

**Delivering results
toward ending
AIDS, Tuberculosis
and Malaria in Africa**
**African Union
accountability report
on Africa–G8
partnership
commitments
2013**

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In this era of transformation across our Continent, Africa is demonstrating its leadership to end AIDS, TB and Malaria as never before. Together with our G8 partners, we have attained significant results. We now need to redouble efforts.

H.E. Hailemariam Desalegn

Chairperson of the African Union and Prime Minister of Ethiopia

Investing in health, particularly in HIV, TB and malaria programmes, is a prerequisite for African economic growth, development and security. Putting African health at the centre of the AU-G8 partnership is fully justified on political, economic and social grounds.

H.E. Macky Sall

Chairperson of NEPAD HSGOC and President of Senegal

This accountability report will generate new ideas on how we can strengthen cooperation with our partners and how we can hold each other more accountable, especially in the context of shared responsibility and global solidarity to end AIDS, TB and malaria in Africa.

Dr. Ibrahim Mayaki

CEO of the NEPAD Agency

The last decade of unprecedented development across Africa coincides with dramatic results in the AIDS response. The visionary Africa-G8 partnership has been central to this progress — progress that should inspire yet bolder ambition and determination to end AIDS, TB and malaria.

Michel Sidibé

UNAIDS Executive Director

Foreword

The African Union's 50th anniversary provides a unique opportunity to reflect critically on African efforts and progress on its developmental path but also on its evolving relationships with the external partners who have joined the Continent on this journey. It is particularly opportune to do so in the context of unprecedented shifts in poles of geo-political power and new approaches to development cooperation and finance.

Arguably one of the deepest partnerships has been in response to the emergencies of AIDS, TB and malaria. Just over a decade ago, there were valid fears that these diseases would not only further set back Africa's development trajectory but also tear apart the very fabric of society. It had the power to destabilize an entire continent.

In the face of despair, strident efforts were made to tackle these complex epidemics. With African leadership, unprecedented and unimaginable progress has been achieved on all three diseases, perhaps most remarkably in the case of HIV where new infections have diminished by 25% and treatment access has increased from a few thousand to over seven million Africans since 2001. And while much remains to be done to bring about an end to these epidemics, the solid and accelerating achievements reflect the dedication of many partners, not least people living with and affected by these diseases, but also a range of external development partners — including the G8 countries.

The G8 has delivered on the major commitments it has made to AIDS, TB and Malaria responses in Africa. As this report reveals, this strong partnership has delivered impressive results. And following the adage of the late Prime Minister of Ethiopia, and then Chairperson of NEPAD HSGOC, that “there is no possibility of us keeping our promise to our people unless we do more and better to take charge of our destiny and depend on our own resources as the primary means of achieving the MDGs”, we see African countries taking increasing ownership of the response to these diseases.

This accountability report, the first of its kind, identifies successes and gaps on the part of both the G8 and African countries in meeting commitments they have made to work together to reverse the epidemics of AIDS, TB and Malaria. Building on this partnership, the African Union adopted in 2012 the *Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria in Africa* – with concrete results outlined for 2015. We hope that the G8 will now respond to this leadership initiative by embarking on a renewed set of commitments to support African efforts to bring an end to these epidemics on the Continent.

Nkosazana Dlamini Zuma, Chairperson, African Union Commission
Michel Sidibé, Executive Director, UNAIDS

25% reduction in annual number of new HIV infections in Africa between 2001 and 2011.

7.1 million people in Africa receiving HIV treatment in 2012.

9 million years added to Africa lives between 1995 and 2011 with the scale up in HIV treatment.

1.3 million lives saved between 2005 and 2011 by TB-HIV treatment.

12.7 million people in Africa treated for TB between 2000 and 2011.

1.1 million deaths averted due to Malaria prevention and control efforts in Africa between 2000 and 2010.

18-fold rise in percentage of households owning at least one bednet since 2000.

33% reduction in Malaria burden since 2000 in Africa.

About this report

In the spirit of accountability, leaders from the African Union (AU) and the Group of Eight (G8) agreed at the Hokkaido G8 2008 Summit in Japan to institute a follow-up mechanism to monitor the delivery of commitments for development made by both sides of their partnership. The AU and its New Partnership for Africa's Development (NEPAD) Programme produced their first accountability report in 2011, while the G8 has reviewed its collective commitments since the 2010 Muskoka Summit in Canada. This document, however, represents the first thematic accountability report summarizing progress towards commitments made in connection with the collective AU–G8 partnership relating to AIDS, Tuberculosis (TB) and Malaria.

The aims of this accountability report are fourfold:

- 1.** Assess the delivery and impact of mutual commitments by Africa and G8 development partners from 2000 to 2012, with particular emphasis on AIDS, TB and Malaria;
- 2.** Highlight progress made by Africa within the context of its own renewal agenda with respect to these three priority diseases;
- 3.** Identify challenges and lessons learned in the AU–G8 partnership to bridge the gap between commitments and delivery in the health sector; and
- 4.** Propose priority policy actions to create an African generation free of AIDS, Tuberculosis and Malaria.

The African Union Commission (AUC) and the NEPAD Agency, with the support of UNAIDS, undertook a review of available data to assess the degree to which commitments made by the AU and the G8 have been implemented. Given the collective nature of the commitments, this review focused on collective achievements of the AU member states and G8 countries, rather than on the specific contributions of individual members of these two groups.

Findings of this review were validated by officials of the AUC, the NEPAD Agency and UNAIDS, as well as by technical experts from the Stop TB Partnership, the Roll Back Malaria (RBM) partnership, the African Leaders Malaria Alliance (ALMA), the Global Fund, the GAVI Alliance, and AIDS Accountability International. Key findings and recommendations of this validation meeting were reflected in a draft of the report reviewed and endorsed by the Steering Committee of the NEPAD Heads of State and Government Orientation Committee (HSGOC). The report was subsequently presented to health experts from AU member states. It was officially launched and adopted at the NEPAD HSGOC meeting in Addis Ababa, Ethiopia, during the 50th anniversary celebrations of the Africa Union in May 2013.

Key messages

- 1.** Over the past decade, African countries, with leadership from the AU, have demonstrated strong political commitment to address health by embracing transformative reforms, particularly with regard to the epidemics of HIV, TB and Malaria. This is reflected in the *AU Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa*.
- 2.** The partnership between Africa and the G8 has delivered unprecedented progress in mitigating the HIV, TB and Malaria epidemics and strengthening health systems, which has resulted in enhanced productivity, protection of vulnerable households and striking improvements in quality of life.
- 3.** The G8 has collectively fulfilled critical commitments to health in Africa—including its US\$ 60 billion pledge for AIDS, TB and Malaria in 2007–2012. The recent financial crisis, however, has resulted in a decline in international investments, exposed the insecurity of this funding and jeopardized the sustainability of recent health gains.
- 4.** These three epidemics continue to claim millions of lives in Africa and represent a continuing global threat. Therefore, the partnership should commit to scaling up investments made in the responses to AIDS, TB and Malaria:
 - More African countries should meet their Abuja commitment to allocate 15% of public expenditures to health, and most importantly, African countries should increase domestic investments and diversify funding sources, including through innovative financing.
 - The G8 is called upon to allocate at least 0.7% of gross national income (GNI) to official development assistance.
- 5.** Both the G8 and the broader global community should actively support favourable trade and investment policies to expand Africa's production of quality-assured, affordable health commodities.
- 6.** Future efforts by the AU and G8 to sustain and accelerate progress in the response to AIDS, TB and Malaria should be grounded in human rights, gender equality and solidarity with marginalized populations.
- 7.** The AU and G8 should expand the partnership to engage the G20 (Group of Twenty Finance Ministers and Central Bank Governors) and BRICS (Brazil, Russia, India, China and South Africa) countries, as well as the private sector and other global actors, in order to contribute to ending AIDS, TB and Malaria in Africa. This expanded partnership should accelerate African efforts to attain the health-related MDGs in the remaining years and ensure a strong focus on the three priority diseases in the post-2015 development agenda for sustainable health in Africa

Executive summary

There is growing recognition that an effective and sustainable response to AIDS, TB and Malaria is a shared responsibility that demands commitment, strategic action and accountability from diverse stakeholders. Since 2000, AU and G8 countries have made a series of concrete, time-bound pledges as part of the responses to AIDS, TB and Malaria. In 2008, African and G8 leaders agreed at the Hokkaido G8 summit to institute a follow-up mechanism to monitor adherence to the parties' commitments on development issues, including the three priority diseases.

This accountability report, which is premised on the *AU Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria*, is unique in assessing progress on AU and G8 health-related commitments. The report, which also offers recommendations on how to strengthen the AU–G8 partnership and accelerate improvements in health outcomes, emerges less than three years before the deadline for targets in the Millennium Development Goals and the 2011 Political Declaration on HIV and AIDS.

The partnership between the AU and G8 has resulted in unprecedented health gains for the region. The annual number of people newly infected with HIV in Africa has fallen by 25% since 2001, new HIV infections among children declined by 24% between 2009 and 2011, and the number of people who died of AIDS-related causes in 2011 was 32% lower than in 2005.¹ As access to TB care has expanded, saving 20 million lives from 1995 to 2011, the prevalence and incidence of TB in Africa have declined.² There are also encouraging signs in the effort to prevent new cases of Malaria, as the percentage of households owning at least one insecticide-treated net rose from 3% in 2000 to 53% in 2012, with a 33% reduction in malaria burden. Eight countries have already achieving the targeted reduction of 75% in Malaria incidence since 2000.

Although much has been achieved, critical gaps remain. More than 40% of people in Africa who were eligible for antiretroviral therapy (ART) under World Health Organization (WHO) guidelines were not receiving treatment in 2011. Africa is not on track to achieve the target of reducing TB incidence, prevalence and mortality by 50% by 2015, and the number of insecticide-treatment bednets purchased for use in Africa dropped by more than half between 2010 and 2012.

G8 countries have largely met their commitments to finance the response to AIDS, TB and Malaria in Africa. The G8 helped establish the Global Fund, provided 78% of funding for the Global Fund in 2001–2009, and met its commitment to generate US\$ 60 billion in health assistance to Africa in 2007–2012.³ In addition to serving as a critical channel for new funding for health programmes, the Global Fund has provided an invaluable platform to engage new partners, such as the private sector and non-G8 countries, in financing the response to these three priority diseases. Although G8 countries met their 2007–2012 funding commitments—a historic achievement, and one that has saved millions of lives—the financial crisis that unfolded in 2008 resulted in sharp reductions in contributions to the Global Fund, and it continues to affect the level of international investments in health in Africa.

For African countries overall, the percentage of total government expenditures devoted to health rose from 9% in 2001 to 11% in 2011. Only six AU member states, however, have met the 15% expenditure benchmark for national health spending, although the share of government expenditure allocated to health exceeded 14% in an additional four countries.⁴ Several AU member states have significantly increased domestic investment in AIDS, and total domestic government funding for Malaria control in Africa was estimated at US\$ 625 million in 2011. International support, however, accounts for more than half of all HIV-related spending in 26 of the 33 countries most heavily affected by AIDS. With stagnating health funding from traditional partners, efforts are urgently needed to increase domestic investments, diversify funding sources and ensure resources are strategically invested for greatest results.

“The partnership between the AU and G8 has resulted in unprecedented health gains for the region. The annual number of people newly infected with HIV in Africa has fallen by 25% since 2001.”

Consistent with pledges to strengthen health systems, 47 AU member states have developed a plan to strengthen health systems,⁵ and regional leaders have pursued strategies on such priority issues as pharmaceutical manufacturing capacity and the health workforce.⁶ The scale-up of HIV funding has been associated with greater service integration, increased utilization of certain non-HIV-specific health services, improved maternal and child health outcomes, and increased life expectancy. Moving forward, the G8 should continue and strengthen its efforts to support health systems while also addressing priority diseases, remaining attentive to domestic resource constraints (such as limited numbers of health workers), and intensifying service integration.⁷

Given that medicines regulatory agencies of AU member states operate independently, there is an urgent need to encourage concerted efforts towards effective utilization of resources and the development of regional markets. As a precursor to a single African regulatory agency, the *AU Pharmaceutical Manufacturing Plan for Africa* (PMPA) outlines an action framework to enhance the local manufacture and distribution of essential drugs and commodities for AIDS, TB and Malaria.

Historic strides have been made towards ensuring access to affordable medicines and technologies, and to research and development. The annual price for first-line antiretroviral drugs has declined from over US\$ 10 000 per person per year in 2000 to less than US\$ 116 for the lowest-cost, WHO-recommended first-line regimen. Prices for second-line regimens, however, remain much higher. Nearly all (42 of 43) Malaria-endemic countries in Africa were distributing artemisinin-based therapy (ACT) in 2008, including 23 that provided ACT free of charge for children under the age of five.⁸ To encourage further price reductions and enhance sustainable commodity security, increased efforts are needed to maximize utilization of the flexibilities permitted under the Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS).

Recognizing the centrality of human rights to an effective AIDS response, 40 AU member states have adopted laws or regulations that prohibit HIV-related discrimination, and 90% report having programmes in place to reduce stigma and discrimination as part of their AIDS response. The persistence of punitive laws pertaining to marginalized populations at higher risk, however, remains a cause for concern.

Reflecting a commitment to monitoring and evaluation (M&E) in order to facilitate accountability, there is evidence of rapid scale-up and strengthening of national M&E systems, although Malaria and TB surveillance has failed to benefit to the same degree as HIV. In response, the EVAL HEALTH Project, of which the New Partnership for Africa's Development (NEPAD) is a consortium partner, has developed a methodology and tools to assist countries in monitoring the impact of their health programmes.⁹

Partnerships are critical to an effective response to AIDS, TB and Malaria. Civil society, including networks of people living with HIV, has played an especially pivotal role in the AIDS response. As of December 2012, 48 countries had ensured full involvement and participation of civil society in the development of their national AIDS strategy, while national AIDS coordinating bodies in 47 countries included people living with HIV.¹⁰

As the results achieved since 2000 underscore, the health and well-being of many millions of people depend on the joint efforts of the AU and G8. By building on prior achievements to produce an even more effective partnership, the AU–G8 collaboration has the potential to lead to the end of AIDS, TB and Malaria.

Moving forward, the AU and G8 should take steps to strengthen, deepen and expand their partnership.

AU member states are called upon to do the following:

1. Collectively meet the Abuja commitments on health investments in the context of diversifying financing—including through increased innovative financing and social protection—and to promote African leadership and ownership.
2. Accelerate efforts towards a harmonized regional approach to the regulation of medicines through the African Medicines Regulatory Harmonization (AMRH) and the manufacture of pharmaceutical products as a means to implement the PMPA Business Plan. This is to enhance access to quality-assured essential drugs and commodities—including those for AIDS, TB and Malaria—with the support of G8 countries and in the context of continued TRIPS flexibilities and the extension of the TRIPS waiver for Least Developed Countries beyond 2015.
3. Strengthen African-led, continental accountability mechanisms—such as the Africa Peer Review Mechanism (APRM), AIDS Watch Africa (AWA) and others—utilizing these platforms to more actively share lessons learnt on accelerating progress towards agreed targets for the three diseases.
4. Ensure full implementation of the *Continental Framework for Harmonization of Approaches among Member States and Integration of Policies on Human Rights and People Infected and Affected by HIV/AIDS in Africa*.

G8 member states are called upon to do the following:

1. Support AU member states in implementing their *Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria* through the articulation of specific and new time-bound pledges in relation to the priority actions.
2. Collectively meet their commitments to substantially increase official development assistance (ODA) to Africa based on the Gleneagles Summit declaration, and to invest 0.7% of GNI in ODA to fill gaps as required. Africa welcomes the efforts of the G8 countries that have individually met their commitments.
3. Actively promote the use of country systems, and more forcefully ensure that investments are coordinated and aligned with African countries' priorities and plans, in line with the Paris Declaration, the Accra Agenda for Action and the Busan Global Partnership for Effective Development Cooperation, focusing on high-burden countries and populations.

