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PROGRESS REPORT ON THE IMPLEMENTATION OF THE MAPUTO DECLARATION ON MALARIA, HIV/AIDS, TUBERCULOSIS AND OTHER RELATED INFECTIOUS DISEASE (ORID)

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EXECUTIVE SUMMARY

In the introduction, the Report reviews the proceedings of the Special Session of the Conference of African Ministers of Health which met from 14 – 15 May 2004 prior to the opening of the World Health Assembly on 17 May 2004 in Geneva, Switzerland.

The main purpose of the Conference was to assess the implementation of Maputo Declaration on Malaria, HIV/AIDS, TB and ORID. Thirty-four (34) Member States were represented among whom were 17 Ministers and one Assistant Minister.

After intensive discussion, the delegates endorsed a Statement as the outcome of the Conference.

The report then dwells on the background which includes reinstatement of the twelve priority areas in the Abuja Declaration on HIV/AIDS, TB, and ORID. Strategies and activities of each of the priority areas form the process of implementation and their indicators measure the progress being made by Member States in the fight against the pandemic.

The report is then divided into the following sections:

(a) Current status of the control of HIV/AIDS in Africa – which indicates the high rate of prevalence of HIV infection in selected cities on the Continent.

(b) Impact of HIV/AIDS on socio-economic Development indicates the role of the pandemic in reducing human resources for productivity hence declining economic growth.

(c) Implementation of the Maputo Declaration by Member States show slower progress in spite of increased availability of financial resources from GFATM, World Bank and bilateral donors; political commitment from leaders and increased partnership.

(d) The section on Roll-Back Malaria indicates that only 18 countries have fulfilled, reduced or eliminated tariffs on ITNs and other materials for rolling back malaria as pledged by Leaders in the Abuja Declaration and Plan of Action on Roll back malaria (2000).

(e) Likewise, the section on TB indicates that 14 countries are implementing DOTs strategy in less than 10% of the total

population and 17 countries are doing the same in over 90% of the total population. Sixteen countries are not implementing the DOTs strategy.

(f) The section on AIDS Watch Africa – chaired by the President of Nigeria with 7 other members needs to be expanded by including Member States with heaviest burden of HIV/AIDS.

In conclusion, the report states major critical issues and recommendations for way forward.

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INTRODUCTION

1. The Special Session of the Conference of African Ministers of Health was held at Ramada Park Hotel, Geneva, Switzerland from 14 to 15 May 2004. Its main objective was to review the progress made in the implementation of the 2003 Maputo Declaration on HIV/AIDS, Malaria, Tuberculosis and Other Related Infectious Diseases (ORID) and other relevant commitments of Heads of State and Government. The Maputo Declaration reaffirmed the 2000 Abuja Declaration and Plan of Action (POA) on Roll Back Malaria, and the 2001 Abuja Declaration and POA on HIV/AIDS, TB and ORID. The Meeting was called by the Minister of Health of Mozambique as current Chair of the African Union Commission, the Minister of Health of the Libyan Arab Jamahiriya as current Chairperson of the AU Conference of African Ministers of Health and the African Union Commission; with the support and collaboration of the WHO/AFRO, Global Fund to Fight AIDS, TB and Malaria (GFATM) and the Global Alliance on Vaccines and Immunization (GAVI). The UNAIDS and UNICEF also provided technical input.

2. The Meeting was timely and useful in that knowledge and experiences were shared and substantive recommendations made for more effective implementation in combating the major causes of morbidity and mortality in Africa. The Special Session preceded the 57th Session of the World Health Assembly (WHA) which was held from 17 to 22 May 2004 in Geneva. The areas of focus by the WHA included those deliberated on by the Special Session of African Health Ministers. The AU Commission took the opportunity to inform the delegates that Control of HIV/AIDS and other pandemic was the one of the priorities of the 2004 - 2007 Work Plan. The NEPAD AU Programme and its Health strategy also have HIV/AIDS high on the Agenda.

3. The Meeting was attended by delegations from the following 34 AU Member States with 17 Ministers and one Assistant Minister: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Chad, Congo Brazzaville, Djibouti, Egypt, Ethiopia, Gabon, Ghana, Kenya, Lesotho, Liberia, Libya, Madagascar, Mali, Mauritania, Mauritius, Mozambique, Nigeria, Rwanda, Seychelles, Sierra Leone, South Africa, Tanzania, Tunisia, Uganda, Zambia and Zimbabwe. The following nine UN and UN Specialized Agencies, and international Organizations also participated in the Meeting: Commonwealth Regional Health Community Secretariat for East, Central and Southern Africa (CRHCS-ECSA); WHO; Roll-Back Malaria Partnership Secretariat; UNICEF, UNAIDS, The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM); Vaccine Fund, Global Alliance for Vaccine and Immunization (GAVI) and the Commission of the African Union.

