rights and People Infected and Affected by HIV/AIDS.

2. The purpose of this Mechanism is to guide the role of Member States, the African Union Commission (AUC), Regional Economic Communities (RECs), Development Partners (bilateral and multilateral organizations), and, the Civil Society and the Private Sector in translating the decisions of the Heads of State and Government at the Abuja 2006 Special Summit into action. It provides a strategic operational framework for the Abuja 2006 Special Summit commitments, identifies broad responsibilities for each stakeholder and provides outlines of implementation activities for program priorities established by the Heads of State and Government in the Abuja 2006 Call. It also identifies agencies or organizations that will lead implementation activities. The Mechanism also includes benchmarks and timelines that will guide the monitoring and reporting on the implementation of the Abuja commitments. It is not intended to supplant or replace the responsibilities of Member States to meet the unique needs of their citizens regarding universal access to HIV/AIDS, TB and Malaria services. However, as noted by Heads of State and Government at the 2006 Abuja Special Summit, the continent can only achieve its objectives if and when various stakeholders at Member State, regional, continental and global levels work together, towards common goals and objectives.

3. This document comprises of the following major sections:

Section 1 discusses an overview of HIV/AIDS, TB and Malaria in Africa, the operational framework for action as mandated by Heads of State and Government at the Abuja 2006 Special Summit and the cross-cutting implementation issues that apply to all stakeholders in the quest for universal access to remedial services for the three diseases.

Section Two briefly describes the continental Monitoring and Reporting Mechanism for HIV/AIDS, TB and Malaria as directed by the Heads of State and Government at the Abuja 2006 Special Summit.

Section Three describes the implementation, monitoring and reporting activities, responsibility centres for each program priority and benchmarks and timelines for the envisaged role of the AU and its organs, Member States, RECs and RHOs Development Partners, the Civil Society and the Private Sector, 2007 through 2010.

Section Four outlines the special need for adequate resource mobilization and proposed parameters for resource mobilization at national and international levels.

Section Five provides an operational framework for the technical role of the AU Commission and other AU Organs and Programmes as they fulfill their mandate of monitoring and reporting on the Implementation plan, including the AU Assembly mandated reviews in 2008 and 2010.

Section Six includes annexes to this document (and a list of selected bibliography) for the background work on the Mechanism. For a complete list of the African Union position papers, resolutions and platforms, readers should consult the African Union Commission website, the Department of Social Affairs or the Conference Services Directorate.

1.2 Situational Analysis

4. The Heads of State and Government at the Abuja 2006 Special Summit on HIV/AIDS, TB and Malaria noted as follows:

a) Countries south of the Sahara constitute 10% of the global population but account for more than 60% of the estimated HIV infected people in the world. Africa accounts for 77.4% of AIDS death worldwide and 90% of all AIDS orphans (0-17 years of age) in the world.

b) Africa accounts for more than 25% of all TB reported cases in the world and is the only region in the world where TB incidence rates are increasing despite the availability of effective TB control strategies and implementation

programs. More than 600,000 people die of TB in Africa and at least 2 million contract TB every year.

c) Malaria is the number one killer of children in Africa. Most childhood Malaria deaths in Africa are eminently preventable if parents had access to prompt diagnosis and treatment. Africa accounts for almost 90% of the estimated 500 million malarial episodes reported every year, worldwide. At least one million people die in Tropical Africa of Malaria, representing more than 90% of all global deaths from the disease**.**

d) Women and children in Africa remain particularly vulnerable to HIV/AIDS, TB and Malaria. African women have the highest rates of HIV/AIDS, TB and Malaria compared to their counterparts in other regions of the world.

1.3 Progress in the Fight Against HIV/AIDS, TB and Malaria

5. Heads of State and Government at the Abuja 2006 Special Summit noted that the continent and Member States have made progress in the fight against HIV/AIDS, TB and Malaria. They noted progress made since the Millennium Declaration of 2000 and on its Millennium Development Goals, the Abuja Declarations and Plans of Action of 2000 and 2001, and, the UNGASS Declaration of Commitments on HIV/AIDS in 2001. They also noted the remarkable progress made at national levels by governments, the civil society, the private sector and development partners in the design and implementation of national strategies against HIV/AIDS, TB and Malaria.

6. The African Union Commission developed its HIV/AIDS Strategic Plan for 2005-2007 and convened and coordinated the adoption of the continental framework on the harmonization and integration of the rights of people living with HIV/AIDS in national policies. The AU Commission also developed an action plan on the AIDS Watch Africa Strategic Plan Framework.

7. The AU Assembly at the Maputo 2003 Summit reaffirmed the Abuja 2000 and 2001 declarations on HIV/AIDS, TB and Malaria and in July 2004 adopted the 2004 Solemn Declaration on Gender Equality in Africa. In 2005, the AU Assembly focused deliberations on HIV/AIDS, TB, Malaria and Polio and urged Member States to take a leading role in the World Trade Organization negotiations on Trade-Related Aspects of Intellectual Property Rights (TRIPS). Regional Economic Communities (RECs) in Africa are working towards the integration of health and social issues in their development strategies and are also working to harmonize development assistance in Member States. The RECs have also taken the lead on cross border cooperation issues and the coordination of migrants, displaced persons and refugee services within the borders of Member States.

8. The WHO Africa Regional Committee declared 2006 the Year for HIV Prevention and also declared a TB emergency. In addition, the WHO Africa Regional Office in November 2006 released the first ever-comprehensive Africa Regional Health Report.

The AU Conference of Ministers of Health adopted in 2005 the Gaborone Declaration on a "*Roadmap Towards Universal Access to Prevention, Care and Treatment"* and reiterated their commitment to the allocation of 15 percent of national budgets to the health sector. In March 2006, representatives from 51 Member States of AU, including Ministers, representatives of the private sector and the civil society adopted the *"Brazzaville Commitment on Scaling Up Towards Universal Access for HIV and AIDS"* in Africa until 2010. This was Africa's contribution to the Global Task Team on Scaling up Towards Universal Access to HIV/AIDS services by 2010.

9. The AU Commission and Member States participate actively in international meetings and forums on HIV/AIDS, TB and Malaria. Many Member States now receive significant support from the Global Fund against AIDS, TB and Malaria (GFATM), the US President's Fund for HIV/AIDS Relief Program (PEPFAR), the World Bank Multi Country AIDS Program (MAP) and other support from bilateral and multilateral agencies.

10. Heads of State and Government at the Abuja 2006 Special Summit also noted that:

a) Leadership against HIV/AIDS, TB and Malaria is now consolidated at national and continental levels. Since 2001, about 50% of African countries have declared HIV/AIDS an emergency. In 2005, African Health Ministers declared TB an emergency. At least 85% of all African countries have either established or strengthened national coordinating agencies for HIV/AIDS, TB and Malaria. Most of the Member States of AU have national policies and guidelines on HIV/AIDS, TB and Malaria;

b) Proportion of national budgets devoted to the health sector is increasing since 2001. At least 33% of Member States have national budgets that allocated at least 10% of all expenditure to the health sector. One country, Botswana, reportedly attained and surpassed the Abuja 2001 benchmark of 15% of national budgets allocated to the health sector;

c) On Malaria control efforts, 29 countries adopted the World Health Organization recommended Intermittent Preventive Treatment (IPT). At least 9 Member States are implementing Artemisinin-based Combination Therapy, with four countries rolling out nationwide programs;

d) On HIV prevention and AIDS clinical care strategies, 3 countries have surpassed the WHO "3 by 5" target of putting at least 50% of individuals that need antiretroviral therapy (ART) on needed drugs by the end of 2005. In addition, at least 5 countries are now locally producing antiretroviral drugs (ARVs). Many countries are reportedly planning local production of ARVs;

e) On TB care and support, most African countries have shown improvement in the rate of Directly Observed Treatment Short Course (DOTS) coverage. Most Member States have access to TB drugs through the Global Drug

Facility. At least 50% of Member States now have property and supply management (PSM) systems in place;

f) National partnership forums that bring together the public sector, the private sector and the civil society now exist in at least 50% of all Member States. Networks of People Living with HIV/AIDS exist in 64% of all Member States.

11. For complete details on the progress made by Africa as a whole since 2000 on HIV/AIDS, TB and Malaria, kindly refer to the website of the Africa Union Commission or contact relevant staff of the Department of Social Affairs of the Commission.

1.3 Challenges to Achieving Universal Access to HIV/AIDS, TB and Malaria Services

12. A fundamental challenge to achieving universal access to HIV/AIDS, TB and Malaria is lack of commensurate resources. Two thirds of African countries are spending below 10% of their national budget on health. Even if all African countries meet the target of 15% national budget allocation to health set in Abuja 2001, more than half of all African countries will still miss the US$34 per capita estimated as the minimum amount needed for better health by the WHO Commission on Macroeconomics and Health (CMH). Although Africa accounts for more than 60% of individuals living with HIV/AIDS in the world, AIDS spending in Africa accounts for 6-10% of all global expenditure on the pandemic. The UNAIDS estimates that Africa needs 80% external support to meet its HIV/AIDS funding requirements.

13. The Heads of State and Government at the Abuja 2006 Summit identified the following major challenges and obstacles to accelerated action that can lead to universal access to HIV and AIDS, Tuberculosis and Malaria services in Africa:

- The triple burden of diseases including non-communicable diseases and injuries;
- The difficulty in ensuring predictable and sustainable financing for HIV, tuberculosis and Malaria services;
- Weak planning partly because of lack of institutional and human resource capacity at national level;
- The health crisis reflected in terms of weak health systems, infrastructures, inadequate laboratory network for diagnosis of diseases, human resources crisis in terms of numbers, mix of skills, motivation and retention, leading to major barriers to the implementation of disease control programmes in general and HIV and AIDS, TB and Malaria programmes, in particular;
- Inadequate access to essential medicines, preventative commodities and technologies across much of the continent; inadequate global supply of long lasting Insecticide Treated Nets (ITNs) and Artemisinin-based Combination Therapy (ACTs); and limited indoor residual spraying (IRS) with effective insecticides;

- Lack of adequate policies and legislation protecting the human rights of people living with HIV/AIDS (PLWHA) and TB by most countries;
- Failure to take into account the link between HIV and AIDS and sexual and reproductive health;
- Stigma, discrimination and gender inequity, which result in inadequate protection of the human rights of people infected or affected by HIV and AIDS and directly hampers their ability to access services;
- Poor or inadequate coordination of regional and national and international partnerships;
- Weak monitoring and evaluation (M&E) systems and cumbersome M&E mechanism for the Abuja Declaration on HIV and AIDS and TB and Malaria;
- Conflicts that result in mass displacement, violence, loss of livelihood and property as well as major breakdowns in essential services;
- Other cross-cutting issues such as ensuring good nutrition and food security, and internal and inter-country migration for reasons other than conflicts;
- Policy planning and programming for addressing health in national development mechanisms by most countries which is reflected by inadequate health system development, low coverage and access to services for the three diseases; and,
- An increasing burden of disease and other development challenges.

14. In addition, the coordination of external donor support is now widely considered an extremely important issue by international development partners. Member States need to work closely with Development Partners on needs assessment priority setting and the implementation of appropriate interventions. The role of the private sector as technical, financial and logistic resource is critical in Member States, even among countries with significant resource challenges. The private sector can work with national governments on resource mobilization, logistics of care and the implementation of services for defined populations. The involvement of the civil society during the conceptualisation, design, monitoring and evaluation of policies and programmes is extremely important in assuring buy-in by target communities and in ensuring the sustainability of viable programs.

SECTION 2: MONITORING AND REPORTING MECHANISM FOR THE IMPLEMENTATION OF THE 2006 ABUJA COMMITMENTS ON HIV/AIDS, TB AND MALARIA

2.1: Overview of the Monitoring and Reporting Mechanism

15. The Abuja 2006 Special Summit focused on the theme: *"Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by 2010."* The main objective of the Special Summit was to review the status of implementation of the Declarations and Mechanisms for Action on the 2000 Abuja Summit on Roll Back Malaria, and the 2001 Abuja Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (ORID), and to adopt a renewed commitment for halting and then reversing the impact of these diseases by ensuring universal access to services. At this Special Summit, Heads of State and Government expressed concern about the continued morbidity, mortality and debility

attributed to HIV/AIDS, TB and Malaria. They also noted the role of the three diseases in the intensification of poverty, marginalization, vulnerability and gender inequalities in the continent. They further directed the AU Commission to develop an implementation plan for achieving universal access to HIV/AIDS, TB and Malaria services in Africa by 2010.