Both partners are called upon to do the following:

1. Focus investments on achieving better value for money, including through continuing to reduce the unit costs of testing and treating the three diseases.
2. Take action to strengthen health systems, particularly human resources for health, and improve the availability of timely, reliable and valid data to guide policy-making, strategic investments, implementation and accountability.
3. Use their collective influence to help ensure that the post-2015 development agenda and accountability framework maintains a priority focus on AIDS, TB and Malaria in order to sustain and accelerate progress.
4. Take action to ensure that national responses are grounded in human rights, gender equality and non-discrimination with respect to marginalized populations, as part of the implementation of the AU framework on the harmonization of human rights approaches.¹¹
5. Undertake a joint mutual accountability review on commitments in 2015 under the auspices of the revitalized AIDS Watch Africa, and consider expanding their partnership to include the BRICS countries and the broader G20.

Figure 1.

Timeline of African Union and G8 commitments on HIV, TB and Malaria, 2000–2012

African Union

Abuja, 2001

Considers AIDS an emergency on the continent. Calls for a comprehensive strategy to mobilize all sectors of society and pledges 15% of public spending for health.

Lome, 2000

Calls for a plan of action to accelerate health sector reform with a focus on HIV and malaria.



Maputo, 2003

Commits to promote partnerships with the UN, pharmaceutical companies and others to increase local and regional production of affordable generic medicines for HIV, TB and Malaria.

Addis Ababa, 2004

Commits to accelerate gender-specific economic, social and legal measures to combat HIV, and to enact legislation to end discrimination against women living with HIV.

Gaborone, 2005

Commits to universal access to prevention, treatment and care for HIV, TB and Malaria. Calls on countries to make full use of TRIPS flexibilities and to work with WTO to remove all constraints on access.

G8

Okinawa, 2000

Commits to several targets for 2010, including reducing HIV infected young people by 25%, TB deaths and prevalence by 50%, and malaria burden by 50%.

Evian, 2003

Reaffirms support for the Global Fund and commits to facilitate the availability of discounted medicines for the poorest in an efficient and sustainable manner.

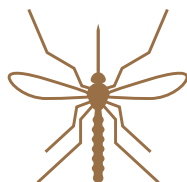
Kananaskis, 2002

Welcomes NEPAD and puts forward the G8 Africa Action Plan, which includes a section on improving health and confronting HIV/AIDS.



Genoa, 2001

Reports on the launch of the Global Fund to Fight AIDS, TB and Malaria and their commitment to provide US\$ 1.3 billion to it.



Gleneagles, 2005

Commits to work with partners to achieve an AIDS-free generation in Africa and universal access to treatment by 2010. Commits to US\$ 60 billion in debt relief and to double aid to Africa by 2010.



Abuja, 2006

Recommits to intensify leadership and mobilize domestic resources for the three diseases. Requests HIV, TB and Malaria to be addressed through the NEPAD African Peer Review Mechanism.

Kampala, 2010

Extends the Abuja call for universal access to 2015, calls for a coordinated effort to end mother-to-child transmission of HIV, and commits to accelerate efforts to improve the health of women and children.

Addis, 2012



Endorses the Roadmap on Shared Responsibility and Global Solidarity for HIV, TB and Malaria and the Pharmaceutical Manufacturing Plan for Africa Business Plan.

2006

2007

2008

2009

2010

2011

2012

Toyako, 2008

Reaffirms development principles of good governance based on transparency and rule of law. Commits to provide 100 million bednets by 2010 and to work towards a ratio of 2.3 health workers per 1000 people.

Deauville, 2011

Commits to continue support for the Global Fund and calls on non-traditional donors and the private sector to provide resources as well.

Heiligandamm, 2007

Commits to provide US\$ 60 billion for infectious diseases and health systems over five years; support HIV treatment for five million people and a 50% reduction in malaria deaths.

L'Aquila, 2009

Reaffirms commitment to universal access to HIV services by 2010 in combination with TB and Malaria efforts. Commits to eliminate travel restrictions on people living with HIV.

St Petersburg, 2006

Commits to intensify scientific research on infectious diseases and improve access to prevention and treatment through stronger health systems.

Muskoka, 2010

Commits to promote integration of HIV and sexual and reproductive health, rights and services within the context of strengthening health systems.

Section 1:

Introduction



1.1 Fifty years of African unity and development progress

Steadfast citizen-centred and effective governance policy reforms are radically changing the landscape of African development and improving the health and well-being of people living in the region. In 2001, African leaders formed the New Partnership for Africa's Development (NEPAD) as a home-grown, integrated strategy and the flagship development programme of the African Union, substantially strengthening the concerted drive for continental transformation and regional integration. An equally critical role has been played by sub-regional and multi-country bodies, primarily the Regional Economic Communities (RECs).¹²

As the new millennium dawned, African countries joined together under the common platform of the African Union and its NEPAD programme to champion an African rebirth. This value-driven, collaborative continental strategy principally aims to place African countries, individually and collectively, on the path to sustainable growth and development. In prioritizing efforts to improve health, African leaders have reiterated that the health of their people is the continent's greatest asset. As part of this historic drive for Africa's regeneration, the continent has forged a special partnership with the industrialised economies in the G8 and other OECD countries, while also taking steps to strengthen South-South partnerships.

As unprecedented opportunities, daunting challenges and the emergence of important new actors have re-defined the frontiers of development in the era of globalization, Africa has re-affirmed its hopes for fairer and more effective development cooperation architecture.¹³ This renewed determination, building on the drive and commitment of African leaders, aims to generate concrete, sustainable results for all African people and to reverse the continent's marginalization. The strategic support of the international community, including the G8, plays an important role in realizing this transformative vision.

The year 2013 marks the 50th anniversary of the establishment of the Organization of African Unity, which was transformed into the African Union in 2000. This occasion offers the continent a unique occasion to reflect on achievements to date and on prospects for fully realizing the vision of an African Renaissance. This landmark anniversary occurs after more than a decade of experience with the Africa-G8 partnership, providing yet another reason for reflection.

Throughout its history, the AU has emphasized the core principles of good governance, African ownership and leadership, as well as equity, fairness, mutual respect, accountability

and transparency—all in the quest to reshape the global partnership architecture.¹⁴ Based on shared values and commitments, both Africa and the G8 have worked to establish a new, solution-focused and inclusive partnership system through regular high-level engagement. This new approach to international cooperation was launched at the G8 Summit in Okinawa, Japan, in 2000, with a formal inauguration in 2001 in Genoa, Italy, at the first of what has since become the annual G8/Africa Partnership Outreach.

In a series of declarations extending from the Genoa summit to the 2012 Camp David summit, the G8 undertook commitments to support Africa in its new development path. Along with relevant sector-specific commitments—such as the G8 2009 L’Aquila Food Security Initiative and the 2010 Muskoka Initiative on Maternal and Child Health—commitments at these summits memorialize the G8’s pledges to take concrete actions to promote attainment of the Millennium Development Goals (MDGs) in Africa.

Accountability begets enhanced leadership, which will be critical not only to ensure the sustainability of gains achieved to date, but also to accelerate progress towards an AIDS-free generation, sustained progress against TB and the elimination of Malaria. Accountability for commitments made to date is also vital to ensure that the post-2015 development framework maintains a powerful focus on health, and specifically on AIDS, TB and Malaria.

1.2 Overview of commitments of the AU and G8 on AIDS, Tuberculosis and Malaria

Between 2000 and 2012, member states of both the G8 and the AU formally prioritized efforts to address AIDS, Tuberculosis and Malaria. These many commitments, which built and expanded upon each other across multiple summits, are graphically illustrated in Figure 1.

The roots of the historic AU–G8 partnership trace back to 2000. In April 2000, African countries committed to undertake extensive actions to halve Malaria mortality in Africa by 2010, a commitment that was subsequently extended to 2015 to align with the MDG deadline. At the Okinawa Summit in 2000, the G8 committed to implement an “ambitious plan on infectious diseases, notably HIV, Tuberculosis and Malaria”, establishing specific targets for the three diseases. In 2001, African heads of state and government adopted the Abuja Declaration and Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and other Related Infectious Diseases, which became Africa’s common position for the 2001 United Nations General Assembly Special Session on HIV/AIDS. Both the AU and G8 actively embraced the commitments and targets set forth in the 2001 Declaration of Commitment on HIV/AIDS, which established the first set of agreed global targets in the AIDS response.

As illustrated in Figure 1, the AU and G8 pledged a series of clear, time-bound actions to transform the African health landscape and lay a strong foundation for the continent’s rebirth. In particular, the parties committed to:

- *ensure robust financing for the response to AIDS, TB and Malaria*, including creation of the Global Fund, doubling aid to Africa and allocating at least US\$ 60 billion for health in Africa in 2007–2012;
- *achieve specific outcomes for each of the three diseases*, including a 50% reduction in new HIV infections, elimination of new HIV infections among children, a 50% decline in TB incidence, and a 50% reduction in Malaria mortality;
- *strengthen health systems* to enable African countries to meet these ambitious targets, sustain gains, and address broader health challenges;

- *guarantee access to affordable, essential medicines and other health tools*, with a particular focus on access, as well as robust research and development efforts to generate vital new drugs, diagnostics and vaccines;
- *protect human rights and promote gender equality* by prioritizing efforts to eliminate stigma, prevent discrimination and empower women to protect their own health; and
- *fortify monitoring and evaluation systems*, including issuance of regular reports on progress towards existing commitments.

More recently, attention has specifically focused on sustaining health gains over the long run. In 2012, the AU endorsed the *Roadmap on Shared Responsibility and Global Solidarity for AIDS, Tuberculosis and Malaria*, promoting African-owned solutions, specifying clear goals and expected results, defining roles and responsibilities for each stakeholder, and focusing on the pillars of diversified financing, access to medicine and enhanced governance. As the global community approaches the 2015 deadlines for AIDS, TB and Malaria—as well as the full array of MDGs—the emphasis on sustainability will inevitably intensify as efforts to conceptualize a post-2015 development agenda accelerate.

This report assesses the extent to which the numerous commitments of the AU and G8 have been translated into action. While other comparable accountability reports have endeavoured to quantify progress towards specific commitments,^{15, 16} the qualitative nature of commitments made on the three priority diseases—as well as the diversity of methodologies used by the various stakeholders to collect relevant data to track progress—makes quantification challenging as a mechanism for accountability. For this reason, this report generally uses a qualitative approach, assessing progress made by the AU and the G8 against their commitments.

For the limited number of time-bound commitments that are quantitatively expressed, however, this report provides a quantitative assessment of the degree to which such commitments have been kept. These include the 2000 Okinawa commitment of the G8 to reduce disease burden by 50%, the Abuja target of allocating 15% of public funding in Africa towards health, the 2005 Gleneagles commitment to provide US\$ 1.5 billion a year for Malaria interventions, and the G8 and AU commitments on universal access to HIV treatment and care.

Accordingly, this report assesses progress against the most significant AU and G8 commitments made with respect to AIDS, TB and Malaria, selected against the criteria of measurability, primacy and political importance.¹⁷

AIDS Trends

Figure 2.

Number of people newly infected with HIV, 2001-2011

Source: UNAIDS estimates.

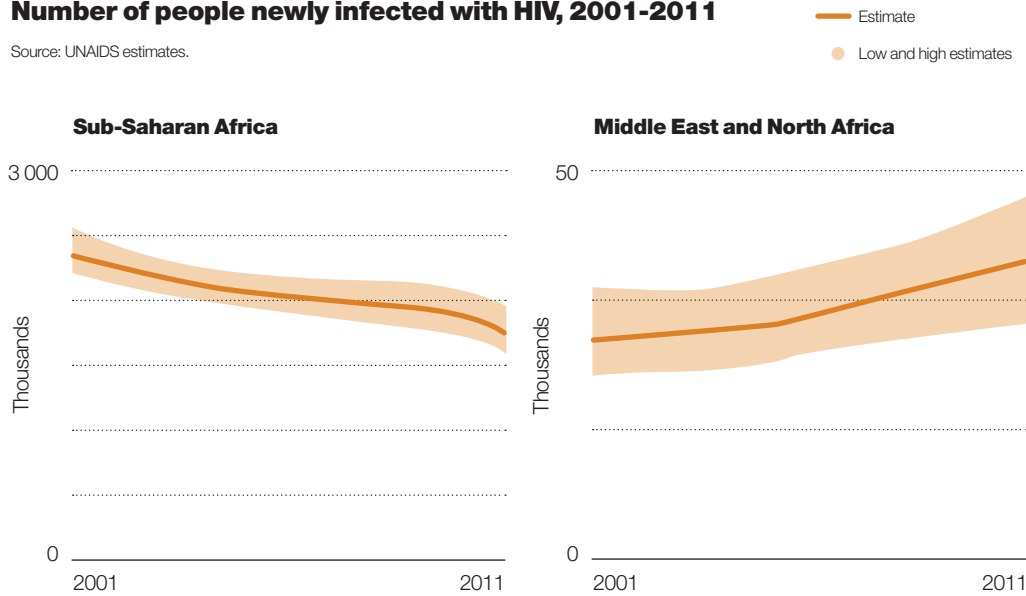


Figure 3.

Annual number of AIDS-related deaths in Africa, 2000-2011

Source: UNAIDS estimates.

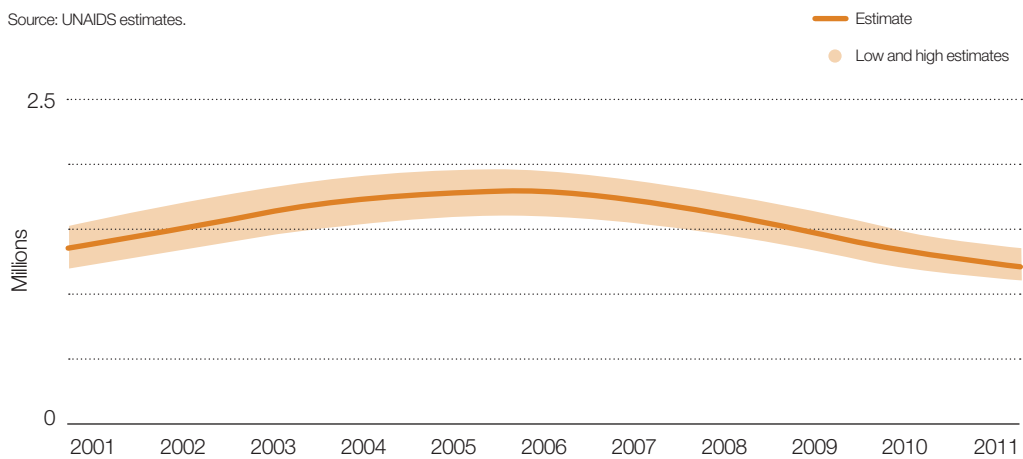
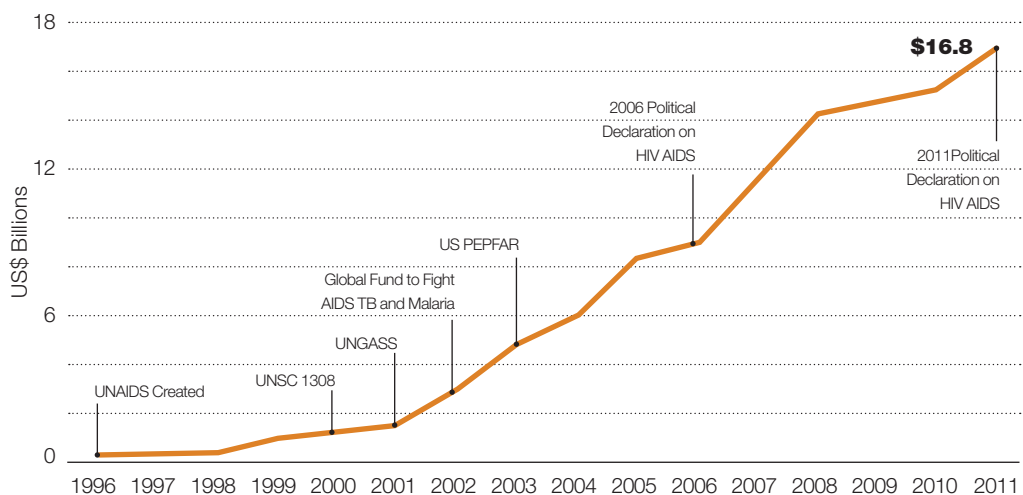


Figure 4.