4. The deliberations of the Special session focused on:

- Status of, critical aspects and key challenges in the fight against HIV/AIDS, TB and Malaria at national, regional, continental and international levels;
- Progress in immunization in Africa including Polio Eradication;
- Procurement of essential drug vaccines, consumable and insecticide-treated bed-nets;
- Financial sustainability;
- Barriers and strengthening partnerships in the Health Sector;
- Donor Coordination;
- The way forward for more effective implementation of commitments of Heads of State and Government.

5. The outcome of the deliberations was the "***Statement of Ministers of Health of the African Union on the occasion of their Special Session, Geneva, Switzerland, 14 – 15 May 2004***" which is annexed to this Report.

BACKGROUND

6. By adopting the Maputo Declaration, Heads of State and Government expressed deep concern about the continuing spread of HIV/AIDS, TB, Malaria and ORID despite the efforts that Member States had exerted to operationalize the commitments made at Abuja and Maputo. They recognized the urgent need to alleviate the impact on the lives of people infected and affected by these diseases, and on their long-term development prospects. The Leaders therefore called for appropriate policies including legal and strategic framework aimed at providing essential services especially for the most vulnerable groups. The Leaders were convinced that care, support and treatment of those infected and affected by HIV/AIDS should be essential components of prevention and control of further spread of HIV infection; and the fight against stigma and discrimination.

7. Implementation is based on the twelve priority areas of the Abuja Plan of Action, namely:

I. Leadership at national, regional and continental levels to mobilize society as a whole to fight HIV/AIDS, TB and ORID;
II. Resource Mobilization at National and International levels;
III. Protection of Human Rights;
IV. Poverty, Health and Development;
V. Strengthening Health Systems;
VI. Prevention;
VII. Improvement of Information, Education and Communication;
VIII. Access to treatment, care and support;
IX. Access to affordable drugs and technologies;
X. Research and Development on HIV/AIDS, TB and ORID including vaccines and Traditional Medicine;
XI. Partnerships.
XII. Monitoring and Evaluation

8. The Mechanism for Monitoring and Reporting on the implementation of Abuja Framework Plan of Action is in place and operationalizes each priority area into strategies; each with a set of activities, responsibilities, time frame, indicators and means of verification. All stakeholders are supposed to utilize this in implementing and preparing reports to the AU Commission which should compile them into a progress Report to AU Heads of State and Government.

Current Status of Control of HIV/AIDS In Africa

9. HIV prevalence among adults in Africa ranges from less than 1% in Mauritania and other North African countries, to almost 40% in Botswana and Swaziland. All over Africa, women tend to be at higher risk at least 1.2 times than men. In the category of 15-24 years old, women are 2.5 times as likely to be HIV infected than men. According to UNAIDS, more than one in five pregnant women are HIV infected in most countries in Southern Africa; whereas in the rest of the continent the prevalence in antenatal clinics exceed 10% in a few countries. While prevalence rates have decreased or stabilized in some countries, they are still increasing in others.

10. The following table indicates examples of HIV prevalence among women in a few cities:

City	% Prevalence (Age 15 to 49)
Gaborone (Botswana)	40
Maurine	40
Blantyre (Malawi)	16
Lusaka (Zambia)	20
Gauteng Province (S.Africa)	>30
Maputo (Mozambique)	18 (2002)
Kampala (Uganda)	8
Kigali (Rwanda)	13

Addis Ababa (Ethiopia)	11 (among 15-24 years females)
Nairobi (Kenya)	10 (2002)
Dakar (Senegal)	14 (among sex workers)
Kaolack	23 (2002) among sex workers
In Sahelian Towns (North Africa)	1-2%
Accra (Ghana)	2(2002)
Abidjan (Côte d'Ivoire)	7

Impact of HIV/AIDS on Socio-Economic Development

11. The pandemic has a devastating effect on the most productive category of the labour force 15-49 years old. It is causing added costs to companies and individuals who pay for the treatment or cover expensive health insurance policies. The affected labour force leads to reduced productivity which in turn adversely affects economic growth. According to UNAIDS, annual gross domestic product (GDP) has been estimated to drop by an average of 2.6% in countries with prevalence rates of over 20%; while life expectancy has fallen by up to 15 years in some countries. The loss of productivity and low economic growth translates into less tax revenue for government-funded services hence undermining a country's ability to respond to AIDS and other pandemics. Fragile health systems are also being robbed of skilled staff by AIDS. This situation is made worse by migration of health professionals, especially to the developed world.