2.2: The Monitoring and Reporting Mechanism

16. At the Abuja 2006 Special Summit on HIV/AIDS, TB and Malaria, Heads of State re-declared a state of emergency regarding the three diseases and collectively resolved to dedicate themselves and their countries to a comprehensive remedial effort anchored on an implementation mechanism that addresses the following program areas:

2.2.1: Leadership at National, Regional and continental Levels

a. To intensify the practical leadership role at national, regional, and Continental levels to mobilize society as a whole to fight HIV and AIDS, TB, and Malaria more effectively;

2.2.2: Resource Mobilization

b. To mobilize local resources for sustainable and predictable financing, including the implementation of the Abuja 2001 Declaration Call for devoting 15% of the National Budget to health and to strengthen collaboration with national and international partners to mobilize adequate financial resources to fight the epidemics; and to ensure that financial resources mobilized to fight all the three epidemics can actually be spent by the removal of the medium-term expenditure ceilings on public spending imposed on African countries by the International Financing Institutions.

c. To negotiate for debt cancellation and the availability of grants at national and regional levels that would specifically be targeted at financing prevention, treatment, care and support of the three diseases.

d. To undertake collective advocacy with multi-lateral and bilateral donors to end all conditionalities except normal fiduciary requirements;

2.2.3: Protection of Human Rights

- To continue promoting an enabling policy, legal and social environment that promotes human rights particularly for women, the elderly, youth and children and to ensure the protection of people infected and affected by HIV and AIDS, TB and Malaria and to reduce vulnerability and marginalization including older people who care for AIDS orphans and vulnerable children, conflict-affected and displaced persons, refugees and returnees;

- To adapt national legislation taking cognisance of HIV and AIDS and TB issues, specifically discrimination and stigmatisation of those infected and affected, and, to encourage Member States to ratify relevant International Conventions such as the Convention on Discrimination and Employment.

- To enact or repeal laws and policies related to gender and human rights in order to align them with AU frameworks including the Solemn Declaration on Gender Equality in Africa, the AU Protocol on the Rights of Women in Africa, the AU Policy Mechanism and Plan of action on Ageing and the Youth Charter.

2.2.4: Poverty Reduction, Health and Development

- To ensure the integration of HIV and AIDS, TB and Malaria programmes into Poverty Reduction Strategies and Programmes and country programmes; and, consequently to ensure access to adequate nutrition and food security by pursuing the realization of an integrated African food production, storage and distribution plan and other social protection measures, including adequate social security schemes to address sustainability of treatment as well as treatment, care and support; ensuring community involvement and participation.

2.2.5: Strengthening Health Systems

- To strengthen health systems and build on existing structures (infrastructure, human resource, financing, supplies and other issues) for scaling up and accelerating Universal Access to prevention, treatment, care and support for HIV and AIDS, TB and Malaria;

- To strengthen data management and surveillance, including disaggregating data by age and gender to include children below 15 and people over 50;

- To meet WHO standards for doctors and nurses

2.2.6: Prevention, Treatment, Care and Support

- To invest heavily in evidence-based prevention as the most cost-effective intervention with focus on young people, women, girls and other vulnerable groups.

- To ensure access to a comprehensive package of prevention interventions for the prevention of primary and secondary infections with HIV and AIDS, and sexually transmitted infections (STIs) (including post-exposure prophylaxis following sexual violence), TB and Malaria, reduction of vulnerability to HIV and AIDS, TB and Malaria;

- To ensure the promotion and integration of access to prevention treatment, care and support in primary health care services, and in education institutions;

- To improve information, education and communication;

- To disseminate, correct, reader-friendly information on prevention, treatment, care and support on HIV and AIDS, malaria and tuberculosis;

- To ensure universal access to male and female condoms for all sexually active persons;

- To integrate HIV and AIDS issues into ongoing immunization programmes and sexual and reproductive health programmes, and conversely sexually and reproductive health issues into HIV and AIDS programmes;

- To awaken traditional values on abstinence but continually increase condom use.

2.2.7: Access to Affordable Medicines and Technologies

- To enact and utilize appropriate legislation and international trade regulations and flexibilities to ensure the availability of medicines and commodities at affordable prices as well as technologies for the treatment, care and prevention of HIV and AIDS, TB and Malaria, including vaccines, medicines and Anti-retrovirus Therapy (ART);
- To promote regional bulk purchase and local production of generic medicines and other commodities;
- To support work on regional local production of generic ARV drugs.

2.2.8: Research and Development

- To promote and support research and development of microbicides, vaccines, diagnostics and treatment for HIV and AIDS, TB and Malaria, including traditional medicine;

- To monitor drug resistance in the treatment of HIV and AIDS, Tuberculosis and Malaria;

- To conduct Demographic and Health Surveys every five years;

- To implement research ethics including for HIV and AIDS;

- To conduct regular national incidence surveys on HIV.

2.2.9: Implementation at national level

- To enhance and support implementation of comprehensive strategic programmes at country and regional levels against HIV and AIDS, TB and Malaria;

- To implement prevention programs against multi-drug resistant TB;

- To accelerate Malaria control programmes with a goal to eliminate Malaria using all effective strategies such as indoor residual spraying, insecticide treated bed nets, Artemisenin Combination Therapy (ACTs) and Intermittent Presumptive Therapy (IPT);

- To implement the Three-Ones (one executing authority, one Plan of Action and one Monitoring and Evaluation Plan) for HIV and AIDS, Tuberculosis and Malaria.

2.2.10: Partnerships

- To further develop and support comprehensive frameworks and mechanisms of well-coordinated partnerships, particularly public, private, civil society, regional and international partnerships, including donors, to promote universal access to prevention, treatment, care and support for HIV and AIDS, TB and Malaria;

2.2.11: Monitoring, Evaluation and Reporting

- To strengthen collaboration with all relevant stakeholders particularly Civil Society partners affected by the three diseases and to enhance planning, monitoring and evaluation and generation of information for quality assurance purposes, sustainability and accountability of programmes, and for advocacy;

- To ensure networking and sharing of best practices and to submit progress reports regularly to appropriate Organs of the AU;

- To undertake to strengthen implementation of NEPAD Health Strategy to fight poverty and under-development.

2.2.12: The **coordinating role of Ministries of Health, National AIDS Councils or Equivalent and Ministries of Finance and Economic Planning** in the realization of a multi-sectoral and integrated approach to disease control, in collaboration with other Sectors, including the involvement of the community in the planning and implementation.

2.2.13: A strong commitment to the implementation of the recommendations and action points enshrined in the "*Brazzaville Commitment on Scaling up Universal Access to HIV and AIDS Prevention, Treatment, Care and Support*"; and to extend these to TB, Malaria and other prevailing diseases.

SECTION 3: IMPLEMENTATION AND MONITORING ACTIVITIES, RESPONSIBILITIES, BENCHMARKS AND TIMELINES

17. Heads of State and Government at the Abuja 2006 Special Summit requested continent wide consultative reviews on the implementation after two years (2008) and five years (2010). The African Union Commission is coordinating the 2008 and 2010 reviews. Heads of States and Government also identified broad roles for the African Union Commission, Member States, Regional Economic Communities, Development Partners and the Civil Society and the Private Sector in the implementation, monitoring and follow up on the Abuja 2006 Commitments.

18. For the rest of this section, each stakeholder in the implementation, monitoring and reporting on the Abuja 2006 Outcomes will have identified related activities, identified agencies or organizations responsible for these activities, and appropriate benchmarks and timelines for monitoring and evaluating proposed implementation activities. A major focus of activity will be on the need for each stakeholder to participate in the AU Commission directed reviews in 2008 and 2010 mandated by Heads of State at the Abuja 2006 Special Summit.

3.1: The Role of the AU Commission and AU Organs in the Monitoring and Reporting Mechanism

3.1.1: Effectively implement the AU Commission HIV/ AIDS Strategic Plan and the AIDS Watch Africa (AWA) Strategic Framework

Implementation Activities:

19. The AU Social Affairs Commission will ensure the implementation of all goals and objectives of the AU Commission HIV/AIDS Strategic Plan, 2005-2007 and AIDS Watch Africa Strategic Framework, 2005-2007; in collaboration with other Departments, Programmes and AU Organs. The close linkage between HIV/AIDS, TB an d Malaria will be emphasised.

Responsibility Centres*:*

20. AU Commissioner for Social Affairs; AU Head of Health; AU Head of HIV/AIDS, TB and Malaria and AWA Coordinator.

Benchmarks and Timelines:

21. Completion of the objectives set out in the AU Commission HIV/AIDS Strategic Plan and AWA Strategic Framework by December 2007. A review will be undertaken and follow up actions for 2008 and beyond planned.

3.1.2: Promote regional integration and collaboration in the areas of Disease Control

Implementation Activities:

22. The AU Commission will organize an annual high level meeting of the major Regional Institutions, the African Development Bank (ADB), the UN Economic Commission for Africa (ECA) and the World Health Organization Africa Region and UNAIDS to discuss, review and implement regional integration and collaboration initiatives.

Responsibility Centres:

23. AU Commissioner for Social Affairs, Office of the AU Commission Chairperson.

Benchmarks and Timelines:

24. AU Commission will organize two high level meetings with RECs, Regional Health Organizations, ADB, ECA, WHO and UNAIDS before the 2008 AU Assembly mandated review and two more meetings before the 2010 review on regional integration and collaboration issues; AU Commission will establish a technical working group of the regional institutions on disease control by June 2007; The technical working group on disease control will design a joint technical plan on disease prevention and control in Africa by April 2008; The AU Commission will present the joint technical plan on disease prevention and control to the AU Assembly by December 2008 for review and approval; Member States to begin implementation of the continental plan on disease prevention and control by July 2009; AU Commission to include progress report on disease control in the AU Assembly mandated review of 2010.

3.1.3: Integration of HIV/AIDS, Tuberculosis and Malaria in the Africa Health Strategy

Implementation Activities:

25. The African Union Health Ministers have adopted the Africa Health Strategy with appropriate weight given to HIV/AIDS, TB and Malaria; The AU Commission will present it to the AU Assembly for endorsement and implementation by different stakeholders. The implementation activities will be in the mechanism of scaling up towards universal access, laying emphasis on prevention, treatment, care and support.

***Responsibility Centres**:*

26. Ministries of Health of AU Member States; AU Department of Social Affairs; NEPAD Health Advisor and RECs.

Benchmarks and Timelines:

27. The Africa Health Strategy should be endorsed by the AU Assembly by July 2007; following this, the Strategy will be disseminated for implementation by all stakeholders.

3.1.4: Ensure that malaria prevention and control is accelerated with the goal to eliminate malaria in Africa by 2010 using all available control strategies

Implementation Activities:

28. Department of Social Affairs hires monitoring and evaluation health experts to lead organized reviews of Abuja 2000 Malaria prevention and control strategies in Member States; AU Commission, WHO and Roll Back Malaria organize high level technical meetings on Malaria to discuss progress made and challenges ahead, involving Member States, Regional Economic Communities, Regional Institutions, the Academia, Civil Society and the Private Sector and Development Partners; AU Commission working closely with WHO, UNICEF, the Roll Back Malarial (RBM) Partnership and other international alliances on Malaria to organize technical assistance to Member States on best practices, access to funding, improved logistics capacity, monitoring and evaluation indicators and accountability mechanisms; AUC will include the progress report on Malaria prevention and control in the AU Assembly mandated reviews; and launch a re-energized malaria elimination campaign (April 2007).

Responsibility Centre:

29. AU Department of Social Affairs will be the lead entity, with AU Commissioner for Social Affairs providing direct leadership at Continental Level; while the Executive Secretaries of RECs will lead at regional level. The development Partners will play a lead role according to their respective mandates.