Available funding for the AIDS response, 1996-2011

Source: UNAIDS estimates.



Tuberculosis Trends

Figure 5.

TB and TB+HIV incidence rates in Africa, 1990-2011

Source: Global tuberculosis report 2012. Geneva, World Health Organization, 2012 (www.who.int/tb/publications/global_report/en).

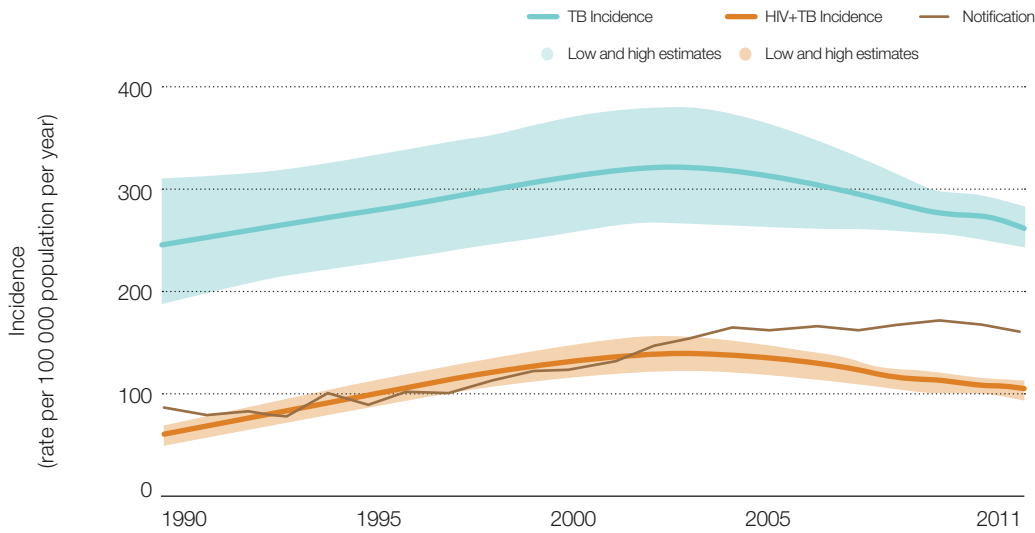


Figure 6.

Reductions in deaths among people living with HIV due to TB, 2004-2011

Source: Global tuberculosis report 2012. Geneva, World Health Organization, 2012 (www.who.int/tb/publications/global_report/en).

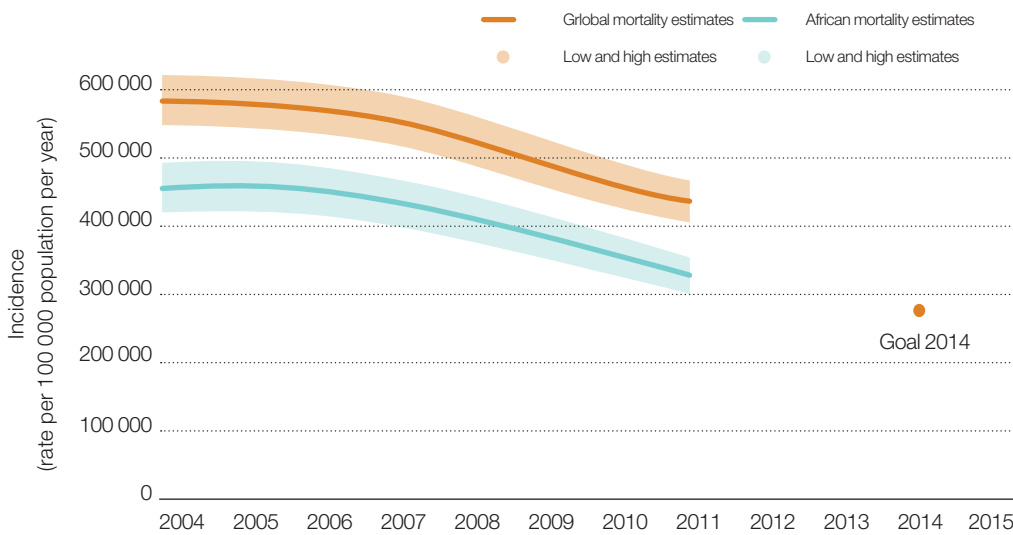
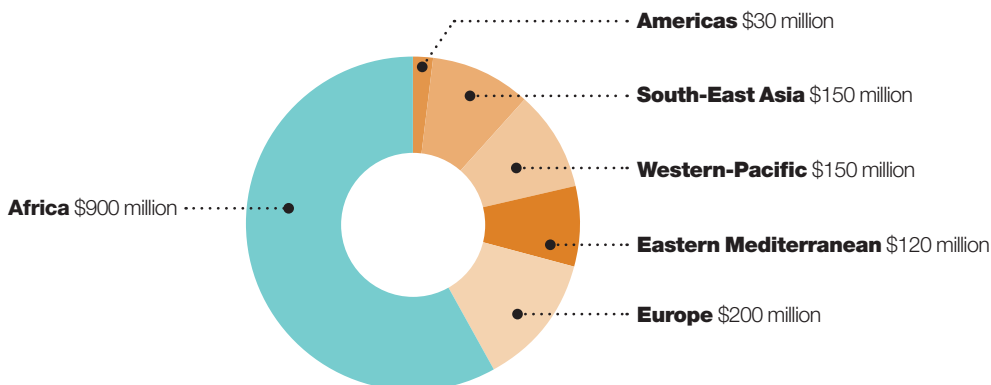


Figure 7.

Projected gaps in international funding to combat TB, 2014-2016

Source: World Health Organization estimates, 2012 (www.who.int/tb).



Malaria trends

Figure 8.

Decreases in reported Malaria case incidence rates in Africa, 2000-2011

Source: World malaria report 2012. Geneva, World Health Organization, 2012 (http://www.who.int/malaria/publications/world_malaria_report_2012/en).

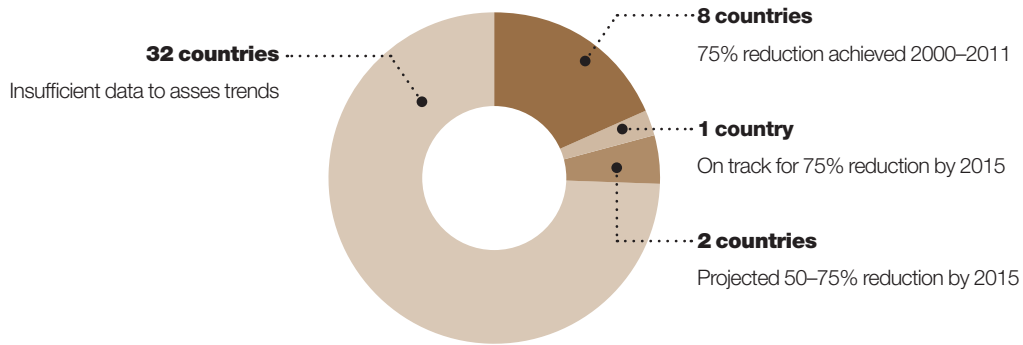


Figure 9.

Annual number of estimated deaths due to Malaria in Africa, 2000-2010

Source: World malaria report 2012. Geneva, World Health Organization, 2012 (http://www.who.int/malaria/publications/world_malaria_report_2012/en).

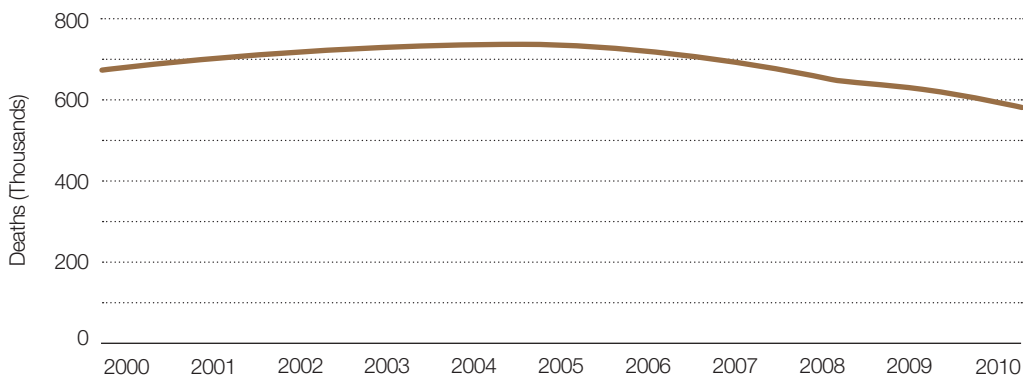
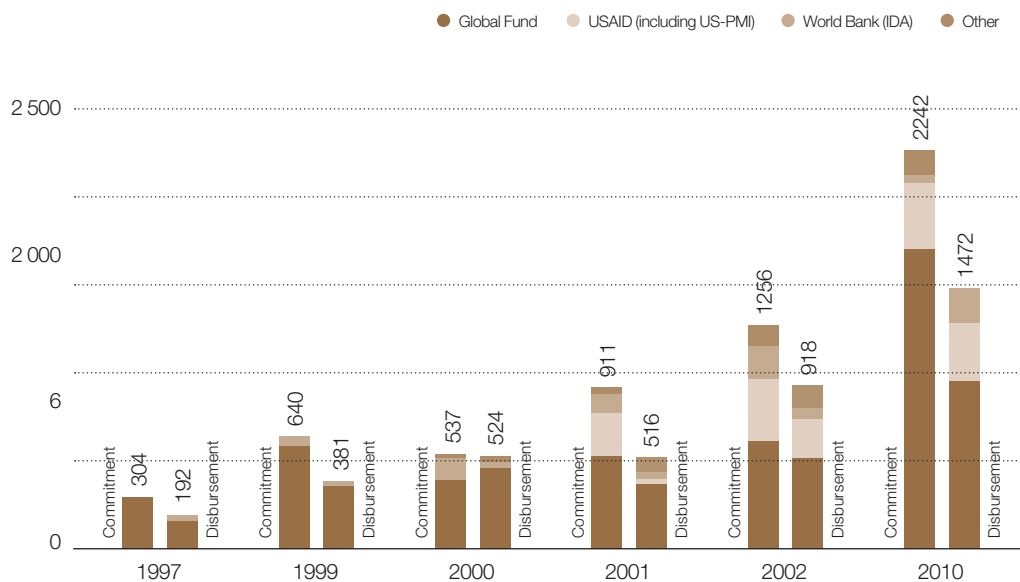


Figure 10.

Annual international investments for Malaria control in Africa (US\$ millions), 2004-2009

Source: Roll Back Malaria Partnership: A decade of partnership and results. Geneva, World Health Organization, 2012 (<http://www.rollbackmalaria.org/ProgressImpactSeries/docs/report8-en.pdf>).



Section 2: **Progress**



Substantial progress has been made over the last decade in the responses to AIDS, TB and Malaria in Africa. While AIDS has arguably received the greatest share of attention (political and public) and the most extensive funding among the three diseases, inclusion of TB and Malaria within the mandate of the Global Fund to Fight AIDS, TB and Malaria (also known as the “Global Fund”) and in Millennium Development Goal 6 (MDG 6) has also contributed to substantial mobilization of resources, communities and governments in the fight against these diseases. Reinvigoration of these disease-specific efforts has a) improved both health systems and the delivery of health services, b) enhanced the security of supplies of essential medicines by advancing local pharmaceutical manufacture and regulation, and by generating new strategies to reduce prices associated with medical innovations, and c) catalysed efforts to protect human rights.

2.1 Leadership

It has long been recognized that political commitment is central to an effective response to AIDS, TB and Malaria. Good leadership inspires, motivates, and creates a supportive environment for action. Since the launch of their unique partnership, the AU and the G8 have repeatedly pledged leadership in the response to AIDS, TB and Malaria, translating these commitments into tangible results that have saved millions of lives.

AU leadership commitments

During summits and ministerial meetings of the AU, African leaders have repeatedly declared their political commitment to the response to AIDS, TB and Malaria. There is evidence that African leaders have followed through on these commitments, as the heads of state government and other high officials have taken specific steps that demonstrate leadership on AIDS in the vast majority (90%) of AU countries.¹⁸ National AIDS Commissions/Councils are highly visible in many countries. In Ghana and Kenya, for example, these bodies are located in the President’s office; in Lesotho and the United Republic of Tanzania, they are placed in the Prime Minister’s office. Sufficient funding, on-going political support, and policies that increase staff retention help maximize the success of National AIDS Commissions/Councils.¹⁹

Lomé, 2000: African leaders commit to “*take personal responsibility and provide leadership for the activities of the National AIDS Commissions/ Councils*”.

The Abuja commitment to lead the national response to AIDS was confirmed in Brazzaville in 2006, where African heads of state and government pledged to lead a social movement in

their respective countries “to provide accurate and reliable information and to make a package of services available, within the context of a rights-based framework”. This commitment has been translated into actions in many countries. In Botswana, South Africa, Uganda and elsewhere, for example, such commitments have been backed up by institutional and budgetary commitments by the national government.

Ten African countries have officially declared TB to be a national emergency. While highlighting the need for urgent action to address TB in the mining sector in 2012, the heads of state and government of Southern Africa Development Community member states reaffirmed their collective commitment to the elimination of TB.

Commitments made at the 2000 Abuja Summit on Malaria have strengthened leadership to achieve concrete Malaria control targets. The African Leaders Malaria Alliance (ALMA), launched in September 2009, unites the heads of state and government of 49 African countries, harnessing their collective will to strengthen Malaria control, providing a forum for advocacy with heads of state, and ensuring that Malaria remains high on the global policy agenda.

Renewed political commitment to the three diseases is reflected in both the Roadmap on *Shared Responsibility and Global Solidarity for AIDS, TB and Malaria in Africa* (adopted by the AU in 2012) and the revitalization of AIDS Watch Africa (which also occurred in 2012; see Box 1).

Political commitment is multi-dimensional and cannot be easily captured by a single quantitative indicator or through routine data collection.²² Efforts have been made to assess political commitment through such composite indicators as the National Composite Policy Index, the AIDS Policy Index and the AIDS Program Effort Index. Over time, however, it has become increasingly clear that an overall quantified value of efforts was less meaningful than responses to individual elements of these indices.²³

Box 1.

AIDS Watch Africa

AIDS Watch Africa (AWA) was founded at the Abuja Special Summit in 2001 to set an agenda for top-level leadership for the African AIDS response. AWA was envisioned as a key instrument in the continent’s fight against AIDS, seeking to mobilize comprehensive local responses and the resources needed to address the pandemic. AWA was also intended to serve as an instrument for peer review, accountability and the measurement of commitments made by member states to address the pandemic.