12. Additionally AIDS has a devastating impact on the education sector. Furthermore it has become apparent that HIV/AIDS has a direct bearing on food insecurity. According to FAO 7 Million Agricultural workers died from ADIS in 25 most affected countries between 1985-2000. Another 16 million may die in the next 20 years. For example in Zambia, a 2002-2003 vulnerability assessment revealed that farming families with a chronically ill head of household planted 53% fewer crops than households without such an ill person. When such conditions are compounded by the general high levels of poverty, then the risk of hunger and malnutrition rises quickly making it difficult for any infected person to cope with the pandemic or slight infection by other related infectious diseases.

How are countries implementing the Maputo Declaration on Malaria, HIV/AIDS, TB and ORID?

13. Over 70% of countries reporting from Africa on efforts to reduce HIV transmission to infants and young children have virtually no programmes to administer prophylactic antiretroviral therapy to pregnant women and to newborns. Almost half the African countries reporting have not adopted legislation to prevent discrimination against people living with HIV/AIDS, and only one in four countries report that at least 50% of patients with other sexually transmitted infections (co-factors for HIV infection) are being diagnosed, counselled and treated. Although treatment coverage remains low (with only an estimated 50,000 people having access to life-saving antiretroviral drugs in 2002/3), some countries, such as Botswana, Cameroon, Eritrea, Nigeria and Uganda have made serious efforts to increase access to antiretroviral drugs through both the public and private sectors.

14. Currently there is an upsurge of political commitment by Africa's leaders, for stronger policy formulation, community mobilization, increased funding and support for civil society organizations and NGOs in the fight against HIV/AIDS. A few countries have put in place specific Ministries for the AIDS control. All countries have an AIDS Council or equivalent. For example there are now several countries with Presidents and Prime Ministers personally steering the response to HIV/AIDS, as illustrated in the following table:

Country	**Chair of National AIDS Coordinating Body**
Botswana	President
Burkina Faso	President
Burundi	President
Cape Verde	President
Congo	President
Ethiopia	Prime Minister
Ghana	President
Kenya	President
Madagascar	Prime Minister
Mozambique	Prime Minister
Namibia	Minister of Health
Niger	President
Nigeria	President
Senegal	Prime Minister
South Africa	Deputy President
Swaziland	President
Togo	President

Opportunities

15. It was noted that there are many opportunities for winning the war against HIV/AIDS; and these include: increased political commitment; increased resources; increased number of partners; reduced prices of anti-retroviral drugs; successful proven approaches especially community mobilization; decentralized initiative, ensuring that more access for all

16. One of the major challenges in the fight against HIV/AIDS is the operationalization of Declarations and national strategies into concrete and well-costed implementable action. The following table indicates the number of countries which are implementing some of the priority areas.

	Priority Area being Implemented	Number of countries
1.	National Coordinating Mechanism	35
2.	National Strategic Plan	32
3.	Costed National Strategic Plan	16
4.	Legislation against Stigma and Discrimination	11
5.	Monitoring and Evaluation Systems in place	4

Resource Mobilization

17. While a few countries are independent financially, most countries in Africa still depend on donor support especially Global Fund to fight AIDS, TB and Malaria, and the World Bank MAP Programme as the main source of funding for AIDS activities. In the Abuja Declaration on HIV/AIDS, TB and ORID, Heads of State and Government committed themselves in allocating at least 15% of national budget to the health sector. Only a handful of countries have or are near achieving this target. According to UNAIDS, in 2002 sub-Saharan Africa spent USD250 million on HIV/AIDS activities. The amount was equivalent to 13% of the region's budgetary needs of the same year.

Disbursement of Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM)

18. It should be noted that 60% of all GFATM's funds are disbursed to African countries. The following table indicates the amount each country has received up to May 2004.

Grants to Countries in Africa, Rounds 1-3 Funding (May 2004)