***Benchmarks and Timelines**:*

30. The AU Commission, WHO, UNICEF and RBM to launch he Malaria Elimination Campaign on 25 April 2007 (Africa Malaria Day). The AU Department of Social Affairs recruits monitoring and evaluation experts by July 2007 to assist the AU Commission discharge its mandate of monitoring and evaluating organized efforts to achieve universal access to HIV/AIDS, TB and Malaria; AU Commission monitoring and evaluation Experts will work with colleagues in Member States, WHO/AFRO and RECs to establish monitoring and evaluation protocols that meet WHO standards by December 2007;

31. AU Commission organizes technical high level meetings to discuss progress on Malaria prevention and control strategies in the continent in 2008 and 2010; AU Commission working with WHO/AFRO and Roll Back Malaria Initiative will coordinate technical assistance consultations with Member States and RECs on financing, logistics, benchmarks and accountability issues in 2007, 2008, 2009 and 2010; AU Commission prepares progress report on Malaria prevention and control as part of the AU Assembly mandated reviews of 2008 and 2010.

3.1.5: Coordinate in broad partnership with Civil Society and the private sector, the effective implementation of the Abuja Call and report annually to the AU Assembly

Implementation Activities:

32. AU Commission and Member States to establish or update broad partnership with civil society and the private sector on Malaria prevention and control; AU Commission begins annual survey of Malaria prevention and control partnerships in Member States and reports findings to the AU Assembly; AU Commission to ensure the participation of Malarial prevention and control partnerships in continental high level meetings on the disease.

Responsibility Centres:

33. AU Department of Social Affairs and the AU Economic Social and Cultural Council (ECOSOCC) are the lead entities.

Benchmarks and Timelines:

34. AU Commission to establish or update broad public/private/civil society partnerships on Malaria prevention and control in 2007; AU Commission Department of Social Affairs and ECOSOCC begin annual survey on Malaria prevention and control partnership in Member States by January 2008; AU Commission to ensure the attendance of the Malaria prevention and control partnership in all high levels meetings on Malaria beginning in 2008; AU Commission will present progress report on Malaria public/private/civil society partnership as part of the AU Assembly mandated reviews in 2008 and 2010.

3.1.6: Request the Pan-African Parliament Committee on Health, Labour and Social Affairs to provide oversight and accountability for the implementation of the commitments made towards universal access and the implementation of the Abuja Declaration

Implementation Activities:

35. AU Commission makes the request to the Pan-African Parliament Committee on Health, Labour and Social Affairs; AU Commission reaches agreement with the

Committee on their oversight and accountability role; AU Commission begins annual report on the oversight and accountability activities of the Committee to the AU Assembly.

Responsibility Centres:

36. AU Commissioner of Social Affairs and the Chairperson of the Pan-African Parliament Committee on Health, Labour and Social Affairs will lead this effort.

Benchmarks and Timelines:

37. AU Commission regularly briefs the Pan-African Parliament Committee on Health, Labour and Social Affairs; Committee meets and begins oversight and accountability function in December 2007; AU Commission begins annual report on the oversight and accountability function of the Committee in 2008; AU Commission includes progress report as part of the AU Assembly mandated reviews in 2008 and 2010.

3.1.7: Request the Peace and Security Council (PSC), and Economic, Social and Cultural Council (ECOSOCC) of the AU, the NEPAD Programme, other AU Organs and National Parliamentarians to play an effective advocacy role and provide necessary support to Member States in the fight against these diseases

Implementation Activities:

38. AU Commission communicates with all stated entities and requests annual updates on effective advocacy roles; AU Commission begins annual report to the AU Assembly on the advocacy roles of the stated entities.

***Responsibility Centres*:**

39. AU Commissioner of Social Affairs and the top leadership of PSC, ECOSOCC, NEPAD and other AU Organs will be responsible for this effort.

Benchmarks and Timelines:

40. AU Commission communicates with all stated entities by May 2007 and requests annual updates to cover period 2007 through 2010; AU Commission provides briefing to the stated entities in 2007; AU Commission provides annual updates to the AU Assembly, starting in 2008.

3.2: The Role of Member States

41. Member States have the unique role of directly implementing the program areas identified in the Abuja 2006 Commitments. The program areas for achieving universal access to HIV/AIDS, TB and Malaria services include: Leadership; Resource

Mobilization; Protection of Human Rights; Poverty Reduction, Health and Development; Strengthening of Health Systems; Prevention, Treatment, Care and Support; Access to Affordable Medicines and Technologies; Research and Development; Implementation; Partnerships; Monitoring, Evaluation and Reporting; and Coordination of Services.

42. At the July 2006 AU Assembly in Banjul, Gambia, Heads of State and Government requested Member States to ensure that Ministries of Health, National AIDS Councils or equivalent and Ministries of Finance and Economic Planning coordinate the realization of a multi-sectoral and integrated approach to disease control, working in collaboration with other Sectors, including the involvement of target communities in the planning and implementation of initiatives and programs. At the same time the AU Assembly reaffirmed the continent's commitment to the **i**mplementation of the recommendations and action points enshrined in the "*Brazzaville Commitment on Scaling up towards Universal Access to HIV/AIDS Prevention, Treatment, Care and Support*" and extended the commitment to TB, Malaria and other prevailing diseases.

43. The Monitoring and Reporting Mechanism on the implementation of programmes on HIV/AIDS, TB and Malaria in Member States relies heavily on Member States completing the following broad action steps:

(1) Documentation of baseline indicators and audit of existing services, programs and initiatives;

(2) Establishment or update of national guidelines and policies to meet WHO, UNAIDS or other international standards;

(3) Vigorous implementation of revised program objectives with appropriate provisions for trend analysis, stakeholder participation and transparent accountability and management mechanisms;

(4) Providing regular progress report to the AU Commission, especially the AU Assembly mandated reviews in 2008 and 2010.

3.2.1: Leadership in Member States

3.2.1.1: To intensify the practical leadership role at national and local levels

Implementation Activities:

44. Top level political leaders and policy makers to intensify leadership on universal access to HIV/AIDS, TB and Malaria at national and local levels through regular statements and press conferences, setting aside more resources (financial and technical) on an annual basis to universal initiatives and programs, better coordination of external development assistance and encouraging the involvement of private sector and civil society stakeholders.

***Implementation Centres*:**

45. Head of State or Government; Minister of Health; Minister of Finance and Economic Development; Governor/Prefect of state governments; Chairperson of local governments and districts, among others.

Benchmark and Timelines:

46. AU Commission Chairperson communicates with Heads of State and Government on the Abuja 2006 mandate for intensified leadership on universal access to HIV/AIDS, TB and Malaria by January 2007 and also requests annual progress report beginning December 2007; AU Commission to begin documentation of the proportion of national budget devoted to health and the proportion of national and health budgets devoted to achieving universal access to HIV/AIDS, TB and Malaria in Member States and report same to the AU Assembly every year starting 2008; AU Commission to include progress report on practical leadership in Member States in the AU Assembly mandated reviews of 2008 and 2010. .

3.2.2: Resource Mobilization in Member States

3.2.2.1: To mobilize local resources for sustainable and predictable financing, including the implementation of the Abuja Declaration Call for 15% of the National Budget to health.

Implementation Activities:

47. Ministries of Health, Finance and Economic Development, National Planning or equivalent, and National Coordinating Authority for HIV/AIDS, TB and Malaria to work with the private sector and the civil society to identify and tap into local resources as part of concerted efforts to implement the Abuja 2001 Declaration Call for 15% of the national budget to be devoted to the health sector; Member States to devote specific proportion of tax revenues from alcoholic drinks and tobacco products towards the fight against HIV/AIDS, TB and Malaria; Member States to work with national Parliamentarians in the promulgation of relevant laws, including recognition of in-kind support.

Responsibility Centres:

48. Heads of State and Government to provide strong political support; Ministers of Health, Finance and Economic Development and National Planning to lead this effort.

Benchmarks and Timelines:

49. From 2007 AU Commission to document the proportion of national budget allocated to health in Member States; By December 2007, Member States to convene national forum on local resource mobilization for achieving universal access to HIV/AIDS, TB and Malaria services; Member States to submit annual reports to the AU Commission

beginning 2008 on local resource mobilization efforts for achieving universal access to HIV/AIDS, TB and Malaria services; By July 2008, Member States to utilize at least 5% of tax revenues from alcoholic drinks and tobacco products towards achieving universal access to HIV/AIDS, TB and Malaria services.

3.2.2.2: To strengthen collaboration with international partners to mobilize adequate financial resources to fight the epidemics and to ensure that financial resources mobilized to fight all the three epidemics can actually be spent by the removal of the medium-term expenditure ceilings on public spending imposed on African countries by International Financing Institutions.

Implementation Activities:

50. Ministries of Health, Finance and Economic Development, and, National Planning to work closely with bilateral and multilateral development partners active in the Member State to increase resource mobilization and removal of medium term expenditure ceilings.

Responsibility Centres:

51. Ministries of Health, Finance and Economic Development and National Planning are the key entities.

Benchmarks and Timelines:

52. By December 2007, Member States to complete discussion and reach agreement with Development Partners on modalities for increasing resource mobilization and agree on an action plan; By December 2007, Member States to reach agreements on the removal of medium term expenditure ceilings with international financial institutions active in each Member State; Between 2008 and 2010 Member States to progressively increase local and external resources mobilized towards achieving universal access to HIV/AIDS, TB and Malaria; Member States to provide progress report on increased resource mobilization and removal of medium term expenditure ceilings to the AU Commission from 2008; AU Commission to include progress report on resource mobilization as part of the AU Assembly mandated reviews in 2008 and 2010.

3.2.2.3: To negotiate for external debt cancellation and the availability of grants for national programs that would specifically be targeted at financing prevention, treatment, care and support of the three diseases.

Implementation Activities:

53. Heads of State and Government and the Ministry of Finance and Economic Development will initiate or continue negotiation on debt cancellation with relevant international institutions and aggressively target international grants for national initiatives

on HIV/AIDS, TB and Malaria; Member States to design a transparent and verifiable mechanism for using savings from debt cancellation or relief to finance health, education and social welfare programs, including organized efforts to achieve universal access to HIV/AIDS, TB and Malaria services.

Responsibility Centre:

54. Office of the Head of State or Government; Ministry of Finance and Economic Development.

***Benchmarks and Timelines*:**

55. Throughout 2007/8, Member States to initiate or continue discussion on debt cancellation with relevant institutions and seek increases in grant supported programs and services; By December 2008, Member States to design transparent, verifiable mechanism for utilizing savings from debt cancellation or relief in health, education and social welfare sector, including initiatives that seek universal access to HIV/AIDS, TB and Malaria services; By December 2009, Member States to achieve cancellation of external debts.

3.2.2.4: To undertake collective advocacy with multi-lateral and bilateral donors to end all conditionalities except normal fiduciary requirements.

Implementation Activities:

56. Heads of State and Government and the Ministry of Finance and Economic Development will work with bilateral and multilateral agencies active in Member States to end conditionalities associated with development assistance; Member States to liaise with AU as part of continental advocacy efforts in the international community.

Responsibility Centres:

57. Office of the Head of State and Government and the Ministry of Finance and Economic Development plus the African Union Commission Chairperson.

Benchmarks and Time Lines:

58. Throughout 2007, AU Commission Chairperson and the African Development Bank and UN Economic Commission for Africa, RECs and Regional Health Organizations to lead continental advocacy efforts on ending conditionalities in development assistance; Member States by September 2007 to establish a national technical working group on ending conditionalities in development assistance. The working group will recommend national guidelines; AU Commission to organize a technical workshop on conditionalities and development assistance by December 2007 with the objective of recommending best exit strategies and parameters for Member States; Member States to convene national forum on ending conditionalities in

development assistance and reach consensus by April 2008; By July 2008, Member States to reach agreement with Development Partners on ending conditionalities; By July 2009, Member States to exit conditionality programs with Development Partners.

3.2.3: Protection of Human Rights in Member States

3.2.3.1: To continue promoting an enabling policy, legal and social environment that promotes human rights particularly for women, youth, children and older people and ensure the protection of people infected and affected by HIV/AIDS, TB and Malaria and to reduce vulnerability and marginalization including conflict-affected and displaced persons, refugees and returnees.