In January 2012, AWA’s mandate was expanded to include TB and Malaria, and its representation was broadened continent-wide. AWA is essential to cultivating an African common voice for the 3 diseases (and other health challenges), to providing oversight of health investments, and to leveraging those investments for broader development as envisioned in the *AU Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria*.

Source: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/20120926_AWA_brochure_en.pdf

G8 leadership commitments

The G8 has also repeatedly pledged to exert leadership on health issues. The G8’s leadership on AIDS, TB and Malaria — reflected by multiple summit declarations that prioritized health issues and by the allocation of unprecedented funding towards programmes addressing these three priority diseases — has had a transformative effect on the global political agenda. The

Abuja Declaration, 2001: African leaders commit to “take personal responsibility and provide leadership for the activities of the National AIDS Commissions/ Councils”.

Maputo Resolution, 2005: African leaders call for “urgent extraordinary action” to address the TB emergency in Africa.

Abuja Declaration, 2000: “We commit ourselves to an intensive effort to halve the Malaria mortality for Africa’s people by 2010”.

G8's prioritization of Africa's health and well-being played a role in the inclusion of clear health targets in the MDGs, and it raised the profile of the three priority diseases in the global political discourse. Especially noteworthy is the effect of G8 leadership on non-G8 countries, which have increased their own financial assistance for AIDS, TB and Malaria over the last decade. In particular, the Global Fund, largely funded by the G8, has provided a critical platform for global financing and cooperation to address health challenges in Africa.

In recent years, AIDS, TB and Malaria have had a lower profile in G8 summits (as has health more generally). Although G8 declarations in 2007–2009 confirmed the commitment to universal access (as well as other commitments for the three priority diseases), the global financial crisis and the challenge posed by climate change has attracted greater attention at recent G8 summits. The summit in Camp David in 2012, for instance, did not mention AIDS, TB and Malaria at all. Although the Deauville and Camp David summits did generate accountability reports that emphasized commitments previously taken by the G8 (including those in support of the Global Malaria Action Plan and the Roll Back Malaria Partnership), the G8 has made no new commitments on AIDS, TB and Malaria since the expiration of their earlier commitment to contribute at least US\$ 60 billion for health programmes in Africa in 2007–2012.

Okinawa, 2000: G8 leaders commit to develop an ambitious plan on AIDS, tuberculosis and malaria, and to work in partnership with other stakeholders to ensure full implementation of this plan.

2.2 Investing in AIDS, TB and Malaria

From its outset, the AU and G8 partnership has recognized that achievement of dramatic improvements in health outcomes in Africa requires major new investments. Commitments by the AU and G8 to mobilize substantial new resources for AIDS, TB and Malaria have helped reshape the health landscape across the continent, but extensive resource gaps persist for all three diseases, underscoring the need to generate significant additional resources in order to achieve health targets.

AU investment commitments

Although per capita health spending arguably provides a better financial test of a strong health system, achieving the 15% Abuja target would nevertheless provide substantial protection against possible global economic shocks to the national responses to the three priority diseases.

Only six member states of the African Union currently meet the 15% benchmark (Figure 11): Rwanda (24%), Liberia (19%), Malawi (19%); Zambia (16%), Togo (15%) and Madagascar (15%). While achievement of the Abuja targets remains unfulfilled by most African countries, AU countries have, on average, increased the proportion of total government expenditures allocated to health from 9% to 11% between 2001 and 2011.

Among countries that have not achieved the Abuja benchmark, a number have substantially increased the proportion of government expenditures allocated to health. Djibouti, Ethiopia, Lesotho and Swaziland have all shown consistent increases in health expenditures and are only slightly below the 15% target.

In many countries, the share of public resources allocated for health increased during this 10-year period, with four countries more than doubling the proportion of health expenditure. For other countries, the share remained the same or declined from 2001 to 2011. The volatility of budget allocations for health is striking, suggesting that the roster of countries that have met or are approaching the 15% threshold may differ from year to year (Figure 12).

Abuja Declaration, 2001: African leaders “set a target of allocating at least 15% of our annual budget to the improvement of the health sector”.

Figure 11.

Expenditure on health as a proportion of public expenditure, 2011

Source: WHO Global Health Expenditure Database (www.who.int/nha/database).

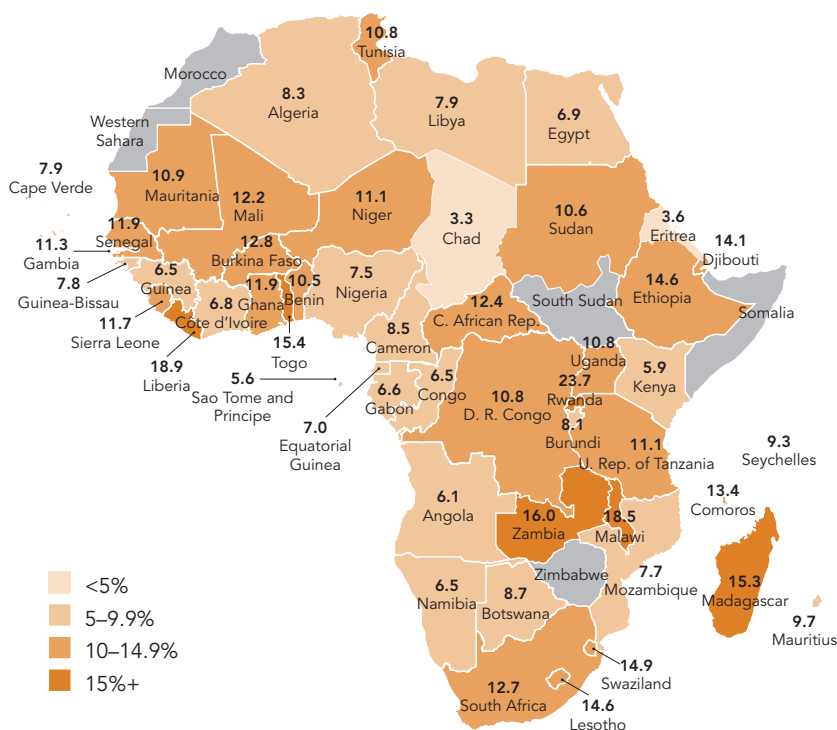


Figure 12.

Volatility in health budgets: trends in the proportion of government expenditures allocated to health, 2001–2011

Source: WHO Global Health Expenditure Database (www.who.int/nha/database).

| Country | 2001 | Trend | 2011 | Country | 2001 | Trend | 2011 |
|-------------------|------|-------|------|-----------------------|------|-------|------|
| Algeria | 9 | | 8 | Liberia | 10 | | 19 |
| Angola | 6 | | 6 | Libya | 6 | | 8 |
| Benin | 12 | | 11 | Madagascar | 15 | | 15 |
| Botswana | 10 | | 9 | Malawi | 9 | | 19 |
| Burkina Faso | 10 | | 13 | Mali | 12 | | 12 |
| Burundi | 8 | | 8 | Mauritania | 8 | | 11 |
| Cameroon | 7 | | 9 | Mauritius | 11 | | 10 |
| Cape Verde | 12 | | 8 | Mozambique | 15 | | 8 |
| C. African Rep. | 14 | | 12 | Nambia | 6 | | 7 |
| Chad | 14 | | 3 | Niger | 10 | | 11 |
| Comoros | 5 | | 13 | Nigeria | 3 | | 8 |
| Congo | 3 | | 6 | Rwanda | 10 | | 24 |
| Côte d'Ivoire | 6 | | 7 | Sao Tome and Principe | 7 | | 6 |
| D. R. Congo | 3 | | 11 | Senegal | 8 | | 12 |
| Djibouti | 12 | | 14 | Seychelles | 8 | | 9 |
| Egypt | 8 | | 7 | Sierra Leone | 14 | | 12 |
| Equatorial Guinea | 10 | | 7 | Somalia | 4 | | : |
| Eritrea | 3 | | 4 | South Africa | 11 | | 13 |
| Ethiopia | 12 | | 15 | Sudan | 8 | | 11 |
| Gabon | 4 | | 7 | Swaziland | 10 | | 15 |
| Gambia | 8 | | 11 | Togo | 8 | | 15 |
| Ghana | 10 | | 12 | Tunisia | 8 | | 11 |
| Guinea | 6 | | 7 | Uganda | 10 | | 11 |
| Guinea-Bissau | 2 | | 8 | U. Rep. of Tanzania | 11 | | 11 |
| Kenya | 9 | | 6 | Zambia | 11 | | 16 |
| Lesotho | 9 | | 15 | Zimbabwe | < | | : |

In 2011, domestic spending on AIDS globally exceeded donor assistance for the first time. Among low- and middle-income countries, South Africa has made the greatest domestic investments in AIDS, spending US\$ 1.9 billion in 2012. From 2006 to 2011, public sector AIDS spending in South Africa increased five-fold. Similar trends in domestic financing are visible in a number of other countries. Kenya doubled its AIDS investments from 2008 to 2010, Togo did the same between 2007 and 2010, and Zambia increased its health spending by 45% in 2012. Rwanda has also devoted considerable national resources to HIV treatment, and it has also created pioneering health financing systems to address HIV and other public health threats.

Domestic government funding for Malaria control programmes also increased through 2005–2011, estimated by WHO at US\$ 625 million globally in 2011 (with governments indicating even greater investments).

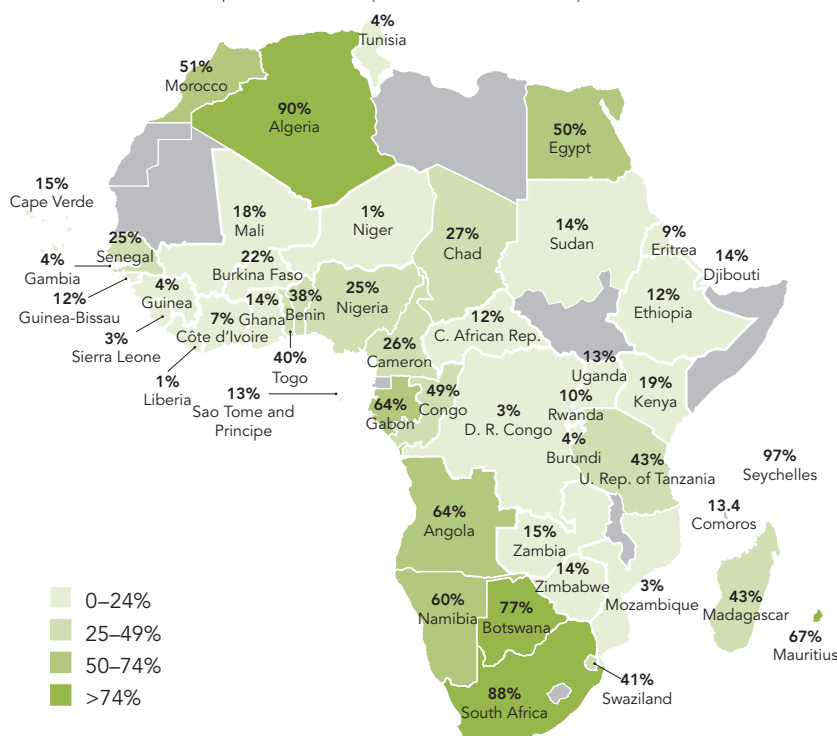
Although investment trends are generally encouraging, health spending in Africa remains low, particularly outside North Africa. Annual per capita health spending in eastern, western and southern Africa ranges from US\$ 25 to US\$ 27. Thirty-two African Union members annually invest less than US\$ 29 per capita. Further increases in health spending, combined with continued global assistance, will be needed to address the continent’s health needs. This is especially true for countries with low GDP, where achievement of the 15% target, while important, would nevertheless mobilize resources far short of the amounts needed to deliver minimally adequate health services.

The sustainability of health gains over the last decade is potentially jeopardized by the heavy dependence of many African countries in external financial support. In 26 of 33 of the African countries most affected by HIV, external partners account for more than half of current investments. In nine countries, partners contribute more than 95% of HIV spending. Similar patterns are evident with respect to TB control; on average, African governments account for 30% of their TB budgets, with the rest provided by external sources.²⁹

Figure 13.

Proportion of total HIV expenditures from domestic sources, 2012 (or latest)

Source: WHO Global Health Expenditure Database (www.who.int/nha/database).



With external financing stagnating, it is crucial to maximize value for money, efficiency and strategic investments as essential touchstones for success. UNAIDS has outlined an investment approach to maximize the impact of finite AIDS resources, calling for focused funding for high-impact, high-value basic programmatic activities, supported by critical enabling policies and synergies with other development efforts.³⁰

Efficiency improvements are needed for other diseases as well. With respect to TB, persistent gaps in access to first-line treatments for drug-susceptible TB vastly reduce the efficiency of efforts to control the disease. These gaps encourage the emergence of drug resistant TB, and treatment regimens for drug-resistant TB are more than 100 times more expensive than those for basic TB.³¹

While countries need to increase domestic health funding, they also need to explore options to diversify funding sources, as outlined in the afore-mentioned AU Roadmap (Box 2). Many of the countries with the heaviest disease burden in Africa have limited means of self-financing their responses to AIDS, TB and Malaria. As a result, global solidarity in the fight against these three priority diseases will remain essential, underscoring the pivotal importance of sustained G8 engagement in the response to AIDS, TB and Malaria in Africa.

Box 2.

African Union Roadmap on Shared Responsibility and Global Solidarity for AIDS, Tuberculosis and Malaria in Africa

In the African Union *Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria*, African leaders embraced the principles of country ownership, efficiency and sustainable financing in responding to the three priority diseases.

The Roadmap charts a clear, achievable course to ensure an orderly and strategic transition to more diversified, balanced and sustainable financing models for AIDS, TB and Malaria. Specifically, the Roadmap commits African leaders to take three priority actions:

- Develop country-specific financial sustainability plans with clear targets through a partnership approach, including with people living with HIV and affected populations.
- Ensure development partners meet existing commitments and do so with long-term and predictable commitments that are aligned with Africa's priorities.
- Identify and maximise opportunities to diversify funding sources in order to increase domestic resource allocation to AIDS, TB and Malaria.

G8 investment commitments

Over the past 12 years, G8 funding has saved millions of lives in Africa. Building on this historic record of achievement and partnership with the AU, the G8 has recently taken steps to extend these advances to other health challenges in Africa, including maternal, newborn and child health.

The G8 has either fully achieved, or begun to approach achievement of, its specific commitments to fund global health in general, and AIDS, TB and Malaria in particular.

Today, the Global Fund serves as an essential pillar for financing health programmes in Africa. From 2001 to 2012, G8 contributions to the Global Fund (including those from the European Commission) totalled US\$ 18.6 billion, 74% of all contributions to the Fund.³² As of 2012, programmes supported with investments in the Global Fund had saved 8.7 million lives, with the Fund accounting for 21% of global funding for AIDS, 82% for TB, and 50% for Malaria.³³

Genoa, 2001: G8 pledges US\$ 1.3 billion to support the establishment of the Global Fund.

Most G8 spending on TB control activities is channelled through the Global Fund, which accounts for 88% of all external financing for TB programmes in Africa. Of every US\$ 100

provided to African countries by the Global Fund, US\$ 6 is allocated to TB control efforts.³⁴

International disbursements for Malaria control by major development partners have risen steeply, from less than US\$ 100 million in 2000 to an estimated US\$ 2 billion in 2012. As funding has risen, international disbursements have been increasingly focused on supporting Malaria control programmes in Africa.

In addition to mobilizing unprecedented new resources for health in Africa, which in turn have resulted in dramatic improvements in health outcomes, G8 financing has also supported broader objectives of the AU. Consistent with the overarching AU principles of transparency and good governance, the financial control systems implemented by the Global Fund have helped Africa combat corruption and ensure that the limited resources for life-saving health programmes are used for their intended purposes.