Country	HIV/AIDS		Tuberculosis		Malaria		HIV/TB		Grand Total	
(In US$)	Over 2 years	Over 5 years	Over 2 years	Over 5 years	Over 2 years	Over 5 years	Over 2 years	Over 5 years	Over 2 years	Over 5 years
Algeria	6,185,000	8,869,360							6,185,000	8,869,360
Angola					25,259,000	38,383,000			25,259,000	38,383,000
Benin	11,348,000	17,726,000	2,173,404	3,104,104	3,773,116	5,118,963			17,294,520	25,949,067
Botswana	18,580,414	18,580,414							18,580,414	18,580,414
Burkina Faso	7,130,400	19,632,122			7,499,988	7,499,988			14,630,388	27,132,110
Burundi	4,877,000	8,657,000			13,792,126	17,766,125			18,669,126	26,423,125
Cameroon	14,641,407	55,735,254	2,986,220	6,218,220	16,938,794	32,770,143			34,566,421	94,723,617
Central African Republic	8,198,921	25,090,588							8,198,921	25,090,588
Chad	7,380,156	18,581,945	1,263,963	3,039,327	3,028,688	8,030,340			11,672,807	29,651,612
Comores	751,700	1,360,900			1,534,631	2,485,878			2,286,331	3,846,778
Congo (Democratic Republic)	34,799,786	113,646,453	6,408,741	7,973,002	24,966,676	53,936,609			66,175,203	175,556,064
Cote d'Ivoire	19,122,932	56,867,112	2,870,122	3,837,301					21,993,054	60,704,413
Egypt			2,480,219	4,032,014					2,480,219	4,032,014
Eritrea	8,124,910	17,354,035			2,617,633	7,911,425			10,742,543	25,265,460
Ethiopia	55,383,811	139,403,241	10,962,600	21,290,742	37,915,011	76,875,212			104,261,422	237,569,195
Gabon	3,154,500	5,405,000							3,154,500	5,405,000
Gambia	6,241,743	14,568,679			5,665,500	13,861,866			11,907,243	28,430,545
Ghana	4,965,478	14,170,222	2,336,940	5,687,055	7,596,111	9,356,933			14,898,529	29,214,210
Guinea	4,804,696	13,230,165			6,893,509	8,798,945			11,698,205	22,029,110
Guinea-Bissau			1,503,587	2,646,004					1,503,587	2,646,004
Kenya	39,593,495	131,925,781	6,740,983	15,022,984	10,526,880	33,586,810			52,861,358	180,535,575
Lesotho	10,557,000	29,312,000	2,000,000	5,000,000					12,557,000	34,312,000
Liberia	7,658,257	7,658,257	4,534,017	4,534,017	12,140,921	12,140,921			24,333,195	24,333,195
Madagascar	17,194,365	26,537,181			6,715,024	12,400,786			23,909,389	38,937,967
Malawi	41,751,500	284,110,722			20,872,000	39,688,000			62,623,500	323,798,722
Mali					2,023,424	2,592,991			2,023,424	2,592,991

Country	HIV/AIDS		Tuberculosis		Malaria		HIV/TB		Grand Total	
(In US$)	Over 2 years	Over 5 years	Over 2 years	Over 5 years	Over 2 years	Over 5 years	Over 2 years	Over 5 years	Over 2 years	Over 5 years
Mauritania			1,104,742	2,728,225	824,044	2,899,074			1,928,786	5,627,299
Morocco	4,738,806	9,238,754							4,738,806	9,238,754
Mozambique	29,692,640	109,338,584	9,202,140	18,190,995	12,217,393	28,205,783			51,112,173	155,735,362
Multi-country Africa (RMCC)					7,090,318	22,387,532			7,090,318	22,387,532
Namibia	26,082,802	105,319,841	904,969	1,532,603	3,719,354	6,304,577			30,707,125	113,157,021
Niger	8,475,297	11,968,331			4,815,109	5,886,835			13,290,406	17,855,166
Nigeria	28,168,386	70,891,576			17,828,808	44,314,691			45,997,194	115,206,267
Rwanda	14,890,735	56,676,465			13,045,301	17,676,240	8,409,268	14,641,046	36,345,304	88,993,751
Sénégal	6,000,000	11,714,285			4,285,714	7,142,857			10,285,714	18,857,142
Sierra Leone			2,569,103	5,698,557					2,569,103	5,698,557
Somalia			5,601,215	13,825,35	8,890,497	12,886,413			14,491,712	26,711,764
South Africa	15,521,456	66,509,557					49,509,529	167,432,018	65,030,985	233,941,575
Sudan	7,842,140	20,781,000	5,842,932	15,252,236	27,093,343	61,067,498			40,778,415	97,100,734
Swaziland	29,633,300	54,872,400	1,348,400	2,507,000	978,000	1,864,500			31,959,700	59,243,900
Tanzania	5,400,000	5,400,000			11,959,076	19,827,716	23,951,034	86,987,868	41,310,110	112,215,584
Tanzania/ Zanzibar	1,116,000	2,302,922	959,482	1,699,867	781,220	1,153,080			2,856,702	5,155,869
Togo	14,185,638	19,882,903	1,752,982	2,617,655	3,479,336	5,885,906			19,417,956	28,386,464
Uganda	106,672,524	170,444,124	4,692,021	5,713,081	23,211,300	35,783,000			134,575,845	211,940,205
Zambia	42,298,000	92,847,000	14,755,256	46,682,000	17,891,800	39,274,000			74,945,056	180,803,000
Zimbabwe	10,300,000	14,100,000			6,716,250	8,877,500			17,016,250	22,977,500

Partnerships

19. The role of partnerships is indicated by the programmes undertaken by the international organizations and funds contributed to AIDS activities in Africa by the same and to the GFATM (see the following table).