Implementation Activity:

59. Member States to report annually to AU Commission, activities, policies and legislation aimed at meeting the eight priority areas of the *"Continental Framework for the Harmonization of Approaches Among Member States and Integration of Policies on Human Rights and Peoples Infected and Affected by HIV/AIDS in Africa."* The eight priority areas include: National Frameworks; Greater Involvement of People Living with HIV/AIDS; Community Partnerships; International Partnerships; Resource Mobilization; Law Review, Reform and Support Services; Promotion of Gender Equality and Equity; Promotion of Supportive and Enabling Environment; Monitoring and Enforcement of Human Rights.

***Responsibility Centres*:**

60. Office of the Head of State or Government; Ministry of Health; Office of the Attorney General and Minister of Justice; National Parliament; National Bar Association; CSOs.

Benchmarks and Timelines:

61. Each Member State conducts an audit of existing frameworks, policies and legislation that supports the Continental Framework by December 2007; Member States to establish or update policies and legislation that promote the Continental Framework by December 2008; Member States to provide progress report to the AU Commission as part of the AU Assembly mandated reviews in 2008 and 2010.

Implementation Activity:

62. Conduct an audit of existing legislation and as appropriate, develop, implement and enforce policies and laws to reduce stigma and discrimination, protect the rights of people living with TB and address the needs of vulnerable groups especially women and children and support these with advocacy campaigns.

Responsibility Centres:

63. Office of Head of State or Government; Office of the Attorney General and Minister of Justice; Ministry of Health; National Parliament; National Bar Association; Central Labour Unions and other CSOs.

Benchmarks and Timelines:

64. Each Member State by December 2007 conducts an audit of existing frameworks, policies and legislation that supports the declarations of the 2006 Abuja Summit as it relates to TB; Member States by December 2008 to establish or update policies and legislation to meet the Abuja 2006 declaration on the rights of people living with TB; and, Member States provide progress report to AU Commission for onward transmission to the AU Assembly during the 2008 and 2010 mandated reviews.

3.2.3.2: To adapt national legislation taking cognisance of HIV/AIDS and TB issues, specifically discrimination and stigmatisation and to encourage Member States to ratify relevant International Conventions such as the Convention on Discrimination and Employment.

Implementation Activities:

65. Member States to carry out audit and review of national anti-discrimination and anti-stigmatisation legislation, policies and programs in general and as they relate to HIV/AIDS and TB, in particular; Member States to establish or update legislation, policies and programmes that meet UNAIDS and WHO standards; Member States to ratify all relevant International, Continental and Regional Conventions on Human Rights, including the Convention on Discrimination and Employment; Member States to send regular progress report to the Africa Union Commission.

Responsibility Centres:

66. Office of the Head of State or Government; Office of the Attorney General and Minister of Justice; National Parliament.

Benchmarks and Timelines:

67. Member States to conduct audit review by December 2007; Member States by December 2008 to establish or update anti-discrimination and anti-stigmatisation legislation, policies and programmes to meet the mandate of the Abuja 2006 Call; Member States to ratify all outstanding International Conventions on Human Rights, including the Convention on Discrimination and Employment by December 2008; Member States to provide progress report to the AU Commission in 2008 and 2010 as part of the AU Assembly mandated reviews.

3.2.3.3: To enact or repeal laws and policies related to gender and human rights in order to align them with AU frameworks including the Solemn Declaration on Gender Equality in Africa, the AU Protocol on the Rights of Women in Africa and the AU Policy Framework on Ageing.

Implementation Activities:

68. Member States to conduct national audit of laws and legislation related to gender and human rights; Member States to enact or update national laws on gender and human rights that is aligned with AU frameworks on the Solemn Declaration of Gender Equality in Africa and the AU Protocol on the Rights of Women in Africa.

Responsibility Centres:

69. Office of Heads of State or Government; Office of the Attorney General and Minister of Justice; National Parliament; Ministry of Women Affairs or equivalent; National Bar Association; National Women Association; Central Labour Unions.

Benchmarks and Timelines:

70. Complete national audit by December 2007; Enact or update national laws by December 2008; Provide progress report to the AU Commission in 2008 and 2010 as part of the AU Assembly mandated reviews.

3.2.4: <u>Poverty Reduction, Health and Development in Member States</u>

3.2.4.1: To ensure the integration of HIV/AIDS, TB and Malaria programmes into Poverty Reduction Strategies and Programmes and country programmes.

Implementation Activities:

71. Member States to mainstream HIV/AIDS, TB and Malaria into all national Poverty Reduction Strategies and Programmes financed with local and external donor resources.

Responsibility Centres:

72. Ministry of Finance and Economic Development, Ministry of Health, National Coordinating Councils for HIV/AIDS, TB and Malaria and local government policy makers are key entities.

Benchmarks and Timelines:

73. Member States to conduct audit on the linkages between national programmes on HIV/AIDS, TB and Malaria and National Poverty Reduction Strategies and Programmes by July 2007; Member States to develop and implement national policies that mainstream universal access to HIV/AIDS, TB and Malaria services into poverty reduction initiatives

at national and local levels by July 2008; Member States to provide progress report to the AU Commission in 2008 and 2010 as part of the AU Assembly mandated reviews.

3.2.4.2: To ensure access to adequate nutrition and food security by pursuing the realization of an integrated African food production, storage and distribution plan and other social protection measures including adequate social security schemes to address sustainability of treatment as well as treatment, care and support; ensuring community involvement and participation.

Implementation Activities:

74. Member States to develop an integrated food production, storage and distribution plan, with special emphasis on the nutritional needs of individuals living with diseases, in poverty and under vulnerable conditions; Member States to explore the feasibility of social security schemes that provide basic support for poor and indigent populations, and, if feasible, to set time line for implementation; Member States to work together with the AU Commission and Development Partners to develop an Africa Food Security Plan; AU Assembly to adopt the Africa Food Security Plan.

Responsibility Centres:

75. In the Member States the key entities are the Ministry of Agriculture and Natural Resources, Ministry of Health, Ministry of Social Welfare Services, Ministry of Finance and Economic Development, central labour unions, schools of agriculture, the civil society and the agro-based private sector; At the continental level the key entity is AU Commission working closely with Development Partners such as the Food and Agricultural Organization (FAO), the World Food Programme (WFP) and WHO.

Benchmarks and Timelines:

76. By December 2007 Member States to convene public/private/civil society national stakeholders to begin discussion on a national food security plan; Member States to decide on the feasibility of a national social security scheme that provides basic support for the poor and indigent by March 2008; Member States to begin the implementation of the national food security plan either as part of a comprehensive national social security scheme or as a standalone initiative by July 2008; Member States to work with the African Union Commission and Development Partners including the FAO, WFP and WHO to develop the continental food security plan by March 2009; AU Assembly to adopt the continental Food Security Plan by July 2009; AU Commission to provide progress report on the continental food security plan by 2010 and in subsequent years.

3.2.5: Strengthening Health Systems in Member States

3.2.5.1: To strengthen health systems and building on existing structures (infrastructure, human resource, financing, supplies and other issues) for scaling up and accelerating Universal Access to prevention, treatment, care and support for HIV/AIDS, TB and Malaria. This is in the mechanism of the Africa Health Strategy.

Implementation Activities:

77. Member States to conduct a nationwide audit of the national health system with emphasis on the state of infrastructure, human resources, financing capacities, supplies and procurement processes, the coordination and the management of services; After comprehensive audit and review of national health systems, Member States, working with national stakeholders and development partners to develop a comprehensive national health system strategy that includes provisions for achieving universal access to HIV/AIDS, TB and Malaria services; Member States to submit progress reports on organized efforts to achieve universal access to HIV/AIDS, TB and Malaria as part of AU Assembly biannual reviews; Member States to achieve or surpass 15% national budget allocation to the health sector.

Responsibility Centre:

78. The Minister of Health will be directly responsible for the initiation and completion of this vital effort.

Benchmarks and Timelines:

79. Member States to complete nationwide review of health systems by December 2007; Member States to develop a comprehensive national health system strategy by July 2008; Member States to begin implementation of comprehensive health system strategy at all levels of government by December 2008; Member States to provide progress report to the AUC in 2008 and 2010 as part of the AU Assembly mandated review; Member States between 2007 and 2010 to progressively increase national budget allocation to the health sector with the aim of meeting or surpassing the 15% benchmark of national budget devoted to health

3.2.5.2: To strengthen data management and surveillance.

Implementation Activities:

80. Member States to strengthen data management and surveillance activities as part of the comprehensive review of the health system outlined in 3.2.5.1, above; In short term, Member States to upgrade the quality of existing data systems dealing with HIV/AIDS, TB and Malaria, and, train and retrain data management staff.

Responsibility Centres:

81. The Ministry of Health (Data Management Services Unit), the Ministry of National Planning and the Bureau of National Statistics will be the lead agencies.

Benchmarks and Timelines:

82. By July 2008, Member States to upgrade its data management systems on HIV/AIDS, TB and Malaria services that meet UNAIDS and WHO standards; Member States to train and retrain data management staff working on universal access to HIV/AIDS, TB and Malaria services; Member States will include strengthening of data management and surveillance activities as part of the comprehensive reform of the health system outlined in 3.2.5.1, above.

3.2.5.3: To meet WHO standards for Doctors and Nurses

Implementation Activities*:*

83. Member States to determine national and local doctor and nurse population ratios; Then, Member States to develop a nationwide strategy to meet or exceed WHO standards**.**

Responsibility Centres*:*

84. Ministry of Health and Ministry of Finance and Economic Development are the lead agencies.

Benchmarks and Timelines:

85. Member States to determine valid doctor and nurse population ratios and compare to WHO standards in 2007 through public sector staff audits, professional registration board records and non governmental organization staff inventory; Member States to develop and begin the implementation of a nationwide strategy to meet WHO standards for doctors by December 2008.

3.2.6: <u>Prevention, Treatment, Care and Support in Member States</u>

3.2.6.1: To invest heavily in evidence-based prevention as the most cost-effective intervention with focus on young people, women, girls and other vulnerable groups

Implementation Activities:

86. Member States to review current HIV, TB and Malaria prevention programs and ensure that it meets evidence-based standards; Member States to work with national

professional institutions and organizations, the WHO/AFRO and WHO/EMRO Region and Development Partners to implement evidence-based prevention.

Responsibility Centre:

87. The Ministry of Health will lead this effort, including the coordination of the activities of all partners in this effort.

Benchmarks and Timelines:

88. Member States to review HIV, TB and Malaria prevention strategies to ensure they are evidence-based and meet UNAIDS and WHO standards or recommendations by December 2007; Member States to work with national stakeholders, WHO/AFRO and WHO/EMRO and Development Partners to design and implement evidence-based HIV, TB and Malaria prevention programs by July 2008; Member States to include progress report on evidence-based prevention in the AU Assembly mandated reviews in 2008 and 2010.

3.2.6.2: To ensure access to a comprehensive package of prevention interventions for the prevention of primary and secondary infections with HIV, and sexually transmitted infections (STIs) (including post-exposure prophylaxis following sexual violence), TB and malaria, reduction of vulnerability to HIV/AIDS, TB and malaria.

Implementation Activities:

89. Member States to set national targets, inspired by continental and international targets on a comprehensive package of primary, secondary and tertiary prevention strategies in such a way that it augments national and continental capacities to meet relevant Millennium Development Goals by 2015.

Responsibility Centre:

90. Ministry of Health will be the lead entity.

***Benchmarks and Timelines*:**

91. Member States to set national targets on primary, secondary and tertiary prevention for HIV, STIs, TB and Malaria by December 2007; Member States to begin implementation of set national targets in 2008; Member States to provide progress report as part of the AU Assembly mandated reviews in 2008 and 2010.

3.2.6.3: To ensure the promotion and integration of access to prevention treatment, care and support in primary health care services, and in education institutions.