Figure 14.

Contributions of G8 members to the Global Fund, 2002–2012

Source: Global Fund to Fight AIDS, Tuberculosis and Malaria (<http://www.theglobalfund.org/en/donors/public/>).

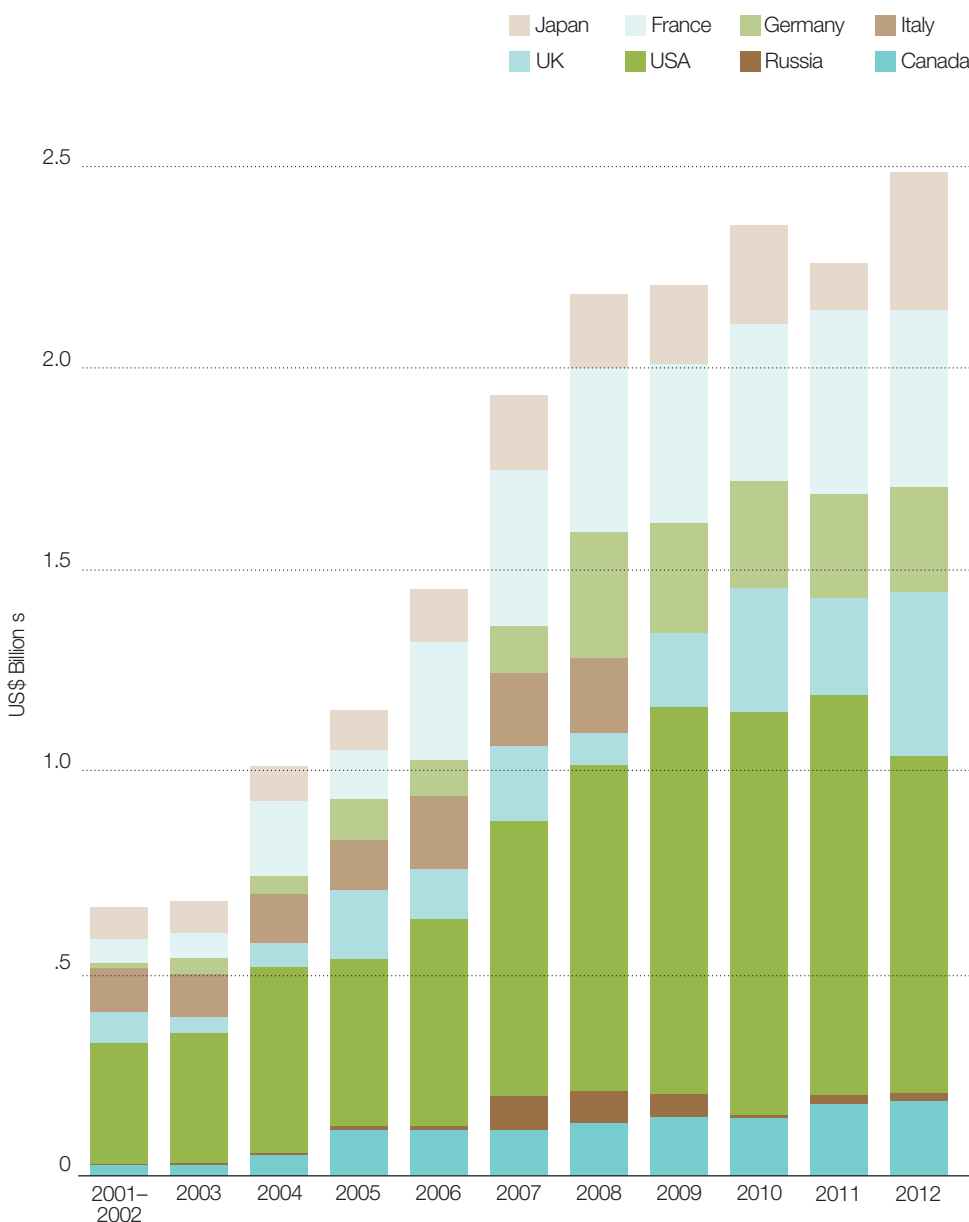
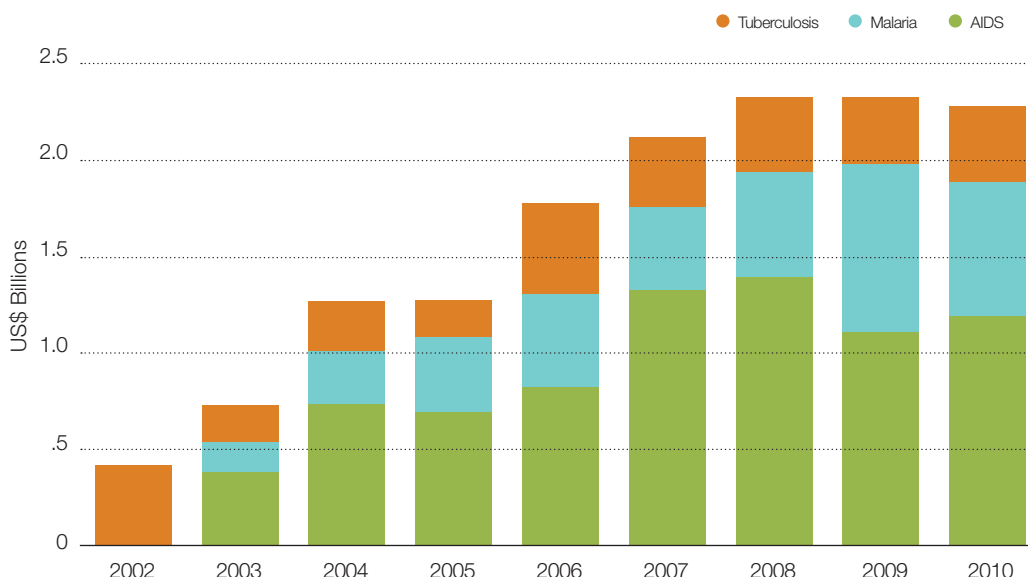


Figure 15.

G8's contributions to the Global Fund allocated to AIDS, TB and Malaria, 2003-2010

Source: Global Fund to Fight AIDS, Tuberculosis and Malaria (<http://www.theglobalfund.org/en/donors/public/>).



Several G8 members met the commitment to double aid to Africa, including the United Kingdom, the United States and Canada, and significant increases were observed from several others, including France and Japan.³⁵ The collective target was not met, however, as Africa only received an additional US\$ 11 billion.³⁶ Despite the fact that this collective commitment was only partially fulfilled, G8 funding for AIDS more than doubled (from US\$ 2 billion to US\$ 4.2 billion) from 2005 to 2010, with Africa receiving the majority of this funding.

In 2009, it was reported that the G8 provided US\$ 13 billion annually.³⁷ When combined, these annual funding levels indicate that the G8 achieved its target of mobilizing US\$ 60 billion over five years (which required an average annual expenditure of US\$ 12 billion).

The lion's share of international assistance for health goes to supporting HIV treatment, especially in high-burden countries. The United States continues to be the largest international financier of HIV treatment—both bilaterally and through multilateral funding channels—accounting for 48% of all international investments.

Recognizing the risk that the unfolding global financial crisis posed to international health assistance for low-income countries, the G8 at the 2008 Hokkaido summit reaffirmed their commitment to “address the health needs of the most *vulnerable*”. Despite this commitment, bilateral expenditures on health from the G8—including contributions to the Global Fund—fell markedly in 2009 and 2010. Given Africa's dependence on overseas development assistance, this fall in expenditures highlights the vulnerability of health systems across the continent.

Although historic strides have been made in financing essential health programmes in Africa, critical gaps remain. These gaps jeopardize gains that have been made, and they highlight the need for strengthened resource mobilization. Globally, amounts available for HIV programmes in low- and middle-income countries in 2011 (US\$ 16.8 billion) were US\$ 5–7 billion short of the global financing target needed to move towards universal access.³⁸ The funding gap for TB control in Africa in 2011 was US\$ 900 million, representing more than half of *global* funding gap for TB.³⁹ Total available funding for Malaria is projected to remain substantially below the US\$ 5.1 billion required to achieve universal coverage of Malaria interventions.⁴⁰

Gleneagles, 2005:
G8 pledges to double aid to Africa by 2010, an annual increase of US\$ 25 billion.

Heiligendamm, 2007:
G8 commits to provide US\$ 60 billion for health between 2007 and 2012.

Sustaining the advancements that have been made over the last 12 years and building on them will require not only that international investments increase as economies recover, but that the source of investments diversifies, including through the increased engagement of emerging economies as providers of international health assistance.

2.3 Prevention, treatment, care and support

Both AU and G8 member states have made specific pledges to generate concrete, visionary health outcomes. Various intermediate targets established in the early years of the AU and G8 partnership were eventually subsumed by the 2015 targets set forth in the MDGs and in the 2011 Political Declaration on HIV/AIDS, which was endorsed by AU and G8 member states. These targets include reducing sexual HIV transmission by 50%, eliminating new HIV infections among children, providing 15 million people with antiretroviral therapy, reducing TB deaths by 50%, and lowering Malaria incidence by 50%. Given the shared nature of these commitments, results towards them are discussed together for the AU and G8 partnership.

Prevention of new HIV infections

Although historic in its impact, the Okinawa target was methodologically flawed in its focus on reducing the number of people living with HIV, effectively confounding the prevention of infection with AIDS-related mortality and neglecting to take population growth into account. Although erroneously framed, the clear aim of the Okinawa target was to ensure a reduction in new HIV infections.

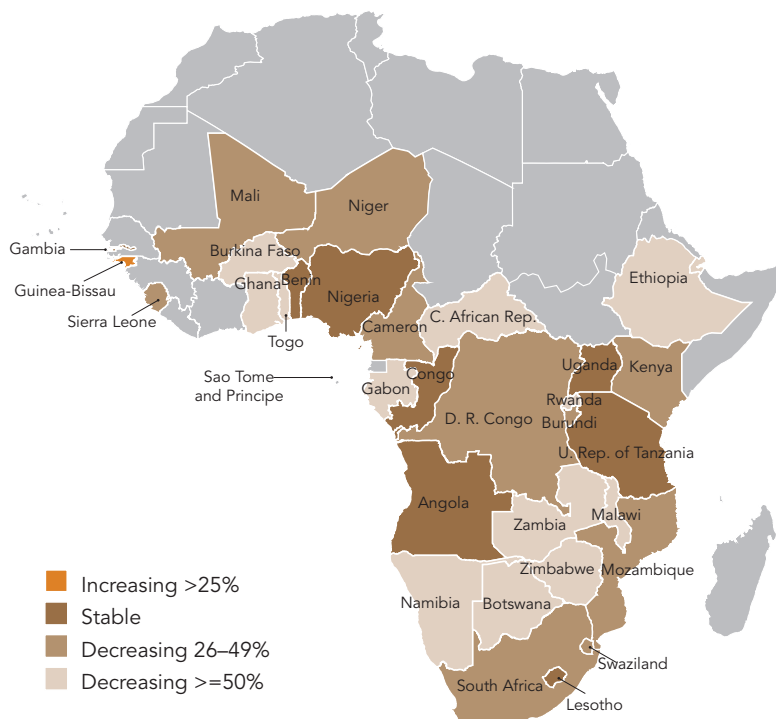
Okinawa, 2000: G8 commits to reduce the number of HIV-infected young people by 25% by 2010.

The target should be considered to have been achieved, in that the annual number of people newly infected in Africa has fallen by at least 25% since 2001.⁴¹ HIV incidence declined by more than 25% from 2001 to 2009 in 22 countries, including some with the largest epidemics, with reductions in new infections of 50% or greater in 13 AU countries. Despite these gains, Africa still accounted for 72% of all new HIV infections worldwide in 2011.

Figure 16.

Reductions in HIV incidence in selected countries, 2001–2011

Source: UNAIDS estimates.



Preventing sexual HIV transmission

As sexual transmission accounts for the vast majority of new HIV infections in Africa, reducing the incidence of HIV across the continent depends on effective prevention of sexual transmission.

Effective HIV prevention involves the strategic combination of behavioural, biomedical and structural approaches that are linked to demonstrated needs and epidemiological patterns in specific settings.

Where countries have scaled up strategic combinations of HIV prevention interventions, there have been sharp declines in HIV incidence. Indeed, studies indicate that favourable changes in sexual behaviour are driving reductions in HIV incidence in many high-prevalence countries. Reported condom use is increasing in several countries with a high prevalence of HIV infection, although nationally representative surveys indicate a decline in condom use in several African countries.

Although education alone does not constitute effective HIV prevention, knowledge about condoms remains low in several of the high-prevalence countries, especially among young women. In Africa in 2011, only nine donor-provided male condoms were available for every man aged 15–49 years, while one female condom was available for every 10 women aged 15–49 years.

Voluntary medical male circumcision represents a potentially transformative new biomedical strategy for HIV prevention. Rapidly scaling up voluntary medical male circumcision could avert an estimated 1 in 5 new HIV infections projected in eastern and southern Africa through 2025. Most countries in which voluntary medical male circumcision is recommended have endorsed the intervention, adopted roll-out policies and begun training health-care workers in administering circumcision procedures.

By the end of 2010, more than 550 000 males in priority countries were circumcised for HIV prevention. Progress towards the target of expanded coverage of male circumcision to 80% of men between the ages of 15–49, however, is still very limited in most countries. Although the pace of scale-up remains too slow, reports from priority countries indicate a quickening of the pace in 2012 and 2013.

In 2011, a large, multi-country clinical trial found that antiretroviral therapy lowered the odds of HIV transmission among serodiscordant couples by 96%. A subsequent study in the KwaZulu-Natal Province of South Africa found that scaled-up antiretroviral therapy led to sharp reductions in HIV incidence.

Towards elimination of new HIV infections among children

In Africa, home to 92% of all pregnant women living with HIV, the number of children newly infected fell by 24% (from 2009 to 2011). In six countries (Burundi, Kenya, Namibia, South Africa, Togo and Zambia) from 2009 to 2011, the number of children newly infected declined by 40–59%. Progress has not been universally apparent, however, as the number of children newly infected has increased in four countries: Angola, Congo, Equatorial Guinea and Guinea-Bissau. Globally, the Middle East and North Africa is the only region that has yet to see a reduction in the number of children newly infected.

The Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive, developed by UNAIDS in concert with diverse stakeholders, calls for delivery of a package of essential interventions to expedite progress towards the global goal of eliminating new infections among children. The *Global Plan* focuses on 22 countries that together account for 90% of all infections among children. The priority countries located in

UN Political Declaration on HIV and AIDS, 2011: All UN Member States commit to a 50% reduction in sexual HIV transmission by 2015.

UN Political Declaration on HIV and AIDS, 2011: All UN Member States commit to eliminating new HIV infections among children by 2015.