Projected 2003 AIDS spending by industrialized nations		
Country	**Budgeted in USD**	**Projected Disbursements in USD**
US	838.3	576.8
UK	408	452.1
Germany	133.7	107.1
Japan	95	85
Canada	93.8	66.3
EC	93.2	65
Netherlands	82	65
Norway	50.8	50.8
Ireland	44.9	40
Australia	39	39
Italy	36.4	25.0
France	36.3	25.0
Other*	49.5	40
Total	2,000.9	1,637.1

All figures in millions of US dollars

*Austria, Beligium, Denmark, Finland, Greece, Luxembourg, New Zealand, Portugal, Spain, Sweden and Switzerland

Source: UNAIDS

20. Another good example of partnership support for Africa is the World Bank's Multi-Country AIDS Programme (MAP) for Africa. MAP gives grants and is flexible and it supports all aspects of national AIDS Programmes including basic prevention through anti-retroviral therapy as well as impact mitigation. MAP puts special emphasis on civil society and community organizations for implementation of their own programmes. MAP also helps countries strengthen their capacity in implementation, financial management; and monitoring and evaluation. Currently MAP supports 23 African countries.

21. The following table compares disbursements from World Bank and GFTAM.

World Bank MAP and Global Fund commitments as of end July 2003 (in US$)

Country	MAP	Global Fund (years 1 and 2)
Benin	$23 million	$11.3 million
Botswana		$18.6 million
Burkina Faso	$22 million	$7.3 million
Burundi	$36 million	$4.9 million
Cameroon	$50 million	
Cape Verde	$9 million	
Central African Republic	$17 million	$8.2 million
Cote d'Ivoire		$26.9 million

Country	MAP	Global Fund (years 1 and 2)
Eritrea	$40 million	
Ethiopia	$59.7 million	$55.4 million
Gambia	$15 million	
Ghana	$ 25 million	$2.8 million
Guinea	$20.3 million	$4.8 million
Kenya	$50 million	$39.6 million
Lesotho		$10.6 million
Liberia		$7.7 million
Madagascar	$20 million	$3.7 million
Malawi		$58.7 million
Mauritania	$21 million	
Mozambique	$55 million	$29.7 million
Namibia		$26.1 million
Niger	$25 million	
Nigeria	$90.3 million	$28.2 million
Rwanda	$30.5 million	$8.1 million
Senegal	$30 million	$6 million
Sierra Leone	$15 million	
South Africa		$60 million
Swaziland		$29.6 million
Togo		$14.2 million
Uganda	$47.5 million	$36.3 million
United Rep. of Tanzania	$70 million	$6.5 million
Zambia	$42 million	$42.3 million
Zimbabwe		$10.3 million
TOTAL	$813.3 Million	$557.6 Million
All figures have been rounded to the nearest USD 100,000 ***Source: World Bank and Global Fund***		

Access to Care and Treatment

22. There is a growing awareness and commitment in Africa that people suffering from HIV/AIDS should have access to life saving and affordable quality controlled anti-retroviral therapy. Hence a number of African countries have taken steps in the public provision of antiretroviral treatment, while others have plans to promote accessibility. The WHO "**3 by 5**" strategy pledging to have 3 million people on antiretroviral treatment by 2005 should be supported by all.

Antiretroviral treatment coverage in selected African countries

Country	% of Adults with advanced HIV infection receiving treatment
Uganda	7
Swaziland	3
Kenya	4
Nigeria	2

Country	% of Adults with advanced HIV infection receiving treatment
Mali	3
Malawi	2
Ghana	2
Gambia	6
Equatorial Guinea	7
Djibouti	2
Cote d'Ivoire	3
Cameroon	2
Burundi	3
Burkina Faso	2
Botswana	8
Benin	3
Mauritius	100 (2003)
Seychelles	68.8 (2003)
UNAIDS Figures (may have changed by now)	

Prevention

23. Since there is still no confirmed effective vaccine against HIV infection and no proven cure for AIDS, prevention is still the surest method of fighting against further spread of HIV infection. However, the fact that more cases of HIV infection are occurring each day, implies that strategies for prevention are still weak and need to be strengthened at all levels of society. Such strategies should be harmonized in order to ensure access to all and affordable package of prevention interventions in one locality. In this regard, Information, Education and Communication about prevention interventions should be operationalized and be accessible especially to adolescents and children, the majority of whom are still free from infection.

Research

24. This area is generally under-developed in Africa and needs urgent attention, especially in traditional medicine as this is accessible and affordable.