Implementation Activities:

92. Member States to conduct a comprehensive review of primary health care services; Member States to re-establish primary health care services as the foundation of national health care through infrastructure development or rehabilitation of existing primary health care centres, proper equipment of primary health care centres, hiring or deployment of relevant staff, and, the organized participation of the local or target community in the design and implementation of programs; Member States to develop and promote guidelines on timely access to quality care at primary, secondary and tertiary levels of care and in school systems; Member States to develop and implement guidelines on integrated service delivery on prevention, treatment, care and support of HIV/AIDS, TB and Malaria services.

Responsibility Centre:

93. Ministry of Health is the lead agency, with the support of the Ministry of Finance and Economic Development, national professional health associations, labour unions in the health sector and Development Partners.

Benchmarks and Timelines:

94. Member States to complete a nationwide audit and evaluation of the primary health care system, including a review of indicators for timely access to services by target populations by December 2007; Member States to complete nationwide review and evaluation of health services in educational institutions, including access to services by December 2007; Member States to design and begin the implementation of primary health care systems that meet WHO standards by December 2008; Member States to begin the implementation of a nationwide school health system that improves access to care and is integrated with the primary health care system by December 2008; Member States to begin the implementation of integrated service delivery on prevention, treatment, care and support of HIV/AIDS, TB and Malaria services in the primary health care system and school health systems by March 2009; Member States to provide progress report to the AU Commission as part of the AU Assembly mandated reviews in 2008 and 2010.

3.2.6.4: To improve information, education and communication campaigns against the transmission of HIV, TB and Malaria and to disseminate, correct, reader-friendly information on prevention, treatment, care and support on the three diseases.

Implementation Activities:

95. Member States to conduct a comprehensive audit of existing information, education and communication (IEC) campaigns against the transmission of HIV, TB and Malaria with principal focus on messages, messengers, target populations, expected outcomes, and, monitoring and evaluation indicators; Member States to implement a new nationwide policy on IEC campaigns against the three diseases with special focus on the message, the messenger, expected outcomes, monitoring and evaluation issues; Member States to work with national stakeholders and Development Partners to design and disseminate correct reader-friendly, gender and age-sensitive information on prevention, treatment, care and support on the three diseases, including universal access to male and female condoms for all sexually active persons, clean living environments and the use of insecticide treated bed nets.

Responsibility Centres:

96. Ministry of Health, Ministry of Finance and Economic Development, National Professional Organizations and Development Partners.

Benchmarks and Timelines:

97. Member States to complete comprehensive audit of existing IEC programs by July 2007; Member States to begin the implementation of new guidelines on IEC by January 2008; Member States to develop and disseminate reader friendly information on prevention, treatment, access and support by July 2008; Member States to provide progress report to the AU Commission in 2008 and 2010 as part of the AU Assembly mandated reviews.

3.2.6.5: To integrate HIV/AIDS, TB, Malaria issues into ongoing immunization programmes (where applicable) and sexual and reproductive health programmes, and conversely sexually and reproductive health issues into HIV/AIDS, TB, Malaria programmes.

Implementation Activities:

98. Member States to mainstream HIV, Malaria and TB prevention programmes into existing nationwide immunization and sexual and reproductive health programmes; Member States to take steps to create one-stop comprehensive preventive health programmes that integrate HIV prevention with immunization, sexual and reproductive programs.

Responsibility Centre:

99. Ministry of Health will be the lead entity.

Benchmarks and Timelines:

100. Member States to mainstream HIV prevention programmes into existing immunization and sexual and reproductive health programs through update or enactment of new national policy and action plan by December 2007; Member States to create and begin the implementation of integrated preventive health programs that link HIV, TB and Malaria prevention programs with sexual and reproductive health services by December 2008.

3.2.6.6: To awaken traditional values on abstinence but also continually increase condom use.

Implementation Activities:

101. Member States to carry out national (information, education and communication (IEC) campaign that promotes the traditional values of abstinence among non-sexually active population but also emphasizes the importance of consistent condom use among sexually active populations.

Responsibility Centres:

102. Ministry of Health, Ministry of Education and Ministry of Information and Culture are the lead entities.

Benchmarks and Timelines:

103. Member States to convene national stakeholder dialogue in 2007 to establish ground rules and best practices for the national IEC campaign; Member States working with Development Partners to begin implementation of national IEC campaign by July 2008.

3.2.7: Access to Affordable Medicines and Technologies in Member States

3.2.7.1: To enact and utilize appropriate legislation and international trade regulations and flexibilities, to ensure the availability of medicines and commodities at affordable prices as well as technologies for the treatment, care and prevention of HIV/ AIDS, TB and malaria including vaccines, medicines and Anti-retrovirus Therapy (ART).

Implementation Activities:

104. Member States to enact or update legislation that mandates the availability of medicines, commodities and technologies for the prevention, treatment, care and support of HIV/AIDS, TB and Malaria under the assumption that basic medicines and other basic commodities are a human right and should be available and accessible to all those in need in the country; Member States enacted or updated legislation to meet the letter and spirit of the AU Continental Framework for Harmonization of Approaches and Policies on Human Rights and People Infected and Affected by HIV/AIDS; Member States to develop national policies or pass legislation that take advantage of favourable provisions in international trade regulations and flexibilities to make public health goods readily available to those in need.

Responsibility Centres:

105. Ministry of Health, Office of the Attorney General and Minister of Justice, National Coordinating Councils of the three diseases, and the National Parliament are the key agencies.

***Benchmarks and Timelines*:**

106. Member States to enact relevant legislation on timely access to medicines, commodities and technologies by December 2007, taking cognisance of continental platforms, UN conventions and World Trade Organization (WTO) Doha declaration on access to public health goods (TRIPS); Member States to provide progress report on organized efforts to improve availability and access to medicines and commodities at affordable prices to the AU Commission as part of the AU Assembly mandated reviews in 2008 and 2010.

3.2.7.2: To promote regional bulk purchase and local production of generic medicines and other commodities.

Implementation Activities:

107. Member States in each of the Regional Economic Communities (RECs) in collaboration with Regional Health Organizations to establish a technical working group on regional bulk purchase and local production of generic medicines and other commodities and to set a firm deadline for the commencement of bulk purchases and local generic drug production; RECs technical working group to submit report to the REC Heads of State meeting to adopt a regional policy on bulk purchase and local production on generic drugs; Regional bulk purchase to commence on the set date; Local production of generic drugs to commence in Member States on a set date.

Responsibility Centres:

108. Ministry of Health as well as Ministry of Finance and Economic Development of Member States; The leadership of RECs.

Benchmarks and Timelines:

109. By October 2007, Member States in each REC to meet and discuss how to set up regional bulk purchase process, set up a regional technical working group and agree on an expected date for the commencement of regional bulk purchase; By October 2007, Member States in each REC to meet to discuss local production of generic drugs, set up a technical working group and agree on an expected date when Member States should begin local production of generic medicines and other commodities; By March 2008, Member States in each REC to reach agreement on bulk purchase and by July 2008, regional bulk purchase programme to begin in RECs; By March 2008, Member States to agree on a regional plan for local production of generic drugs and other commodities; By July 2008, Member States to begin discussions and negotiations with WHO approved generic drug manufacturers on local drug production; By December 2008, Member States to reach agreement with WHO approved generic drug manufacturers and to begin the construction of manufacturing plants and facilities; By December 2009, at least 50% of Member States to have local generic drug manufacturing service functional and producing generic drugs for HIV/AIDS, TB and Malaria; Member States to provide progress report to the AU Commission in 2008 and 2010 as part of the AU Assembly mandated reviews.

3.2.7.3: To support work on regional local production of generic ARV, TB and Malaria drugs

Implementation Activities: Please, see 3.2.7.3, above.
Responsibility Centres: Please, see 3.2.7.3, above.
Benchmarks and Life Lines: Please, see 3.2.7.3, above.

3.2.8: Research and Development in Member States

3.2.8.1: To promote and support research and development of microbicides, vaccines and preventive materials, diagnostics and treatment for HIV/AIDS, TB and malaria, including traditional medicine.

Implementation Activities:

110. Member States to ensure that at least 2% of national health budget is spent on research initiatives in accordance with Abuja 2001 mandate; Member States to progressively increase the proportion of national health budget devoted to research activities; Member States to increase collaboration between the Ministry of Health and indigenous academic research institutions; Member States to increase financial and technical support for research and development activities on microbicides, vaccines,

diagnostics and treatment for AIDS, TB and Malaria; Member States to increase financial and technical support for research and development activities in traditional medicine; Member States to progressively increase Development Partner financial support for research and development of microbicides, vaccines, diagnostics and treatment for HIV/AIDS, TB and Malaria in Member States; Member States to establish or update existing national reference laboratories to meet WHO standards; Member States to establish or update existing national oversight bodies on research and development in the health sector; Member States to progressively increase the number and types of scientists engaged in research and development activities in the health sector;.

***Responsibility Centres*:**

111. The Ministry of Health is the key entity, assisted by oversight professional bodies and Development Partners.

Benchmarks and Timelines*:*

112. Member States to ensure that 2% of national health budget is devoted to research activities by 2008; Member States to establish or update policies on national reference laboratories to meet WHO standards by December 2008; Member States to establish or update existing national oversight bodies on research and development to meet international gold standards by December 2009; Between 2007 and 2010, Member States to progressively increase the number and types of research and collaborative agreements between the Ministry of Health and indigenous academic institutions; Between 2007 and 2010, Member States to progressively:

a) Increase the proportion of health budget devoted to research and development activities;

b) Increase local and Development Partner financial and technical support for research and development in microbicides, vaccines and other preventive materials, diagnostics and treatment for AIDS, TB and Malaria;

c) Increase financial and technical support for research and development activities in traditional medicine; and,

d) Increase the number and types of scientists working on research and development activities in the health sector.

(e) Participate actively in TRIPs negotiations;

3.2.8.2: To monitor drug resistance in the treatment of HIV/AIDS, Tuberculosis and Malaria

Implementation Activities:

113. Member States to establish or update national policy on monitoring drug resistance in the health sector, including the treatment of HIV/AIDS, Tuberculosis and Malaria; Member States to progressively increase financial and technical resources towards monitoring of drug resistance in the health sector and in the treatment of HIV/AIDS, TB and Malaria.

Responsibility Centres:

114. Ministry of Health; National Agency responsible for drug safety or equivalent; National Medical and Pharmacy boards; Teaching Hospitals and Academic Research institutions.

Benchmarks and Timelines:

115. Member States by March 2008 to establish or update national policy on monitoring drug resistance in the health sector, including the treatment of HIV/AIDS, TB and Malaria; Between 2007 and 2010, Member States to progressively increase financial resources devoted to the monitoring of drug resistance in the health sector and the treatment of HIV/AIDS, TB and Malaria; Between 2007 and 2010, Member States to progressively increase the number and types of experts working on drug resistance research and monitoring activities.

3.2.8.3: To conduct Demographic and Health Surveys every five years

Implementation Activities:

116. Member States to conduct Demographic and Health Surveys every five years; Member States to progressively increase the number of indigenous demographers, epidemiologists, statisticians and survey experts; Member States to link findings from the Demographic and Health Surveys with specific national policy and programme initiatives for better health.

Responsibility Centres:

117. Ministry of Health, Ministry of Finance and Economic Development, Ministry of National Planning, National Bureau of Statistics and Development Partners.

Benchmarks and Timelines:

118. Member States to begin nationwide, indigenously organized and managed Demographic and Health Surveys on or before December 2008, and thereafter, every

five years; Between 2006 and 2010, Member States to progressively increase the number of indigenously qualified demographers, epidemiologists, statisticians and survey experts; Beginning with the findings from the first survey in 2008, Member States to provide progress report to the AU Commission on specific national policy and programme initiatives that resulted from survey findings.

3.2.8.4: To implement research ethics including for HIV/AIDS, TB and Malaria
Implementation Activities:

119. Member States to establish or update existing research ethics guidelines in the health sector so that, among others, it meets internationally accepted standards on informed consent, confidentiality and safeguard of records; Member States to establish or update existing guidelines on HIV/AIDS research to meet WHO, ILO and UNAIDS standards and protect the privacy and rights of individuals living with HIV/AIDS.

Responsibility Centre:

120. Ministry of Health.

Benchmarks and Timelines:

121. Member States to establish or update existing guidelines on HIV/AIDS research by 2008; Member States to establish or update existing research ethics guidelines in the health sector by December 2008.