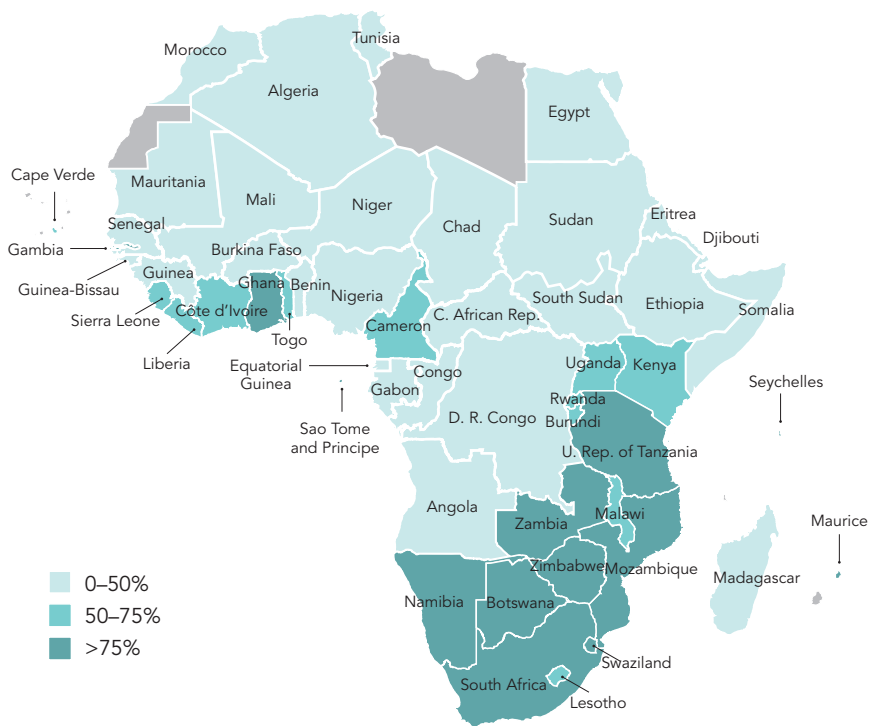
Africa (21 of 22) have developed operational plans to implement the programmatic and policy recommendations of the *Global Plan*.

Recent gains in bringing antiretroviral- and infant feeding-based prevention services to scale are primarily responsible for the sharp reductions in the number of children who have been newly infected. In 2011, 59% of pregnant women living with HIV received antiretroviral therapy or prophylaxis. To sustain and accelerate these gains, greater progress is needed in reducing unintended pregnancies, as only 5 of 15 African countries with available national household surveys show a decline of more than 5 percentage points in unmet need for family planning in 2000–2011.

Figure 17.

Percentage of pregnant women in African countries living with HIV who received antiretroviral medicines to prevent transmission to their child, 2011-2012

Source: 2012 country progress reports (www.unaids.org/cpr).



HIV treatment

A milestone in the AIDS response, the G8's Gleneagles commitment to universal access underscored the feasibility of providing treatment to all people living with HIV. It also contributed momentum toward the global endorsement of the goal of universal access to HIV prevention, treatment, care and support contained in the 2006 Political Declaration on HIV/AIDS.

Following the embrace of the goal of universal access by the AU and G8 partnership, treatment programmes in the most affected countries expanded rapidly. The number of people receiving antiretroviral therapy increased from less than 300 000 in 2002 to more than 7 million in Africa by the end of 2012, with a total coverage of 56% in the most affected regions of Africa. Important intraregional differences in coverage were observed, however: while 56% of the people who were eligible for antiretroviral therapy in eastern and southern Africa obtained it, coverage was considerably lower in western and central Africa (30%) and in north Africa (10%).

While universal access to treatment had been achieved in only three African countries by the original target date of 2010 (Botswana, Namibia and Rwanda), achievements to date have nevertheless been profound, with antiretroviral therapy adding 9 million life-years in Africa between 1995 and 2011.⁴² In 2011, an additional two countries in Africa (Swaziland and Zambia) achieved universal access to HIV treatment, and 10 countries had coverage levels of 50–69% (Benin, Ethiopia, Gabon, Guinea, Kenya, Lesotho, Malawi, Senegal, South Africa, Togo and Zimbabwe).⁴³

The G8 member states, both as the leading contributors to the Global Fund and through bilateral programmes, provided the vast majority of funding to support this scale-up. In 2011, 5.6 of the 6.6 million people receiving antiretroviral treatment were funded by the Global Fund, the United States President's Emergency Plan for AIDS Relief, or both. This represented over 85% of all people receiving treatment in low- and middle-income countries.

AIDS has claimed at least 1 million lives annually in Africa since 1998, with AIDS-related deaths peaking at 1.7 million in 2005. In 2011, the number of people who died from AIDS-related causes was 33% lower than in 2005, with southern Africa accounting for almost two-thirds of all AIDS-related deaths in 2011. As programmatic scale-up has continued, health gains have accelerated, and the number of life-years saved by antiretroviral therapy in Africa has quadrupled in the last four years.

Scale-up of antiretroviral treatment is generating broad-based gains in health and social indicators. In the hyper-endemic KwaZulu-Natal Province of South Africa, HIV treatment scale-up has produced striking macroeconomic and household livelihood benefits, with employment prospects sharply increasing among individuals receiving antiretroviral therapy.

Progress in national responses to TB

In Africa, TB prevalence and incidence are on the decline. Between 2009 and 2011, TB deaths in Africa declined by 10%.⁴⁴ Africa is however the only region in the world not on track to achieve a 50% reduction in TB mortality by 2015.⁴⁵

Africa has 24% of the world's TB cases, nearly 80% of TB cases among people living with HIV, and the highest proportion of TB cases co-infected with HIV (39%). In 2011, there were an estimated 8.7 million new cases of TB (13% co-infected with HIV) in Africa.

Important strides have been made in addressing the fundamental elements of effective TB control. Since 2000, 12.7 million people in Africa were treated for TB. G8 contributions have been central to these gains, with the Global Fund alone financing treatment services for two-thirds of all TB patients on treatment in 2012.⁴⁶

Gleneagles, 2005: G8 commits to aim of as close as possible to universal access to treatment for all those who need it by 2010.

Gaborone, 2005: African Health Ministers commit to the achievement of universal access to AIDS, TB and Malaria prevention, treatment and care by 2015.

MDG 6: Achieve a 50% reduction in TB mortality by 2015.

Okinawa, 2000: G8 commits to achieve a 50% reduction in TB incidence and prevalence by 2015.

Nearly 4 in 10 TB cases in Africa remained undetected in 2011,⁴⁷ although the number of TB cases globally that were detected and treated through Global Fund grants rose by 21% in the 18 months prior to mid-2012.⁴⁸ The number of TB patients tested for HIV in Africa increased from 3% in 2004 to 69% in 2011, with Africa vastly outpacing other regions (global average of 40%) in determining the HIV status of all people with TB.⁴⁹

In Africa, 46% of TB patients known to be living with HIV in 2011 were started on antiretroviral therapy, an improvement over previous years, but still about half of what is required to ensure prompt HIV therapy for TB patients living with HIV.⁵⁰ In the 18 months prior to June 2012, the number of individuals receiving dual HIV and TB treatment supported by the Global Fund doubled.⁵¹

Progress in responding to multidrug-resistant TB (MDR-TB), however, remains slow. While the number of cases of MDR-TB notified in the 27 high MDR-TB burden countries is increasing, only one in five (19%) TB patients estimated to have MDR-TB are identified. Despite this, there are some encouraging signs. From the beginning of 2011 through mid-2012, the number of MDR-TB patients receiving treatment with Global Fund support rose by 50%.⁵²

Between its endorsement by WHO in December 2010 and the end of June 2012, Xpert MTB/RIF, a rapid molecular test that can diagnose TB and rifampicin resistance within 100 minutes, has been rapidly rolled out. Over one million tests have been purchased by 67 low- and middle-income countries, with South Africa (37% of purchased tests) the leading adopter. New or re-purposed TB drugs and novel TB regimens to treat drug-sensitive or drug resistant TB are advancing in clinical trials and regulatory review, and 11 vaccines to prevent TB are in various stages of development.

Although clear progress has been achieved, additional efforts are urgently needed to close persistent gaps in access to essential TB services. Unless an emergency response is rapidly brought to scale, WHO projects that TB will sicken 23 million Africans over the next decade and result in 5.5 million deaths.⁵³

Progress in national responses to Malaria

In 2010, Africa accounted for 81% of all Malaria cases worldwide.⁵⁴ Nine member states of the African Union are on track to achieve a targeted 50–75% reduction in incidence between 2000 and 2015: Algeria, Botswana, Cape Verde, Eritrea, Namibia, Rwanda, São Tomé and Príncipe, South Africa and Swaziland.⁵⁵ As insufficient data are available to assess incidence trends in 18 of 39 African countries with endemic Malaria, it is not possible to draw reliable conclusions as to whether the continent as a whole is on track.⁵⁶ The best available evidence points towards very modest changes in the number of new Malaria cases in Africa from 2000 to 2010.⁵⁷

As a result of the tremendous expansion of financing and implementation of Malaria control programmes over the past decade, the percentage of households owning at least one insecticide-treated net (ITN) in Africa (excluding North Africa) is estimated to have risen from 3% in 2000 to 53% in 2012.⁵⁸ According to household surveys, approximately 90% of persons with access to an ITN within the household actually use it. In 2008–2010, the Global Fund alone accounted for one-third of all ITNs distributed for Malaria control.⁵⁹

The percentage of households protected by indoor residual spraying (IRS) in the African region rose from less than 5% in 2005 to 11% in 2011. The numbers of rapid diagnostic tests (RDTs) and artemisinin-based combination therapies (ACTs) procured is increasing, and the percentage of suspected cases that receive a parasitological test has also risen from 68% globally in 2005 to 77% in 2011, with the largest increase in Africa (from 20% to 47%).⁶⁰

MDG 6: All UN Member States to achieve a 50–75% reduction in Malaria case rates by 2015.

Africa Malaria Elimination Campaign, 2007: AU commits a 75% reduction in Malaria deaths and cases by 2015.

Gleneagles, 2005: G8 commits to scale-up action against Malaria in order to reach 85% of vulnerable populations with key interventions that will save the lives of 600 000 children a year by 2015.

Although substantial progress has been achieved, efforts urgently need to be accelerated if Malaria is to be eradicated. Indeed, there are ominous signs that recent gains could be in jeopardy, as the number of ITNs procured in 2012 (66 million) was less than half the number procured in 2010 (145 million). With the average useful life of ITNs estimated to be two to three years, ITN coverage is expected to decrease if ITNs are not replaced in 2013.⁶¹

2.4 Strengthening health systems

The pledge by the AU and the G8 to strengthen health systems has been translated into concrete actions, with 47 AU member states having developed a plan in 2012 to strengthen their health system.⁶² In 2007–2009, multiple regional declarations, processes and initiatives were launched to strengthen health systems in Africa, including the Social Policy Framework for Africa, the Africa Health Strategy (2007–2015), the Development of Human Resources for Health, the Global Health Workforce Alliance, and the Declaration and Plan of Action on Africa Fit for Children.⁶³ The extent to which these plans have been effectively implemented and have achieved their desired results, however, is unclear, in part due to the lack of quantitative measurable targets, the ambiguity in the definition of health system strengthening, and the limitations in data availability.^{64, 65}

African leaders have taken steps to strengthen the health workforce. The African Medical & Research Foundation (AMREF)—working collaboratively with ministries of health—is training a wide range of health workers in close to 40 African countries, including more than 10 000 community health workers each year in Africa’s most marginalised communities.⁶⁶ The programme on nursing and midwifery education, designed as a need- and demand-driven source of education for primary health care, has developed curricula for a clinical course work and research Master’s degree that will be approved by universities in five target countries (Chad, Kenya, Republic of Congo, Rwanda and the United Republic of Tanzania) and by development partners.

The G8 is actively assisting the AU’s efforts to build strong and durable health systems, with particular emphasis on strengthening human resources for health. The U.S. passed the *African Health Capacity Investment Act* in 2007, authorizing US\$ 650 million over three years for training and retaining health workers in Africa, and for building basic health infrastructure. The Global Fund has partnered with the GAVI Alliance, World Bank and WHO to establish a health systems funding platform. To date, 22 of 36 eligible African countries have received funding totalling US\$ 300 million from the Global Fund for activities intended to strengthen health systems.⁶⁷ From 2002 to mid-2012, the Global Fund supported 14 million person-episodes of training for health workers.⁶⁸

In addition to broader efforts to build strong and durable health systems, disease-specific programmes are being leveraged to buttress health systems and generate health benefits that extend beyond their application to the three priority diseases.

Investments in AIDS, TB and Malaria strengthen health systems

As the reach of AIDS programmes has expanded, so too have opportunities to integrate AIDS, TB and Malaria into broader health efforts. The resulting systems proving greater than the sum of their parts: for example, AIDS funding has supported the refurbishment of health infrastructure and contributed to increased uptake of maternal health services.⁶⁹ As access to antiretroviral therapy expands and survival improves for people living with HIV, HIV care and treatment programmes are increasingly focusing on managing chronic disease. There are

Kampala, 2010: AU commits to accelerating the implementation of the Abuja Call through the strengthening of health systems.

Evian, 2003: G8 commits to strengthening health systems as a framework for increasing access to health care, drugs and treatments for the neediest populations of developing countries.

many examples of this: in Ethiopia, lessons learned in the AIDS response are now informing clinical management of diabetes; FHI360 has added services for non-communicable diseases to existing HIV programmes in Kenya; and South Africa has embarked on an integrated testing campaign focused on HIV, high blood pressure and diabetes.⁷⁰ Moving forward, donors should take proactive steps to be more attentive to domestic resource constraints (such as limited numbers of health workers) and seek to integrate disease-specific programmes with existing health systems.⁷¹

Services to prevent children from acquiring HIV infection have been integrated in maternal and child health services in all 21 African priority countries of the *Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive*. Integrating provider-initiated HIV testing and counselling in antenatal settings has increased testing utilization, although such gains are threatened as a result of limited access to facility-based antenatal care or weak systems for commodity forecasting, procurement and supply chain management.⁷²

HIV is being integrated into sexual and reproductive health services throughout Africa. For example, Botswana, Burkina Faso, Malawi, the United Republic of Tanzania, and Zimbabwe have recently completed rapid assessments to inform their strategies and determine priorities for their national plans towards the scale-up and intensification of integration. Kenya is evaluating a national strategy, launched in 2002, that integrated HIV counselling and testing in family planning services.⁷³

The number of health facilities with integrated HIV and TB screening, diagnosis and treatment has rapidly increased in Africa since 2005. Swaziland recently demonstrated that integrating TB case-finding in routine HIV care delivery in rural community clinics and district hospitals is both operationally feasible and effective. In 2012, South Africa launched an integrated five-year strategy addressing AIDS, TB and sexually transmitted infections.⁷⁴

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

Malaria diagnostics have strengthened peripheral health centres by either deploying rapid diagnostic tests or enhancing the use of light microscopy. This has resulted in extensive training for health professions that may also be useful for the confirmation, exclusion and management of other diseases. Intermittent preventive treatment strategies for Malaria reinforce antenatal care systems, while distribution of bednets in health centres have encouraged more clients to access other health services. Some countries are starting community management of Malaria, a platform that can be used to improve treatment of other common illnesses at the community level, including pneumonia and diarrhoea. By decreasing the overall disease burden, Malaria control frees up limited human resources to address other health priorities.⁷⁵

2.5 Development of and access to affordable medicines & commodities

Both the AU and the G8 have committed to ensuring the availability and affordability of essential health commodities for the three priority diseases. At the third session of the AU

Muskoka, 2010: G8 commits to mobilize US\$5 billion above the 2008 baseline by 2015 in order to reduce the number of maternal, new born and deaths of children under the age of five in developing countries.