ROLL-BACK MALARIA PARTNERSHIP

25. Malaria has always presented and still presents obstacles to socio-economic development in Africa. According to WHO, malaria has been estimated to cost Africa about USD12 billion every year in lost GDP; even though the disease could be controlled for a fraction of that amount, being preventable and easily curable. Malaria is a leading-cause of under-five mortality of 20% and constitutes 10% of the overall disease burden. It accounts for 40% of public health expenditure, 30-50% of inpatient admissions and up to 50% of out patient visits in areas with high malaria transmissions. Perhaps the greatest malaria risk in Africa is that the disease leads to loss of life and lost productivity and hampers children's schooling and social development through both absenteeism and permanent neurological and other damage associated with severe episodes of the diseases. In short, malaria causes more than 270 million episodes of acute illness and over 900,000 deaths annually on the continent annually (WHO). To control malaria which was on the increase, the Roll Back Malaria Partnership was established in 1998.

26. The Abuja Summit on Roll-Back Malaria (2000) pledged to take effective action against malaria in order to improve the health of the people. The Heads of State and Government resolved that at least 60% of those at risk of malaria particularly pregnant women and children under five years of age, benefit from the most suitable combination of personal and community protective measures such as insecticide treated mosquito nets and other materials to prevent infection and suffering. To that end Africa's leaders pledged to reduce or waive taxes and tariffs for mosquito nets and malarials, insecticides, anti-malarial drugs and other recommended goods and services that are needed for malaria control strategy. To this, end only the following countries have fulfilled the pledge: **Benin, Burundi, Cameroon, Cote d'Ivoire, The Gambia, Ghana, Kenya, Liberia, Mali, Mozambique, Namibia, Nigeria, Senegal, Sudan, Uganda, Zambia and Zimbabwe. Tanzania has gone beyond the pledge by being the leader in production of affordable ITNs and Research into Malaria.**

27. An integrated approach involving many sectors and the communities to control the vector (mosquito), protect individuals against infection and institute immediate and correct treatment should be adopted. This entails viable Health Systems, empowering communities and families with knowledge and means to look after themselves. The environment also has to be protected as changes in the ecosystem result in malaria spreading to areas that were previously free. The same infrastructure should be utilized for control of all these diseases.

TUBERCULOSIS (TB)

28. Africa has an estimated TB prevalence of 384 cases per 100,000 in the general population. HIV is the commonest risk factor for reactivation of latent TB infection to active disease. Thus countries with high prevalence of HIV infection, 20 – 50% of people infected by HIV will eventually develop related TB during the course of the diseases. Already, countries severely affected by HIV have witnessed a high increase in the incidences of TB in the past decade. In this regard, WHO in collaboration with partners and Ministries of Health of Member States have targeted DOTs (directly observed treatment – short course) expansion to countries according to the burden of TB disease and population size:

(i) **Countries Implementing DOTs Strategy in less than 10% of the total population**
Angola, Cameroon, DRC, Egypt, Eritrea, Ethiopia, Ghana, Mali, Mauritania, Nigeria, Somalia, South Africa, Sudan and Zimbabwe.

(ii) **Countries Implementing DOTs Strategy in over 90% of the total population**
Benin, Botswana, Burkina Faso, Burundi, Chad, Djibouti, Guinea, Kenya, Libya, Malawi, Mauritius, Namibia, Rwanda, Senegal, Tunisia, Uganda and Tanzania.

(iii) **Countries not Implementing DOTs Strategy**
Cape Verde, Comoros, Equatorial Guinea, Gambia, Guinea Bissau, Lesotho, Liberia, Madagascar, Mozambique, Niger, Seychelles, Sierra Leone, Togo and Zambia.

GENERAL COMMENTS

(a) **The Integrated Approach**

29. The priority areas listed under implementation of HIV/AIDS policies and strategies also apply to Malaria, Tuberculosis and other related infectious diseases as the same Health Systems are the channel for implementation. These three being the major causes of morbidity and mortality in Africa need to be tackled together. Although a lot is being done, much more needs to be done if Africa's renaissance is to be realized.

(b) **International Partnership Against AIDS in Africa (IPAA)**

30. IPAA was created in 1999 by a coalition of actors who included African Governments, African and International Civil Society, the UN System, Donors, Foundations, Private and Corporate Sectors. Their aim was to work together to achieve a common vision, goals and objectives based on a set of mutually agreed principles with a set of key milestones. In this regard, the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases called for harmonization of programmes and the rational use of resources through national and international partnerships. This implies that IPAA should not be defined by Nations versus International Agencies. Rather, the partnership should extend up to communities in any one country through a continuum of Strategies understood by all stakeholders. In this context, partnerships should include a package of interventions bearing on a package of major pandemics – HIV/AIDS, TB, Malaria and other related infectious diseases. Realization and sustainability of such partnership should form the basis of health systems reform in African countries. The many players have to be coordinated through the "Three by Ones" Principle already referred to.