3.2.8.5: To conduct regular national incidence surveys on HIV/AIDS, TB and Malaria

Implementation Activities:

122. Member States to conduct regular incidence surveys on HIV, TB and Malaria; Member States to publish findings from the regular incidence surveys; Member States to conduct national stakeholders review of findings from regular incidence surveys

Responsibility Centre:

123. Ministry of Health, Local or District governments and Development Partners.

Benchmarks and Timelines:

124. Member States to conduct a minimum of two national HIV incidence surveys between 2007 and 2010; Member States to publish results from the minimum of two incidence surveys between 2007 and 2010; Member States to convene national stakeholder meetings of public sector, private sector and civil society representatives to discuss findings from the HIV national incidence survey and to make recommendation on next steps, at least two times between 2007 and 2010.

3.2.9: Implementation in Member States

3.2.9.1: To enhance and support implementation of comprehensive strategic programmes at country and regional levels against HIV/AIDS, TB and Malaria.

Implementation Activities:

125. Member States to enhance and support implementation of comprehensive programmes against HIV/AIDS, TB and Malaria through specific focus on financing, technical, logistics and, accountability issues.

Responsibility Centres*:*

126. Ministry of Health, Ministry of Finance and Economic Development and Development Partners.

Benchmarks and Timelines:

127. Member States to review existing HIV/AIDS, TB and Malaria programme efforts by December 2007 where necessary to ensure alignment with the program areas established in Abuja 2006 Commitments; Member States by December 2007 to establish measurable benchmarks on how to asses the technical, logistics and accountability mechanisms for HIV/AIDS, TB and Malaria programmes using standards set by UNAIDS and WHO; Beginning 2008, Member States to progressively increase the proportion of national budgets devoted to the health sector with the aim of achieving the 15% target in 2010; Beginning 2008, Member States to progressively increase the budgetary allocation to HIV/AIDS, TB and Malaria programmes; Beginning 2008, Member States working with Development Partners, to progressively increase the total cost of external funded support for HIV/AIDS, TB and Malaria programmes; Member States to submit progress report to the AU Commission for the AU Assembly mandated reviews of 2008 and 2010.

3.2.9.2: To implement prevention programs against multi-drug resistant TB.

Implementation Activities:

128. Member States to establish or update baseline indicators on multi-drug resistant TB; Member States to establish or update national multi-drug TB resistant guidelines to meet WHO standards; Member States to continue providing aggressive Free TB drugs programmes and improve access to poor and marginalized populations; Member States to ensure that all districts or local governments are implementing national DOTS plan and all health workers are trained in DOTS.

Responsibility Centres:

129. Ministry of Health, WHO, STOP TB Partnership, Development Partners.

Benchmarks and Timelines:

130. Member States by December 2007 to establish or update baseline indicators on multi-drug resistant TB and to publish annual updates in 2008, 2009 and 2010; Member States to establish or update national multi-drug resistant guidelines that meet WHO standards by December 2007; Member States of endemic TB areas to progressively increase the number of health personnel trained in the management of drug-resistant TB from 2007 until all health personnel have received training by 2010; Member States to progressively increase the proportion of individuals with drug-resistant TB who successfully complete clinical treatment protocols and are TB free between 2007 and 2010; Member States to establish or update regional collaborative efforts through RECs by July 2008; Between 2007 and 2010, Member States to provide Free TB drugs services to ALL those in need through the Global Drug Facility and Global Drug Facility Direct Procurement service.

3.2.9.3: To accelerate Malaria control programmes with a goal to eliminate malaria using all effective strategies such as indoor residual spraying, insecticide treated bed nets, Artemisenin Combination Therapy (ACTs) and Intermittent Presumptive Therapy (IPT).

Implementation Activities:

131. Member States to progressively increase community awareness and involvement, indoor residual spraying, insecticide bed nets, ACTs and IPT; Member States to reduce morbidity and mortality from Malaria.

Responsibility Centres:

132. Ministry of Health, Ministry of Finance and Economic Development, Roll Back Malaria Initiative, WHO/AFRO and Development Partners.

Benchmarks and Timelines:

133. By December 2007 all Member States have removed taxes and tariffs on insecticide treated nets (ITNs) (compared to 64% of all countries in 2006) and by 2010, all Member States have met the Abuja 2001 declaration that 60% of children under the age of five sleep under ITNs; By December 2008, all Member States have introduced indoor residual spraying (compared to 50% in 2006); By December 2008 all Member States have adopted national policies that include effective drugs against Malaria (compared to two-thirds of Member States in 2006); By December 2008 all Member States have adopted IPT (compared to 29 countries in 2006); By July 2009 all Member States have established Malaria Medicines and Supplies Services to facilitate access and deployment of ACTs and other anti-malaria products; By December 2009, all Member States are implementing ACTs on a nationwide level (compared to only 4 countries in 2006) with the objective of reducing the morbidity and mortality associated with Malaria.

3.2.9.4: To implement the "Three-Ones" (one executing authority, one Plan of Action and one Monitoring and Evaluation Plan) for HIV/AIDS, Tuberculosis and Malaria).

***Implementation Activities**:*

134. Members adopt and begin implementation of "Three-Ones" for HIV/AIDS, TB and Malaria.

Responsibility Centres:

135. National AIDS Coordinating Council, Ministry of Health and Development Partners.

Benchmarks and Timelines:

136. All Member States adopt and begin the implementation of "Three-Ones" for HIV/AIDS, TB and Malaria by December 2007; All Member States to provide progress report on the implementation of "Three-Ones" to the AU Commission as part of the AU Assembly mandated reviews in 2008 and 2010.

3.2.10: Partnerships in Member States

3.2.10.1: To further develop and support comprehensive frameworks and mechanisms of well-coordinated partnerships, particularly public, private, civil society, regional and international partnerships, including donors, to promote universal access to prevention, treatment, care and support for HIV/AIDS, TB and Malaria.

Implementation Activities:

137. All Member States to have functional national public/private/civil society consortium on Universal Access to HIV/AIDS, TB and Malaria services; The National Public/Private/Civil Society consortium to have measurable objectives and outcomes; The National Consortium to publish annual reports that is available to all members of the society; Member States to participate in existing regional, continental and global partnerships and alliances on universal access to HIV/AIDS, TB and Malaria services.

Responsibility Centre:

138. Ministry of Health to provide strong leadership on this effort.

Benchmarks and Timelines:

139. All Member States to have functional national public/private/civil society consortium on universal access to HIV/AIDS, TB and Malaria by December 2007, with measurable objectives and outcomes; The National consortium to begin the publication of

annual report in 2008; All Member States to participate in regional, continental and global partnerships and alliances dedicated to universal access to HIV/AIDS, TB and Malaria by July 2008; Member States to provide progress report to the AU Commission as part of the AU Assembly mandated reviews in 2008 and 2010.

3.2.11: Monitoring, Evaluation and Reporting in Member States

3.2.11.1: To strengthen collaboration with all relevant stakeholders particularly Civil Society partners affected by the three diseases and to enhance planning, monitoring and evaluation and generation of information for quality assurance purposes, sustainability and accountability of programmes, and for advocacy.

Implementation Activities:

140. Member States to establish or update the national monitoring and evaluation policy in the health sector that meets WHO standards; Member States to establish or update national monitoring and evaluation plan for HIV/AIDS, TB and Malaria services that meet UNAIDS and WHO standards, including process and impact indicators, quality assurance indicators, accountability indicators, sustainability indicators and advocacy indicators; Member States to ensure that monitoring and evaluation issues are part of the major focus of national public/private/civil society consortium on achieving universal access to HIV/AIDS, TB and Malaria services.

Responsibility Centres:

141. Ministry of Health; National Coordinating Councils for HIV/AIDS, TB and Malaria; Ministry of Finance and Economic Development; National Bureau of Statistics; Ministry of National Planning or equivalent.

Benchmarks and Timelines:

142. Member States to establish or update the national policy on monitoring and evaluation in the health sector by December 2007; Member States to establish or update the national monitoring and evaluation plan for HIV/AIDS, TB and Malaria by July 2008; Member States to document the inclusion of monitoring and evaluation issues in the activities of the national public/private/civil society partnerships that seek universal access to HIV/AIDS, TB and Malaria services on or before July 2008; Member States to provide progress report to the AU Commission as part of the AU Assembly mandated reviews in 2008 and 2010.

3.2.11.2: To ensure networking and sharing of best practices and submit progress reports regularly to appropriate Organs of the AU.

Implementation Activities*:*

143. Member States to share best practices and lessons learned through the publication of annual reports of the national public/, private/civil society partnership; Member States to participate in the Abuja 2006 Special Summit mandated reviews.

Responsibility Centres:

144. Ministry of Health; National Coordinating Councils for HIV/AIDS, TB and Malaria; National public/private/civil society partnership.

Benchmarks and Timelines:

145. Member States to produce annual report of the national public/private/civil society partnership that shares best practices and lessons learned every year beginning 2008; Member States to participate in the Abuja 2006 Special Summit mandated reviews of 2008 and 2010.

3.2.11.3: To undertake to strengthen implementation of NEPAD Health Strategy to fight poverty and under-development.

Implementation Activities:

146. Member States to work closely with AU Commission and NEPAD Secretariat to implement African Health Strategy; Member States to provide progress report on a regular basis regarding the implementation African Health Strategy.

Responsibility Centres:

147. Ministry of Health; AU Commission; NEPAD Secretariat.

Benchmarks and Timelines:

148. Member States by October 2008 to begin implementation of the African Health Strategy after meeting the timelines and benchmarks set forth in 3.1.3, above; Member States to provide progress reports on the implementation of African Health Strategy as part of the AU Assembly mandated reviews in 2008 and 2010

3.3: Call to Civil Society and the Private Sector

149. Recognizing and commending the progress made by Member States, the efforts and achievements of the Civil Society and Private Sector, call upon the respective national, regional, continental and international partners including NGOs, and civil society

(including those for youth, women, people with disability, older persons, religious organizations, trade unions, employers organizations, traditional health practitioners, traditional rulers, people living with HIV /AIDS and other Groups)

3.3.1: To intensify their efforts more than ever before for the fight against HIV/AIDS, Tuberculosis and Malaria

Implementation Activities:

150. Member States to establish public/private/civil society consortium at all levels (national, state/prefect and district/local government) that represent stakeholders in all sectors to work toward universal access to HIV/AIDS, TB and Malaria services; Member States to ensure that individuals living with or affected by HIV/AIDS, TB and Malaria, support groups, caregivers and traditional health practitioners are represented in the public/private/civil society consortium; Member States to ensure that individuals living with or affected by HIV/AIDS, TB and Malaria, caregivers and traditional health practitioners are consulted in the design or refinement of national policies and programmes; Member States to ensure that the National public/private/civil society consortium participate in regional, continental and global partnerships and alliances working towards universal access to HIV/AIDS, TB and Malaria.

Responsibility Centres:

151. Office of the Head of State or Government; Ministry of Health; National public/private/civil society consortium on HIV/AIDS, TB and Malaria.

Benchmarks and Timelines:

152. All Member States to have functional national public/private/civil society consortium on universal access to HIV/AIDS, TB and Malaria by December 2007, with measurable objectives and outcomes; The National consortium to begin the publication of annual report in 2008; All Member States to participate in regional, continental and global partnerships and alliances dedicated to universal access to HIV/AIDS, TB and Malaria by July 2008; Member States on or before July 2008 to establish verifiable mechanisms for ensuring that individuals living with HIV/AIDS, TB and Malaria, support groups and traditional health practitioners are consulted in the design or refinement of national health policies and programmes; Member States to provide progress report to the AU Commission as part of the AU Assembly mandated reviews in 2008 and 2010.

3.3.2: Member States to develop and implement well-coordinated and harmonized frameworks which will provide concrete results, and support the mobilization of additional resources for prevention, care and support and treatment-related activities for HIV/AIDS, TB and Malaria.

Implementation Activities:

153. Member States to ensure that national public/private/civil society consortium on universal access to HIV/AIDS, TB and Malaria coordinate and harmonize their activities with policy and program officers, and, play specific role in the mobilization of additional resources for prevention, care and support and treatment related activities.