Conference of Ministers of Health in 2007, member states adopted the *Pharmaceutical Manufacturing Plan for Africa* (PMPA) (Box 4) to strengthen Africa's ability to locally manufacture and supply essential drugs and commodities to fight HIV, TB and Malaria. This long-term approach aims to reduce Africa's dependence on external suppliers, while simultaneously improving commodities supply. The political will to boost the African drug industry was further reflected by the adoption of the *Global Strategy on Public Health, Innovation, and Intellectual Property* at the World Health Assembly in May 2008, and by the creation of sub-regional initiatives with East African Community (EAC) and the Southern African Development Community (SADC).⁷⁶

To date, national regulatory authorities of the individual AU member states operate independently, and this could potentially result in waste, the duplication of effort, and substantial delays in accessing important new medical tools. In an effort to minimize fragmentation with respect to the regulation of essential medicines and devices, NEPAD is collaborating with partners to coordinate the African Medicines Regulatory Harmonization (AMRH) initiative. The AMRH initiative aims to accelerate progress towards the health-related MDGs by generating a sound regulatory environment for the development of the pharmaceutical sector in Africa. The initiative is assisting Regional Economic Communities (RECs) and countries in a) developing harmonised, effective and efficient regulatory approval processes and b) instituting governance and accountability mechanisms to ensure transparency in regulatory services delivery. In this way, the AMRH initiative is designed to increase access to safe medicines throughout Africa, an important step towards the ultimate goal of a single African Regulatory Agency. AMRH's first project on harmonization of medicines registration was successfully launched in the East African Community.

Access to HIV treatment and commodities

In the past decade, the annual price of first-line antiretroviral drugs has plummeted from over US\$ 10 000 per person in 2000 to less than US\$ 116 in 2010 (for the lowest cost WHO-recommended regimen). This represents a reduction of nearly 99%. The average price paid for second-line regimens, however, continues to be significantly higher.⁷⁷ Factors contributing to these sharp price reductions include the sustained scaling up of treatment programmes, growing transaction volumes and predictability of demand, competition between a growing number of WHO-prequalified products, regional bulk purchasing efforts, and favourable pricing policies from pharmaceutical companies.⁷⁸

Further reductions are expected to occur in coming years, as treatment scale-up continues and local drug production increases. Currently, as many as six plants in Africa are producing generic antiretrovirals (primarily for local consumption), although some have been prequalified for export to other countries.⁷⁹

The flexibilities contained in the Trade-related Aspects of Intellectual Property Rights (TRIPS) Agreement—reaffirmed by the 2001 Doha Declaration—provide important opportunities for further reductions in prices of, and expanded access to, HIV medicines. While these flexibilities have thus far been underutilized, there are encouraging examples of their use. In South Africa, competition law was used to increase the number of antiretroviral drug suppliers, resulting in increased competition and the lowering of essential medicine prices. Mozambique, Zambia and Zimbabwe have used compulsory licensing and other measures to increase access to affordable health commodities. Waivers under the TRIPS Agreement are scheduled to end in 2015, potentially restricting the ability of Least Developed Countries in Africa to ensure access to affordable medicines, underscoring the need for international action to extend the TRIPS provisions beyond 2015.

Abuja, 2001: AU commits to enact and utilize legislation and international trade regulations to ensure the availability of affordable drugs and technologies for HIV, TB and other infectious diseases.

Deauville, 2011: G8 commits to facilitate the production of affordable generic medicines and encourages the voluntary participation of patent owners, private and the public.

Box 3.

Use of TRIPS flexibility (the “30 August 2003” mechanism) by Rwanda

In 2006, the Government of Rwanda passed legislation that required the use of generic medicines (when available) for all treatment programmes. In July 2007, Rwanda became the first country to announce its intention to use the World Trade Organization’s 30 August 2003 decision to import a generic fixed-dose combination of zidovudine, lamivudine and nevirapine from a Canadian generic manufacturing company. The compulsory licence issued under the Canadian Access to Medicines Regime authorized the delivery of sufficient quantities of this combination to treat 21 000 people for a year, at what was then the most affordable price globally (US \$0.19 per tablet). To date, Rwanda is the only African country to have used this flexibility.⁸⁰

Despite sharp reductions in the cost of antiretrovirals, many challenges remain in the quest to ensure a reliable, sustainable supply of affordable drugs and commodities. In 2011, 50% of responding countries reported varying degrees of antiretroviral stock outs in one or more facilities that provide HIV treatment.⁸¹ Similar challenges remain for the provision of CD4 testing, a shortcoming that will become increasingly important as countries move towards policies to treat patients with higher CD4 counts. Many countries also still lack the required technology for early diagnosis of infant HIV infection.

In addition to supporting efforts to increase access to affordable HIV commodities, the G8 has pledged to support research to develop new HIV prevention tools at multiple summits. Particular emphasis has been placed on the development of vaccines and microbicides, and AU member states have partnered with the G8 on this endeavour by hosting and supporting numerous clinical trials. G8 countries sponsored breakthrough research demonstrating the effectiveness of voluntary medical circumcision for HIV prevention, providing proof of concept for a vaginal microbicide gel, demonstrating the effectiveness of antiretroviral therapy for HIV prevention, validating pre-exposure antiretroviral prophylaxis, and generating the first evidence of efficacy for any candidate preventive vaccine. Since 2001, governments and philanthropic foundations in G8 countries have invested US\$ 8 billion in HIV vaccine research and nearly US\$ 2 billion in research on microbicides.⁸²

Access to TB treatment and commodities

Availability of first-line anti-TB drugs has significantly improved. Since 2001, the Global Drug Facility has provided affordable drugs for 20 million TB patient treatments, and it has offered first-line TB treatments to an average of 20 African countries and access to second-line drugs for the treatment of MDR-TB to six countries annually since 2005.⁸³ In 2013, the Global Drug Facility is the exclusive source for second-line TB drugs in Africa. Production capacity for high-quality, second-line drugs is being established in at least one AU Member State, although the cost of such treatment poses considerable challenges as incidence of drug-resistant TB increases in Africa.⁸⁴ WHO also prequalified the first-ever paediatric TB medicine, and prices for paediatric therapies have fallen as the number of manufacturers has increased.⁸⁵

Innovative market interventions have enhanced the efficiency of TB control programmes in Africa. As a result of discounts stemming from an up-front, bulk purchase of the Xpert MDR/RIF technology, unit prices for this critical diagnostic tool fell from US\$ 17 to US\$ 10 in one year. In 2012, the Global Drug Facility provided access to TB diagnostic technologies to 11 countries in Africa.

To expand access to MDR-TB diagnosis and treatment—and to push for price reductions—

AU member states collaborate with organizations such as UNITAID, the Global Drug Facility of the Stop TB Partnership, the Green Light Committee, and the Global Fund.⁸⁶

Access to Malaria treatment and commodities

Several initiatives across Africa have emerged in recent years to increase access to affordable Malaria control commodities, including the Affordable Medicines facility for Malaria (AMFm), which was established to accelerate the phase-out of mono-therapy.⁸⁷ Eight countries have received funding from the Global Fund to implement this approach, which was demonstrated to be successful in a pilot project in East Africa.

In further recognition of the need for affordable commodities to combat Malaria, 74% of African nations have waived taxes on anti-Malarials, 64% have removed taxes or introduced waivers on ITNs, and about half have waived taxes and tariffs on bednets, netting materials and insecticides. In 2008, 42 of the 43 Malaria -endemic countries in Africa were distributing ACT for treatment of Malaria, and in 23 of these countries, ACT was free of charge for children under five. The Global Fund, working closely with many African countries and manufacturers, has moved to a system of voluntary pooled procurement of commodities to reduce unit prices and enhance access to commodities whose accessibility was previously hampered by inefficient procurement and supply chain management systems.⁸⁸ In 2013, the Economic Community of West African States announced that Côte d'Ivoire, Ghana and Nigeria would host major new factories for the production of biolarvicides used in the Malaria control programmes.

The total number of rapid diagnostic tests distributed in 2008 corresponded to only 13% of all Malaria cases in the 12 countries reporting, highlighting a continuing gap in Malaria diagnostic capacity. In 18 high-burden African countries for which data were available in 2008, only 22% of reported suspected Malaria cases were confirmed with a parasite-based test.

Challenges remain regarding the capacity to forecast needs and ensure timely flow of information about these commodities, from producers and suppliers, to Government bodies, implementing agencies and consumers. Unless these challenges are addressed, there is a risk that shortages will emerge for ACT and other essential commodities.

Box 4.

Testing the efficacy of indigenous remedies

"We commit ourselves to explore and further develop the potential of traditional medicines and traditional health practitioners in the prevention, care and management of HIV/AIDS, tuberculosis and other related infectious diseases."

– AU Summit Abuja 2001

Sondashi Formula 2000 (SF2000) is a traditional remedy for HIV that stemmed from indigenous knowledge provided by Dr L. Sondashi from Zambia. The remedy has a long history of use among people living with HIV, with unconfirmed reports that clinical symptoms disappeared in some patients after they began taking the medication.

NEPAD, working under the African Biosciences Initiative, facilitated scientific efforts to validate these claims. In vivo testing in mice showed no cytotoxic effects. A team of clinicians and researchers from Zambia and South Africa subsequently designed a Phase I Clinical Trial Protocol to assess safety and tolerability levels of the remedy in capsule form in healthy adults. Ethics approval has been applied for in Zambia, and steps have been taken to protect the intellectual property associated with this experimental treatment.

Box 5.

The Pharmaceutical Manufacturing Plan for Africa (PMPA) and its business plan

African leaders believe that local production of pharmaceuticals will not only promote a sustainable supply of quality-assured and affordable medicines, but that it will also promote industrial development, the knowledge economy and, ultimately, sustainable development. Local production of generic medicines promises the affordability and availability of needed drugs, employment opportunities, and overall public health benefits, including shortened supply chains, reduced risk of stock outs, and enhanced capacity of local regulatory authorities to oversee the quality standards of essential medicines.

In 2012, following the adoption of PMPA, the African Union Commission and other partners elaborated a business plan for PMPA, which was subsequently endorsed by the Assembly of heads of state and government. The Business Plan seeks to:

- develop strong, independent and predictable national regulatory authorities;
- build regulatory capacity;
- increase and enhance competition;
- reduce demand uncertainty;
- strengthen forecasting capacity;
- increase investments in the development of needed medicines; and
- provide time-limited, easily understood and accessible incentives to accelerate progress towards pharmaceutical self-sufficiency in Africa.

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

The Business Plan aims to capitalize on opportunities that continued economic growth in the region will bring. By 2020, Africa will have 1.3 billion people, a combined gross domestic product of US\$ 2.9 trillion, health expenditure of approximately US\$ 200 billion, and a total pharmaceutical market valued at US\$ 23 billion. Demand for medicines also will grow, in part due to the continued demands associated with AIDS, TB and Malaria, but also as a result of an aging population, a rise in non-communicable disease burdens, and improving environments for health insurance.

Achieving PMPA's vision of a competitive, sustainable and self-reliant industry will demand increased human resource capacity, access to affordable financing, strong regulatory systems, strategic partnerships and business linkages, and enhanced market data and information systems. Other challenges will also need to be overcome. Patent restrictions and non-competition requirements of some bilateral cooperation agreements impede efforts to move towards development of robust pharmaceutical manufacturing capacity in Africa. Development assistance under bi-lateral and multi-lateral arrangements often includes restrictions on the participation of local firms in the procurement bids, restricting access to local markets.

2.6 Promotion of human rights and gender equality

The AIDS movement has historically been at the forefront of efforts both to reduce stigma and discrimination, and to protect the human rights of people affected by and living with infectious diseases. AIDS has given rise to grassroots activism and legal action to recognize the universal right to health, and it has also played a critical role in highlighting the negative health and human effects of inequitable gender norms and their manifestation in discriminatory inheritance laws and other legal and policy measures.

Human rights

Both the AU and the G8 have recognized that an effective response to AIDS must be grounded in human rights, and they have pledged to take steps to eliminate stigma and discrimination. As an addendum to the Abuja Call, the AU adopted the *Continental Framework for Harmonization of Approaches among Member States and Integration of Policies on Human Rights and People Infected and Affected by HIV/AIDS in Africa*. In 2012, 44 AU member states reported that they have non-discrimination laws or regulations that specify protections for orphans and vulnerable children, and 40 have laws that protect people living with HIV.⁸⁹ Additionally, 90% of African countries report implementing programmes to reduce stigma and discrimination as part of their AIDS response.⁹⁰

These efforts appear to be showing results. In Lesotho, where instances of HIV-related stigma and discrimination have declined, more than 80% of the population reported in 2009 that they would be willing to care for a person living with HIV—a sharp increase over the 50–55% who responded favourably to the same questions in 2006.⁹¹

Although progress has been made in grounding AIDS responses in human rights principles, substantially less progress has been seen with respect to the rights of marginalised populations. Most African countries lack laws specifying protections for marginalized populations at highest risk of HIV.⁹²

Social marginalization also impedes effective TB control, as migrants, mining communities, residents of substandard housing, prisoners, and other groups are least likely to be able to access TB services. In Ethiopia and other countries, use of community health workers and other innovative outreach programmes have proven effective in reaching marginalized populations with life-saving TB services.⁹³

Both globally and among AU and G8 member states, there is a clear trend towards the repeal of discriminatory travel policies. Three African countries retain restrictions on the entry, stay or residence of people living with HIV, as does one G8 member.⁹⁴

Gender equality

The AU and G8 partnership has committed to promote gender equality and address women's HIV-related needs. In Africa, women account for nearly 60% of all people living with HIV. In addition to their heightened physiological risk of acquiring HIV during heterosexual intercourse, women are made vulnerable to HIV by extensive social, economic and legal disadvantages. According to results of the People Living with HIV Stigma Index surveys, women living with HIV are more likely to experience stigmatizing and discriminatory treatment than are men living with HIV.⁹⁵ With studies consistently finding higher rates of HIV among women who have experienced sexual or gender-based violence, the United Nations Security Council Resolution 1983 committed countries to take action to address the scourge of violence against women.⁹⁶

Nearly all African countries include women-focused initiatives in their national AIDS strategies, although the nature and degree of implementation for these measures vary.⁹⁷ Globally, only about 1 in 10 countries effectively engage men and boys in national efforts to promote healthy gender norms in the context of HIV.

Brazzaville, 2006: AU commits to enact or repeal laws and policies in order to promote gender and human rights, and strengthen their implementation, in line with the AU framework on human rights and HIV and AIDS.

L'Aquila, 2009: G8 commits to counter any form of stigma, discrimination and human rights violation, and to promote the elimination of travel restrictions on people living with HIV.

G8 countries are the primary providers of financing for HIV treatment programmes in Africa. HIV treatment coverage in Africa is higher among women than among men, in part due to the fact that antenatal care settings serve as a vital portal for HIV testing, counselling and treatment for many women living with HIV.

2.7 Monitoring, evaluation and reporting

Accountability systems are critical to ensure that AIDS, TB and Malaria -related commitments and results are realized, as well as to generate further political commitments. Comprehensive and timely monitoring and evaluation (M&E) data are crucial to optimize the use of limited resources, to ensure effective programmes and to build accountability. Reliable monitoring systems play a critical role in building and sustaining political support, providing proof that investments are making a difference in people's lives. Data systems also promote key values of the African rebirth, including transparency, accountability and good governance.

M&E systems in AU member states

In multiple summits, the AU has pledged to provide reliable, timely reports about the progress towards AIDS, TB and Malaria targets. Assessing progress in addressing the three priority diseases in Africa demands strong national and regional M&E mechanisms. The African Peer Review Mechanism (APRM), a mutually agreed policy diagnostic and self-monitoring instrument adopted by AU member states, represents a unique and innovative approach that monitors political, socio-economic and corporate governance values, codes and standards. Established in 2003 as an integral part of NEPAD, APRM not only promotes knowledge and experience sharing, but also the reinforcement and dissemination of best practices with respect to health care delivery. The APRM has undertaken reviews of strategies to address AIDS, TB and Malaria in 17 countries to date.