(c) **Critical Issues:**

31. The major critical issues noted include:

- Limited human resource and technical capacity;
- Under-developed Health Systems;
- Stigma and Discrimination;
- Decentralization and scaling up;
- Access to prevention and treatment;
- Gender inequality;
- Poverty, conflicts and famine;
- Harmonization of donor support;
- Coordination and partnership development;
- Concerning monitoring and reporting:
  Limited communication between the AU Commission and Ministries of Health; the main channel of communication being Foreign Affairs Ministries.

AIDS WATCH AFRICA (AWA)

32. At the Heads of State and Government level, the monitoring and follow-up of the implementation is coordinated by AIDS Watch Africa (AWA), comprising 8 (eight) Heads of State, chaired by H.E. President Olusegun Obasanjo of Nigeria. In this regard, it is hoped that a progress Report will be submitted to the Summit. In the NEPAD Health Strategy, it has been proposed that AWA be expanded to include more Members from the five regions of the Continent, especially those bearing the heaviest burden of HIV/AIDS.

RECOMMENDATIONS

33. The following recommendations were finally made by Health Ministers:

I. **At Member State level**:

(i) To strengthen partnerships, and plan strategies properly and coordinate programmes under the "Three Ones" Principle as proposed by UNAIDS and other partners i.e., one action framework for coordinating partners, one national AIDS authority with broad-based multi-sectoral mandate and one agreed country-level monitoring and evaluation mechanism.
(ii) More efforts should be made to mobilize (additional) national resources for control of HIV/AIDS, Tuberculosis and Malaria, especially for essential drugs. External funding should be accessed as a supplementary source.
(iii) Proposals to the Global Fund should be carefully drafted to reduce delays in processing; and proposals by civil society organizations should be entertained together with those by Government. The funds so accessed should be used rationally, as scheduled and accounted for.
(iv) Development and maintenance of health systems should be mainstay of health promotion and disease control. In this regard, adoption of the integrated approach for disease control was underscored as the same infrastructure e.g. immunization would be utilized for other areas.
(v) Even if drugs especially anti-retrovirals were made available, countries need to plan for sustained supplies or procurement, e.g. after the expiry of the WHO "3 by 5" strategy or other initiatives.
(vi) Prevention and the central role of nutrition were still paramount in the control of HIV/AIDS, Tuberculosis and Malaria, and therefore, should be given due attention. In this regard, there was need to strengthen information, education and communication.
(vii) Research including in traditional medicine was encouraged.
(viii) Countries were urged to respect human rights of people infected and affected by HIV/AIDS and to fight stigma and discrimination.
(ix) Communication and networking with other Ministries was encouraged.

II. **At Regional Economic Communities (RECs) Level**:

(i) Regional cooperation and integration should be encouraged especially as concerns access to essential drugs and Research.
(ii) Regional Centres of Excellence should be established.
(iii) RECs should be encouraged to work with the AU Commission.

III. **At the AU Commission (AUC) Level**:

(i) Programmes of the AUC should focus on improving the quality of life of people and mobilizing African leaders to understand this.
(ii) While following the normal channel of communication through the Ministries of Foreign Affairs, the Commissioner for Social Affairs should establish a direct link with Health Ministries. Focal points should also be identified in Ministries for quick contact.
(iii) The AUC should arrange to prepare a detailed progress Report on the implementation of the Declarations, in matrix format. The draft should be circulated to Member States for input.
(iv) The capacity at AUC should be strengthened.
(v) The interface between AUC and WHO should be strengthened, with AUC participating actively in decision-making meetings of WHO-AFRO.
(vi) The AUC should review past Declarations and Decisions, evaluate the status of implementation and propose a more effective way forward.

IV. **At International Community Level**:

(i) To mobilize additional resources on sustained basis to support the Global Fund and national programmes.
(ii) To provide technical support and guidance to all countries, including those that do not require financial support.
(iii) Support the WHO "3 by 5" strategy to promote access to anti-retrovirals.
(iv) International Community players to plan to meet the needs of countries rather than bringing finished packages; and to harmonize and coordinate their activities.
(v) The Global Fund to simplify the process of availing countries the funds it coordinates.