Responsibility Centres:

154. Ministry of Health; National public/private/civil society consortium on universal access to HIV/AIDS, TB and Malaria.

Benchmarks and Timelines:

155. By December 2008, Member States to ensure that public/private/civil society consortium at all levels implement coordinated and harmonized frameworks on universal access to HIV/AIDS, TB and Malaria services, including a harmonized and integrated resource mobilization strategy.

3.3.3: To facilitate through enhancing their monitoring role, the operationalisation of commitments at all levels.

Implementation Activities:

156. Member States to ensure that public/private/civil society partnership at all levels have strong monitoring roles in organized efforts to achieve universal access to HIV/AIDS, TB and Malaria.

Responsibility Centres:

157. Ministry of Health at all levels; Public/private/civil society consortium at all levels.

Benchmarks and Timelines:

158. Member States to conduct annual training programmes on monitoring functions (process and impact issues and indicators) for the public/private/civil society consortium at all levels, every year starting in 2008; Member States to prepare annual report starting 2009 on the monitoring activities of the public/private/civil society consortium on achieving access to HIV/AIDS, TB and Malaria.

3.4: Call to Regional Economic Communities (RECs)

159. Call upon Regional Economic Communities (RECs) and other Regional Groupings to:

3.4.1: Intensify the implementation of inter-country and cross-border health initiatives.

Implementation Activities:

160. All RECs and Regional Health Organizations to update their inter-country and cross-border health policy; All RECs to implement goals and objectives of the revised inter-country and cross-border health policies; All RECs to implement inter-country and cross-border health initiatives in consonance with Member States.

Responsibility Centre:

161. The leadership of RECs.

Benchmarks and Timelines*:*

162. All RECS and Regional Health Organizations to collaborate and complete update of their inter-country and cross-border health policy by December 2007; All RECs to begin implementation of the goals and objectives of the revised inter-country and cross-border health policy by July 2008; All RECs working with Member States and Development Partners to implement at least one inter-country health initiative in each Member State and to implement one cross-border health initiative between two member states before July 2010.

3.4.2: Coordinate inter-country efforts and provide support to Member States.

Implementation Activities:

163. RECs to establish specific offices that deal with inter-country efforts on universal access to HIV/AIDS, TB and Malaria; RECs to publish regular report on specific support to Member States.

Responsibility Centre:

164. Leadership of REC.

Benchmarks And Timelines*:*

165. RECs to establish or update a specific office that deals with inter-country efforts in Member States by July 2007; RECs to publish beginning 2008 annual report on specific support to Member States on universal access to HIV/AIDS, TB and Malaria services.

3.4.3: Mobilize resources for HIV and AIDS, Tuberculosis and Malaria programmes in their respective regions.

Implementation Activities:

166. RECs working with Member States, Regional Health Organizations and Development Partners to establish or update the regional resource mobilization plan for universal access to HIV/AIDS, TB and Malaria services; RECs to implement all goals and objective set forth in the regional resource mobilization plan; RECs to convene regular consultative meeting on resource mobilization and to disseminate the findings of the consultative meeting to the government and people of Member States and Development Partners.

Responsibility Centre*:* Leaders of the REC.

Benchmarks and Timelines*:*

167. RECs working with Member States and Development Partners to establish or update the regional resource mobilization plan for universal access to HIV/AIDS, TB and Malaria services by December 2007; RECs to begin implementation of the regional resource mobilization plan on or before March 2008; RECs to convene annual consultative meeting on regional mobilization of resources beginning 2008 and to publish the outcome of the consultative meeting in the same calendar year.

3.4.4: RECs to report back to AU Assembly through the AU Commission on the progress made in the implementation of this Call.

Implementation Activity:

168. RECs to provide annual progress to the AU Assembly through AU Commission.

Responsibility Centre:

169. Leadership of RECs.

Benchmark and Timelines:

170. RECs to provide annual progress report to the AU Assembly through the AU Commission beginning 2008; RECs to provide progress report to the AU Commission as part of the AU Assembly mandated reviews of 2008 and 2010.

3.4.5: To accelerate the prevention and control of malaria, learning from best practices on the continent with the aim of eliminating malaria in Africa using all available control strategies including indoor residual spraying, use of insecticide-treated nets, ACT combination therapy and intermittent preventive therapy.

Implementation Activities:

171. RECs to establish or update the unit on Malaria control efforts; RECs working with Development Partners to provide technical assistance to Member States.

Responsibility Centre:

172. Leadership of RECs.

Benchmarks and Timelines:

173. RECs to establish or update the unit on Malaria control efforts by December 2007; RECs to provide technical assistance to Member States on Malaria control efforts and to publish overviews of these technical assistance efforts beginning 2008.

3.5. Call to the International Community

3.5.1: Development partners to continue to work closely with Member States, the AU Commission and the RECs to ensure long term, predictable financing commensurate with the burden of these diseases and to provide financial and technical support to our efforts in a coordinated, efficient and country and AU led manner

Implementation Activities:

174. AU Commission to convene a high level meeting on the harmonization, coordination and consolidation of international development assistance in the continent; At the end of this high level meeting, AU Commission to produce a draft continental platform on the harmonization, coordination and consolidation of development assistance to Africa; AU Assembly to adopt a continental platform on the harmonization, coordination and consolidation of international development assistance in Africa; AU Commission, Member States and RECs to work closely with the G-8 nations to fulfill the 2005 Gleneagles Summit pledge on significant new monies for development efforts in Africa; Member States to significantly increase the number, scale and types of grant awards from the Global Fund against AIDS, TB and Malaria; Member States that qualify for the US President's Emergency Relief HIV/AIDS, TB and Malaria Initiative (PEPFAR) and US Millennium Challenge Account to significantly increase the level of support received; Member States to significantly increase development support received from the European Union on health and development, including universal access to HIV/AIDS, TB

and Malaria services; Member States to significantly increase grant-based, non loan resources from the World Bank for universal access to HIV/AIDS, TB and Malaria services; Member States to significantly increase grant support from bilateral development partners on universal access to HIV/AIDS, TB and Malaria services; AU Commission and Member States to increase the level of South-South support and collaboration on universal access to HIV/AIDS, TB and Malaria services, especially with the emerging economies of China, South Korea, India and Brazil; AU Commission and Member States to increase the level of support and collaboration with the Africa Diaspora on universal access to HIV/AIDS, TB and Malaria.

Responsibility Centres:

175. African Union Commission working with Africa Development Bank (ADB), UN Economic Commission for Africa (ECA) and relevant UN Agencies to engage Development Partners; Member States; Regional Economic Communities; Development Partners.

Benchmarks and Timelines:

176. AU Commission working together with ADB, ECA, RECs and relevant UN agencies to organize a high level meeting with Development Partners on the harmonization, coordination and consolidation of external supported development assistance programmes in the health sector by December 2007; AU Commission to present for the review and ratification of the AU Assembly in July 2008 a continental platform for harmonized, coordinated and consolidated development assistance; AU Commission, Member States and RECs to continue working closely with G-8 nations during the annual meetings and also work closely with the host country to fulfil pledges made to Africa at the 2005 Gleneagles Summit and at subsequent summits between 2006 and 2010; Member States to provide annual progress report beginning 2007 to the AU Commission on the amount and type of support for HIV/AIDS, TB and Malaria services provided by Development Partners; AU Commission to provide annual progress report on the amount and type of support for HIV/AIDS, TB and Malaria services in Member States from Development Partners to the AU Assembly beginning 2008; AU Commission and Member States to increase the level and type of support and collaboration with South Development partners, especially those from China, India, South Korea and Brazil beginning 2008; AU Commission and Member States to increase the level and type of support for universal access to HIV/AIDS, TB and Malaria with the African Diaspora, including countries and institutions beginning 2008.

3.5.2: **The UN Agencies and other Development Partners to provide technical, material and financial support and to facilitate follow up on the implementation of this Call**

Implementation Activities:

177. As part of the activities for the adoption of a continental platform on harmonized, coordinated and consolidated development assistance stated in 4.1 above, AU Commission working with Member States to engage Development Partners on specific technical, material and financial support for the health sector; AU Commission working with Member States to reach agreement with Development Partners active in the support of HIV/AIDS, TB and Malaria services on specific technical, material and financial support for the implementation of the Abuja 2006 Special Summit mandates.

Responsibility Centres:

178. AU Commission will lead this effort. Other entities include Member States and Development Partners.

Benchmarks and Timelines:

179. After the adoption of a continental platform on harmonized, coordinated and consolidated development assistance by July 2008, AU Commission to organize by December 2008 a high level meeting of UN agencies and other Development Partners on increased technical, financial and material support for HIV/AIDS, TB and Malaria services in Member States; Member States to publish annual progress report on the financial, technical and material support from UN agencies and other Development Partners, beginning 2009; AU Commission to provide annual progress report to AU Assembly beginning 2009 on the increase in technical, material and financial support from UN agencies and other Development Partners on universal access to HIV/AIDS, TB and Malaria services in Member States.

3.5.3: **The Development partners to mobilize additional and adequate resources on long-term basis for the fight against HIV and AIDS, Tuberculosis and Malaria**

Implementation Activities:

180. Development Partners to mobilize long term additional and adequate resources for the fight against HIV/AIDS, TB and Malaria through increased allocation to bilateral agencies and multilateral organizations.

Responsibility Centres:

181. AU Commission will lead this effort, working with Member States, GATM and Development Partners.

Benchmarks and Timelines:

182. AU Commission and Member States to engage Development Partners and reach agreement on increasing budgetary allocation to the fight against HIV/AIDS, TB and Malaria at bilateral and multilateral levels on or before December 2008; AU Commission working with Member States and Development Partners to provide biannual progress report on increased budgetary allocation at bilateral and multilateral by Development Partners to the AU Assembly, beginning 2010.

3.5.4: **The international community to reaffirm its commitment to strengthening the partnership with Africa for the fight against HIV and AIDS, Tuberculosis and malaria, other major causes of morbidity and mortality**

Implementation Activities:

183. Member States to conduct an audit of existing partnerships with Development Partners in the fight against HIV/AIDS, TB and Malaria, and, identify gaps; Member States to engage Development Partners in each country on closing identified gaps; Member States to send AU Commission progress report on strengthening partnerships with Development Partners in the fight against HIV/AIDS, TB and Malaria and other major causes of morbidity and mortality in Africa; AU Commission to provide progress reports in 2008 and 2010 as part of the AU Assembly mandated reviews.

Responsibility Centres*:*

184. Ministry of Health in Member States; African Union Commission.

Benchmarks and Timelines:

185. Member States to conduct an audit of existing partnerships with Development Partners and identify gaps by December 2007; Member States to organize high level consultations on meeting identified gaps with Development Partners active in each country by March 2008; Member States to provide progress report to the AU Commission as part of the AU Assembly mandated reviews in 2008 and 2010; AU Commission to provide progress report to the AU Commission in 2008 and 2010.

Section 4: Critical Issues in Resource Mobilization for HIV/AIDS, TB and Malaria services in Africa

186. Africa with 10% of the global population accounts for 25% of the global disease burden, 2% of the global health workforce and less than 1% of the global health spending. With low levels of domestic revenue mobilization, low levels of per capita income and uncertain economic growth prospects in many Member States, the continent faces tremendous challenges in financing health services. The continent also faces serious challenges in managing existing health services or expanding available services in the face of higher demand for services. Only 12% of countries in Sub-Sahara Africa

have met the World Health Organization recommended US$34 per capita in the health sector.

187. To meet the mandate of the Abuja 2006 Special Summit on HIV/AIDS, TB and Malaria, it is very important for Member States, the African Union Commission and Regional Economic Communities (RECs) to dramatically close the gap on resource mobilization in Africa. This effort requires careful attention to the financial, technical and material needs for achieving universal access to HIV/AIDS, TB and Malaria services. It would also require a coordinated and comprehensive approach for engaging national stakeholders, regional stakeholders and international Development Partners.