-The Statement of African Ministers of Health is annexed to this Report

STATEMENT OF THE MINISTERS OF HEALTH OF THE AFRICAN UNION ON THE OCCASION OF THEIR SPECIAL SESSION, GENEVA, SWITZERLAND, 14 - 15 MAY 2004

WE, Ministers of Health of the African Union, meeting in Geneva on the occasion of the Special Session, organised in partnership with the World Health Organization (WHO), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and the Global Alliance for Vaccines and Immunization (GAVI);

RECALLING the Abuja Declaration and Plan of Action on Roll Back Malaria of 2000, the Abuja Declaration and Plan of Action on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases of 2001, the Maputo Declaration on Malaria, HIV/AIDS, Tuberculosis and Other Related Infectious Diseases of 2003, the Maputo decision on Polio Eradication of 2003, AU/NEPAD Health Strategy of 2003 and the Millennium Development Goals;

CONSIDERING the challenges of implementing the above Declarations and Decisions; critical issues in the fight against HIV/AIDS, TB, Malaria and Other Related Infectious Diseases; the progress of immunization in Africa; access to essential drugs and consumables for HIV/AIDS, TB and Malaria; health systems in Africa; partnerships in the health sector; ownership and sustainability of initiatives in public health;

APPRECIATING **the support of all our Partners in the implementation of our health programmes;**

REALIZING the importance of accelerating the effective implementation and monitoring of the above Declarations and Decisions;

HEREBY RESOLVE TO:

1. Mobilise total political commitment and leadership at all levels and facilitate greater involvement of communities and civil society in meeting Africa's health challenges in the 21st Century.

2. Ensure both national ownership and leadership of health initiatives and programmes, and encourage each country to establish one national strategy, one coordinating body and one monitoring framework for all initiatives to combat HIV/AIDS, TB and Malaria, and Other Related Infectious Diseases.

3. Improve communication and coordination between relevant ministries, private sector, civil society and international development partners.

4. Mobilise greater domestic resources to fight HIV/AIDS, TB, Malaria and Other Related Infectious Diseases, including for vaccines and immunization, and in particular to ensure the realization of the target of allocating at least 15 per cent of our national budgets to the health

sector as set at the Abuja Summit of Heads of State and Government of the Organization of African Unity in 2001.

5. Urge all Member States of the African Union to contribute resources to the Global Fund, in order to demonstrate solidarity and shared responsibility in the call made by Heads of State and Government of the African Union in the Maputo Declaration.

6. Develop mechanisms to ensure sustainability of global health initiatives in the African region, looking beyond planned initial target dates, in particular the "3 by 5" Initiative beyond 2005.

7. Accelerate the strengthening of health systems in order to improve access to health services, paying particular attention to:

- Improving Information, Education and Communication at all levels in the implementation of health strategies;

- Promoting appropriate policies and strategies to train, motivate and retain human resources and increase their deployment in rural areas;

- Developing and maintaining infrastructure, especially technical capacity in health units particularly laboratories;

- Reinforcing and expanding research capacity;

- Utilizing existing services to improve delivery and access to Insecticide Treated Nets, as well as indoor residual spraying with insecticides;

- Ensuring the attainment of Polio Eradication targets;

- Developing and improving capacity to respond more effectively to health challenges.

8. Strengthen health programmes that address non-communicable diseases and place special focus on programmes related to maternal and child health, health promotion, nutrition and health literacy.

9. **Develop** and utilize Africa's capacity in biotechnology to produce drugs and vaccines at national or sub-regional levels.

10. **Engage** in more active dialogue with pharmaceutical companies to ensure universal, equitable access to affordable quality drugs (including generics) and vaccines.

11. Mobilise adequate resources to expand research and use of traditional medicine in line with the Decade for African traditional medicine (2001 – 2010).

HEREBY REQUEST:

1. The African Union Commission to:

- Improve communication and coordination with the Ministers of Health;
- Ensure effective and timely monitoring, evaluation and reporting on the implementation of Declarations and Decisions;
- Strengthen its capacity to respond effectively to its mandate on health;
- Collaborate with WHO Regional Offices for Africa and Eastern Mediterranean, and Regional Economic Communities of the African Union in harmonising the implementation of initiatives in health;
- Participate in major fora where important health issues are discussed and decisions taken.

2. External donors to make available increased, sustainable financing, towards health system improvement in general and priority health interventions, in particular through mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Global Alliance for Vaccines and Immunization (GAVI), and through such development financing opportunities as the proposed International Finance Facility and the European Development Fund (EDF).

3. Multilateral and Bilateral Agencies to harmonize and coordinate their activities and also streamline their procedures to improve access to, and efficient utilization of resources.

4. The Bureau of the Conference of the Ministers of Health to monitor the implementation of these Decisions in collaboration with the Commission of the African Union and report to the next meeting.

2004

Progress report on the implementation of the Maputo declaration on malaria, HIV/AIDS, tuberculosis and other related infectious disease (Orid)

African Union

African Union