188. The key national parameter for resource mobilization in Member States is the proportion of the national government budget expenditure devoted to the health sector. The Abuja 2001 Declaration established a 15% national benchmark. Another key parameter for local mobilization of resources is the level of public-private partnership in the national response to HIV/AIDS, TB and Malaria. All Member States should have national and local public-private sector cooperative agreements by 2010. An effective public-private collaboration can lead to the mobilization of local and national financial, technical and logistics resources towards universal access to HIV/AIDS, TB and Malaria services. Member States should design and implement a National Resource Mobilization Strategy.

189. The National Resource Mobilization Strategy should be based on the following frameworks:

1) A comprehensive and transparent public/private resource mobilization partnership;
2) An unwavering commitment to the “Three-Ones” implementation guidelines;
3) A long-term focus on predictable and sustainable financing strategies;
4) A clear guideline on priority setting for prevention, treatment, care and support activities and programs;
5) An evidence-based system for cost estimations of proposed interventions;
6) A transparent mechanism for financing intervention programs, allocating resources, setting and enforcing accountability processes, and keeping track of incoming and outgoing expenditure;
7) A transparent mechanism for monitoring and evaluating intervention programs and services; and,
8) A strong focus on tapping into existing bilateral and international funding sources and also taking advantage of emerging external philanthropic funding opportunities and global alliances.

190. A major part of the National Resource Mobilization Strategy in Member States is the need to review and strengthen partnerships with Development Partners. In this regard, the partnership between Member States and Development Partners should address the following issues:

1) Ensuring that external donor support is aligned with national priorities;
2) Ensuring that Development Partners adhere to the "Three-Ones" implementation principles;
3) Increasing financial and technical support from existing bilateral and multilateral sources of funding for universal access to HIV/AIDS, TB and Malaria;
4) Closing the gap between external donor commitments and disbursements;
5) Utilizing additional sources of bilateral and multilateral sources of technical and financial support for universal access to HIV/AIDS, TB and Malaria;
6) Negotiating Debt Relief or Cancellation and utilize savings for verifiable expenditure in health, education and social programs, including universal access to HIV/AIDS, TB and Malaria; and,
7) Seeking direct funding partnerships with emerging deep pocketed philanthropic organizations and the emerging global partnerships established to address HIV/AIDS, TB and Malaria.

SECTION 5: Strengthening the Capacity of the African Union Commission for its Monitoring and Reporting Functions

191. The African Union Commission is charged with the responsibility of monitoring and reporting on the implementation mechanism of commitments by Heads of State and Government at the Abuja 2006 Special Summit. As noted in Section 3.1 of this document, the African Union Commission will work with Member States, the Civil Society, the Private Sector, Regional Economic Communities, Regional Health Organizations and Development Partners to ensure the implementation of the mandate from the Abuja 2006 Summit. The African Union Assembly mandated the AU Commission to conduct two continental progress reviews in 2008 and 2010.

192. To meet the mandate of the Abuja 2006 Special Summit on universal access to HIV/AIDS, TB and Malaria, the AU Commission will have to strengthen its capacity in the following areas:

1) The capacity to monitor and report on the role of Member States, RECs, civil society and the private sector and Development Partners in the implementation of the mandate from the Abuja 2006 Special Summit. The AU Commission will need additional expertise to develop a continental M&E Mechanism based on international indicators. The monitoring and evaluation mechanism assist the AU Commission in preparing reports for the AU Assembly mandated reviews of 2008 and 2010;

2) AU Commission will need to strengthen technical partnership with WHO, UNECA, ADB, UNAIDS, RBM, STOP TB Partnership, UNFPA, UNICEF and other entities in the areas of technical assistance, resource mobilization and logistics. Where technical expertise is not in-house, AU Commission will have to hire independent experts for this effort;

3) AU Commission and AU Organs will also need to work closely together to implement the mandates of the Abuja 2006 Special Summit. The AU Commission may have to provide logistics and technical support to the AU Organs that have oversight functions in the implementation of the Abuja 2006 Commitments;

4**)** AU Commission will need to work closely with RECs and Regional Health Organizations to promote a regional approach to universal access to HIV/AIDS, TB and Malaria services. This task may require AU Commission's additional deployment of technical, logistics, programmatic and financial support;

5**)** AU Commission will need to engage Development Partners on two levels: Political and Technical. AU Commission may have to increase technical skill sets to deal with issues such as debt cancellation or relief, donor finance, intellectual property rights, implementation programs on universal access to prevention, treatment, care and support for HIV/AIDS, TB and Malaria, and, direct programme monitoring and reviews;

6) AU Commission will need to invest significantly on management information systems, research and development data management systems, and, data management experts (in-house or consultants) to meet the reporting, monitoring and evaluation requirements of the mandates from the Abuja 2006 Special Summit.

193. To meet the onerous monitoring and reporting mandates of the Abuja 2006 Special Summit on HIV/AIDS, TB and Malaria, AU Commission will have to significantly raise its technical capacity on health and work very closely with specialized continental and international organizations. The technical resource capacity needs may be met by direct hiring of new staff; seconding of staff from Member States or collaborating organizations and hiring of independent consultants.

SECTION SIX

ANNEX DOCUMENTS

ANNEX 1: Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis and Malaria (ATM) Services in Africa.

ANNEX 2: (a) Africa's Common Position to the UN General Assembly Special Session on AIDS (June 2006).

(b) Brazzaville Commitment on Scaling up Towards Universal Access to HIV/AIDS Prevention, Treatment, Care and Support by 2010 (March 2006)

ANNEX 3: The Continental Framework for Harmonization of Approaches and Policies on Human Rights and People Infected and Affected by HIV/AIDS.

SELECTED BIBLIOGRAPHY

Africa Union (2006). Report on the Outcome of the Special Summit on HIV/AIDS, TUBERCULOSIS AND MALARIA (ATM), Abuja, Nigeria, 2-4 May 2006. Addis Ababa: African Union Commission.

African Union (2006). Progress Report on the Implementation of the Plans of Action of the Abuja Declaration on Malaria (2000), HIV/AIDS and Tuberculosis (2001). Special Session of the African Union on HIV/AIDS, Tuberculosis and Malaria (ATM), Abuja, Nigeria, 2-4 May 2006. Sp/Ex.CL/ATM/4 (1). Addis Ababa: African Union Commission.

African Union (2006). Health Financing in Africa. Background Document for the Special Summit of African Union on HIV/AIDS, Tuberculosis and Malaria (ATM), Abuja, Nigeria, 2-4 May 2006. Sp/PRC/ATM/5 (1). Addis Ababa: African Union Commission.

African Union (2006). AIDE MEMORE. Continental Consultative Meeting on Universal Access to Prevention, Treatment, Care and Support in Africa, Brazzaville, Congo, 6-8 March 2006. Addis Ababa: African Union Commission.

African Union (2006). Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa. Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007-2010. Special Session of the African Union Conference of Ministers of Health, Maputo, Mozambique, 18-22 September 2006. Sp/Min/CAMH/5(1). Addis Ababa: African Union Commission.

Africa Union (2005). Review of the Millennium Declaration and the Millennium Development Goals (MDGs): An African Common Position. Executive Council Seventh Ordinary Session, 28 June - 2 July 2005, Sirte, Libya. EX.CL/181 (VII). Addis Ababa: African Union Commission.

Africa Union (2005). Review of the Millennium Declaration and the Millennium Development Goals (MDGs): Towards an African Common Position. Executive Council Seventh Ordinary Session, 28 June-2 July 2005, Sirte, Libya. EX.CL/181 (VII) Annex 1. Addis Ababa: African Union Commission.

African Union (2005). Gaborone Declaration on a Roadmap Towards Universal Access to Prevention, Treatment and Care. 2nd Ordinary Session of the Conference of African Ministers of Health (CAMH2), Gaborone, Botswana, 10-14 October 2005. CAMH/Decl.1 (11). Addis Ababa: African Union Commission.

Chinua Akukwe (2006). Don't Let Them Die: HIV/AIDS, TB, Malaria and the Healthcare Crisis in Africa. Adonis&Abbey Publishers, London, United Kingdom.

Chinua Akukwe (2006). Beyond the Rhetoric: Essays on Africa's Development Challenges. Adonis&Abbey Publishers, London, United Kingdom.

Chinua Akukwe (2006) (Editor). Healthcare Delivery in Africa: Issues, Challenges and Opportunities. Special Edition. Africa Renaissance Journal, Volume 3, Number 4, July/August.

Rhoi Wangila and Chinua Akukwe (2006). AIDS Orphans in Africa and their Grandparents. Successes and Preventable Hidden Dangers. Tsehai Publishers, Los Angeles, California, United States.

Chinua Akukwe (2005). Rethinking the Global War on AIDS. World Press Magazine. Available at: http://www.worldpress.org/Americas/2182.cfm

Chinua Akukwe (2003). TB and Malaria in Africa: The Forgotten Diseases. The Perspective Magazine, Smyrna, Georgia, United States. Available at: **http://www.theperspective.org/2004/may/forgottendiseases.html**

UNAIDS (2005). Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. United Nations General Assembly Special Session on HIV/AIDS. Geneva, Switzerland: Author.

UNAIDS (2005). UNAIDS Unified Budget and Work plan 2006-2007. Annex. Key Result Details, Co-Sponsors, Secretariat and Interagency. Geneva, Switzerland: Author.

UNAIDS (2006). Setting National Targets for Moving Towards Universal Access. Operational Guidance. Geneva, Switzerland: Author.

UNAIDS (2005). Mainstreaming AIDS in Development Instruments and Processes at the National Level. A Review of Experiences. Geneva, Switzerland: Author.

UNAIDS (2005). The "Three Ones" in Action: Where We Are and Where We Go From Here. Geneva, Switzerland: Author.

Office of the Prime Minister (2005). Our Common Interest. Report of the Commission for Africa. Her Majesty Government, London United Kingdom: Commission for Africa.

World Health Organization (2006). Guidelines for the Treatment of Malaria. Geneva, Switzerland: Global Malarial Programme.

World Health Organization Africa (2006). The Health of People. The African Regional Health Report. Brazzaville, Congo: Author.

World Health Organization (2006). Strategic Orientation Paper on Prevention and Control of Malaria. For National and International Programme Officers Involved in Malaria Control

at Country Level. First Edition. Geneva, Switzerland: Roll Back Malaria Department, Operations Support and Capacity Development.

World Health Organization (2006). The Global Plan to Stop TB, 2006-2015. Actions for Life. Towards a World Free of Tuberculosis. Geneva, Switzerland: Stop TB Partnership.

World Health Organization (2005). Working with the Non-State Sector to Achieve Public Health Goals. Making Health Systems Work. Geneva, Switzerland: Working Group on the Non-State Sector, Department of Health System Policies and Operations Evidence and Information Policy.

World Health Organization (2003). Treating 3 Million by 2005. Making it Happen. The WHO Strategy. Geneva, Switzerland: The WHO and UNAIDS Global Initiative to Provide Antiretroviral Therapy to 3 Million People with HIV/AIDS in Developing Countries by the End of 2005. Geneva, Switzerland: WHO and UNAIDS.

World Health Organization (2003). Global Health-Sector Strategy for HIV/AIDS, 2003-2007. Providing a Framework for Partnership and Action. Geneva, Switzerland: Department of HIV/AIDS and Department of Family and Community
Health.

World Health Organization Commission on Macroeconomics and Health (2001). Investing in Health for Economic Development. Report of the Commission on Macroeconomics and Health. Geneva, Switzerland: World Health Organization.

United Nations General Assembly (2006). Scaling Up HIV Prevention, Care and Support. Note by the Secretary-General. Sixtieth Session. Agenda item 45. Follow-up to the Outcome of the twenty-sixth Special Session: Implementation of the Declaration of Commitment on HIV/AIDS. A/60/737. New York, USA: Office of the Secretary General.

United Nations General Assembly (2006). Political Declaration on HIV/AIDS. Draft Resolution Submitted by the President of the General Assembly. Sixtieth Session. Agenda item 45. Follow-up to the Outcome of the twenty-sixth Special Session: Implementation of the Declaration of Commitment on HIV/AIDS. A/60/L.57. New York, USA: Office of the UN General Assembly President.

2007

Report of the third ordinary session of the African Union conference of ministers of health

African Union

African Union