National AIDS M&E systems have been rapidly scaled up and strengthened, with considerable technical and financial support from UNAIDS. These M&E gains are also reaching sub-national and civil society partners with essential training and capacity-building support, and they have contributed to functional health information systems at both national and sub-national levels in several countries. As one indicator of increased commitment to accountability and ownership, the rate of countries reporting to the United Nations on progress in implementing the 2001 Declaration of Commitment is among the highest for any development issue (Box 5).⁹⁸

TB surveillance systems tend to be much weaker than those developed for AIDS. Monitoring TB trends is frequently undermined by considerable discrepancies between diverse reporting channels in the same countries, reducing the ability of public health agencies to reliably report key strategic information.⁹⁹ Due to the weakness in national reporting systems and the insufficient collaboration on reporting between HIV and TB systems, WHO uses various methods to estimate TB-related outcomes for people living with HIV.

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

Brazzaville, 2006: AU commits to develop national account systems to monitor expenditure and resource allocations, and to create a framework under which they are held accountable.

commodity procurement, implementation, and the impact on maternal and child health. ¹⁰⁰

The AU has called for regular reporting on progress towards the Abuja targets. Most AU member states, however, have failed to provide regular progress reports: for the most recent review, covering 2010–2012, only nine countries submitted data to the AU Commission.

Much remains to be done to strengthen accountability for health results in Africa. Health systems in Africa often continue to suffer from an absence of reliable, high-quality data, underscoring the need for further efforts to ensure the availability of timely, reliable, valid data to inform programme management and policy development.

G8 accountability

Following the Heiligendamm Summit, the G8 undertook on-going monitoring of progress towards its commitments. The accountability reports prepared for the 2009 l'Aquila and the 2010 Muskoka Summit summits, for example, provide direct assessment of disbursements made against the financial commitments announced in Gleneagles in 2005 and St Petersburg in 2006. Information to assess accountability for non-financial pledges by the G8 (such as commitments to promote human rights, non-discrimination, and gender-sensitive responses), however, is less plentiful or straightforward.

Heiligendamm, 2007:
G8 agrees to a process of monitoring progress against commitments, including financial commitments.

Box 6.

Case study: AIDS monitoring and reporting system

The reporting framework developed for the 2001 Declaration of Commitment on HIV/AIDS has been cited as a model for the development of accountability mechanisms for other diseases. ¹⁰¹ The international HIV reporting system was renewed at both the 2006 and the 2011 High-Level Meetings on AIDS.

Under the HIV reporting framework, countries submit biennial reports to the UNAIDS Secretariat, describing progress against a set of core indicators that are published at least 12 months in advance of the reporting deadline. Indicators are reviewed after each reporting period to assess their continued validity, although efforts are made to avoid changes to indicators in order to preserve the ability to monitor trends.

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

The reporting system has witnessed remarkable engagement by member states, with response rates exceeding 95%. Among AU members, the response rate is a perfect 100%, and all but one G8 member submit reports. Factors that have contributed to this high response rate include:

- delegation of a specific entity with the responsibility of implementing the system;
- clear technical guidance;
- the provision of financial and technical assistance to facilitate accurate and timely reporting;
- extensive national consultation and data vetting;
- engagement of civil society; and
- rapid review and extensive communication with reporting entities.

While the reporting rate under the AIDS reporting system is impressive, the quality and comprehensiveness of country varies. In large measure, this stems from persistent weaknesses in national M&E capacity, underscoring the need for continued efforts to build robust and sustainable M&E systems in countries.

Figure 18.

Africa/G8 Partnership: a timeline

Source: UNAIDS

| 2000 | 2001 | 2002 | 2003 |
|---|--|--|--|
| AU/G8 dialogue on health begins in Okinawa, the first G8 Summit to invite African leaders | G8 responds to the formation of NEPAD by articulating the Genoa Plan for Action and appointing Africa Personal Representatives | G8 launches the Africa Action plan, inaugurating the G8/Africa partnership | G8 creates the Africa Partnership Forum (APF) for dialogue between Africans and development partners beyond the G8 |

2.8 Partnerships for implementation

Over the past decade, much has been learned as the G8 and AU partnership has evolved. As the AIDS response has made plain, the importance of securing input from the full spectrum of civil society partners cannot be overstated. Key partners in the AIDS response include groups and networks of people living with HIV, AIDS service organizations, harm reduction networks, people who use drugs, sex workers, men who have sex with men, transgender people, organizations of young people, women, health professionals and scientists, sports entities, national and international NGOs, faith-based organizations, humanitarian and human rights organizations, and academia.¹⁰²

Africa has recognized and responded to the critical importance of a working partnership with civil society. As of December 2012, 48 countries ensured full involvement and participation of civil society in the development of their national strategy on AIDS, with an additional three reporting moderate involvement. In 47 countries, a mechanism existed to promote interaction between government, civil society organizations and the private sector for implementing HIV strategies and programmes.¹⁰³

People living with HIV play a pivotal role in the response to AIDS. As human rights, people living with HIV are entitled to appropriate services, gender equality, self-determination and participation in decisions affecting their quality of life. The *Greater Involvement of People Living with HIV* (GIPA) is therefore critical for the implementation of effective programmes with a high degree of acceptability and service uptake.¹⁰⁴ In 2012, national AIDS coordinating bodies included representation of people living with HIV in 47 AU member states.¹⁰⁵

The private sector is an important, if under-utilized, partner. Private sector representatives participate on many national AIDS councils and in country coordinating mechanisms of the Global Fund, which have served as a critical vehicle for engaging a broad array of stakeholders in national AIDS, TB and Malaria efforts. In many countries, national AIDS Business Councils also provide a platform for private sector engagement and the sharing of best practices in HIV workplace policies and programmes. Various networks, such as the African Broadcast Media Partnership against HIV/AIDS, facilitate the active engagement and leadership of different components of the private sector in AIDS responses.

As the AU and G8 partnership itself illustrates, many critical partnerships in the AIDS response occur at global and regional levels. The Global Fund, for example, has served as a vital instrument for engaging OECD countries beyond the G8, as well as emerging economies (such as those in the BRICS alliance).

More than 1000 organizations—including non-governmental organizations, private sector entities, academic institutions, national and local governments, and consumer alliances—participate in the Stop TB Partnership, which is leading global efforts to meet TB targets. Since the Abuja Declaration on Roll Back Malaria (RBM) in 2000, all endemic countries in sub-Saharan Africa have established country-based RBM partnerships.

Abuja, 2001: AU commits to strengthen the response to HIV, TB and other infectious diseases through a multisectoral strategy that mobilizes all appropriate development sectors of governments, as well as organizations at the community level, including civil society, NGOs, the private sector and people living with HIV.

Section 3: **The way forward**



This report provides a unique snapshot of progress made by the AU and the G8 in keeping the commitments they have made to ensure results for people in relation to AIDS, TB and Malaria. Many of these commitments have been kept, including the AU pledge to demonstrate extraordinary leadership in the response to AIDS, TB and Malaria, and the G8 pledge to finance health in Africa. Others—including the push for universal access to essential health services and the Abuja commitment to allocate at least 15% of national public expenditure to health—remain to be fully realized. Even in the case of commitments not yet fulfilled, major gains have been made, in large measure due to a shift towards shared responsibility for sustainable responses for AIDS, TB and Malaria.

While highlighting historic gains that have been achieved over the last decade, this review has also identified critical challenges that need to be addressed in moving forward. Significant service gaps persist, in part due to considerable funding shortfalls for each of the three diseases. The continued dependence of many African countries on external partners potentially places in doubt the sustainability of many of the historic health outcomes achieved over the last decade. The failure of marginalized populations to share equally in the fruits of expanded health coverage not only contravenes fundamental human rights principles, but it also undermines efforts to achieve Africa's health targets. Although much has been accomplished in addressing key aspects of good health governance—including political leadership, partnerships for implementation, and transparency of financial governance—additional advances are needed, especially to ensure that limited resources are used as effectively and strategically as possible.

Urgent steps are required to improve the predictability and reliability of essential health funding. The G8 should develop multi-year spending plans for country programmable assistance and make such plans publicly available in order to increase transparency and reduce volatility in external assistance.¹⁰⁶ The predictability and sustainability of national programmes would be further improved if all AU member states fulfilled their pledge to allocate 15% of national budgets to health. This achievement—in combination with required improved per capita investment in health, and other key factors such as separate investment in production, distribution and utilisation of commodities and medicines, investment in education for training, retention of more health workers and addressing key social determinants of health—would provide substantial protection against possible global economic shocks to national responses to the three priority diseases. Failure to follow through on the commitments that have been made by the AU and the G8 would have long-term consequences, particularly for Africa's future economic development, which depends on a healthy, productive population.

“The global community has embarked on an historic quest to lay the foundations for the eventual end of the AIDS epidemic”

Just as challenges exist, however, enormous opportunities are also present. The global community has embarked on an historic quest to lay the foundation for the eventual end of the AIDS epidemic. Unprecedented gains have been achieved in reducing the number of both adults and children newly infected with HIV, lowering the numbers of people dying from AIDS-related causes and implementing enabling policy frameworks that accelerate progress. It is increasingly clear that an AIDS-free generation is feasible to achieve, but only through renewed and sustained commitment and global solidarity.

The tools also exist to make the scourge of TB a thing of the past. New diagnostic tools have dramatically strengthened the capacity to address the emergence of drug-resistant TB, and research efforts hold the promise of generating new preventive and therapeutic tools to add to the TB toolkit. For this promise to be realized, however, the historic neglect of TB must be reversed and a greater commitment made to reach the marginalized populations that are most likely to fall outside the TB service system.

With commitment, solidarity and continued effort, Africa can also eliminate Malaria. The Global Malaria Action Plan's strategy for Africa aims to reduce morbidity to 79 million cases and reach near zero mortality for all preventable deaths by 2015, and to maintain that target beyond 2015. An analysis of 20 high-burden African countries indicates that achievement and continuation of the 2010 coverage goals would save more 4.2 million lives by 2015.¹⁰⁷

In moving forward with renewed determination, additional efforts are needed to encourage and support South-South collaboration and technical support, and to engage new partners to realise the AU goal of overall development effectiveness on the continent. In particular, new opportunities must be explored and innovative mechanisms established to promote partnership and linkage between stakeholders in the three priority diseases.

Preserving a strong focus on health in the post-2015 development agenda is central to future progress. The specific commitments on AIDS, TB and Malaria—as well as the broader targets set forth in the MDGs—have galvanized greater political commitment, attracted unprecedented new funding, focused attention on issues of poverty, intensified the focus on results, and united diverse stakeholders in a common undertaking to lay the foundation for a fairer, healthier, more prosperous world for future generations.¹⁰⁸ These same aims will remain critical after 2015. Although work is ongoing to formulate a common African position on the post-2015 development agenda, a consensus is emerging to finish the unfinished MDG business, building and expanding on them as necessary to address important issues (e.g. health of the aged, peace and stability) that may not have been prioritized in the original MDGs.¹⁰⁹

Recommendations for a stronger partnership

AU member states are called upon to do the following:

1. Collectively meet the Abuja commitments on health investments in the context of diversifying financing—including through increased innovative financing and social protection—and to promote African leadership and ownership.
2. Accelerate efforts towards a harmonized regional approach to the regulation of medicines

through the African Medicines Regulatory Harmonization (AMRH) and the manufacture of pharmaceutical products as a means to implement the PMPA Business Plan. This is to enhance access to quality-assured essential drugs and commodities—including those for AIDS, TB and Malaria—with the support of G8 countries and in the context of continued TRIPS flexibilities and the extension of the TRIPS waiver for Least Developed Countries beyond 2015.

3. Strengthen African-led, continental accountability mechanisms—such as the Africa Peer Review Mechanism (APRM), AIDS Watch Africa (AWA) and others—utilizing these platforms to more actively share lessons learnt on accelerating progress towards agreed targets for the three diseases.
4. Ensure full implementation of the *Continental Framework for Harmonization of Approaches among Member States and Integration of Policies on Human Rights and People Infected and Affected by HIV/AIDS in Africa*.

G8 member states are called upon to do the following:

1. Support AU member states in implementing their *Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria* through the articulation of specific and new time-bound pledges in relation to the priority actions.
2. Collectively meet their commitments to substantially increase official development assistance (ODA) to Africa based on the Gleneagles Summit declaration, and to invest 0.7% of GNI in ODA to fill gaps as required. Africa welcomes the efforts of the G8 countries that have individually met their commitments.
3. Actively promote the use of country systems, and more forcefully ensure that investments are coordinated and aligned with African countries' priorities and plans, in line with the Paris Declaration, the Accra Agenda for Action and the Busan Global Partnership for Effective Development Cooperation, focusing on high-burden countries and populations.

Both partners are called upon to do the following:

1. Focus investments on achieving better value for money, including through continuing to reduce the unit costs of testing and treating the three diseases.
2. Take action to strengthen health systems, particularly human resources for health, and improve the availability of timely, reliable and valid data to guide policy-making, strategic investments, implementation and accountability.
3. Use their collective influence to help ensure that the post-2015 development agenda and accountability framework maintains a priority focus on AIDS, TB and Malaria in order to sustain and accelerate progress.
4. Take action to ensure that national responses are grounded in human rights, gender equality and non-discrimination with respect to marginalized populations, as part of the implementation of the AU framework on the harmonization of human rights approaches.¹¹⁰
5. Undertake a joint mutual accountability review on commitments in 2015 under the auspices of the revitalized AIDS Watch Africa, and consider expanding their partnership to include the BRICS countries and the broader G20.

Snapshot: AU & G8 commitments*, progress* and gaps

| G8 commitment | AU commitment | Progress | Gaps |
|--|--|---|--|
| Leadership | | | |
| <ul style="list-style-type: none"> An ambitious plan on infectious diseases, notably AIDS, Tuberculosis and Malaria (Okinawa, 2000) Action Plan for Africa (Kananaskis, 2002) High-level political engagement to reduce stigma against people living with HIV (l'Aquila, 2009) | <ul style="list-style-type: none"> Contain and reverse the spread of HIV, TB and other infectious diseases, as a top priority (Abuja Declaration, 2001) Ensure that leadership is exercised by everyone in his or her area of responsibility in the fight against AIDS, TB and Malaria (Abuja Declaration, 2001) Halve the Malaria mortality for Africa's people by 2010, through implementing the strategies and actions for Roll Back Malaria (Abuja Declaration, 2000, extended to 2015 by Kampala Declaration, 2010) Take "urgent extraordinary action" to address TB (Maputo WHO Regional Office for Africa committee), address TB in the mining sector (Southern African Development Community, or SADC, 2012), and recognize TB as a national emergency (national declarations in 10 countries) | <ul style="list-style-type: none"> 90% of AU countries report that the head of state or government or other high officials have taken action in the past year that demonstrated leadership in the response to AIDS AIDS Watch Africa established and eventually expanded to address TB and Malaria ALMA established in 2009 SADC issued Declaration on TB in the Mining Sector, expressing strong political support for a strengthened response to TB From 2000 to 2010, G8 declarations highlighted the response to AIDS, TB and Malaria | <ul style="list-style-type: none"> Little-to-no mention of AIDS, TB or Malaria in final declarations of the 2011 and 2012 G8 summits No new commitments on AIDS, TB and Malaria made by G8 following expiration of funding commitment for 2007–2012 |
| Resource mobilization | | | |
| <ul style="list-style-type: none"> US\$ 1.3 billion for Global Fund (Genoa, 2001) Double aid to Africa by 2010 (an additional US\$ 25 billion) (Gleneagles, 2005) US\$ 60 billion for infectious disease and health system strengthening (over five years) (Heiligendamm, 2007) US\$ 1.5 billion needed annually for Malaria, including access to bednets, combination therapies, presumptive treatment for pregnant women and babies, household spraying, and the capacity in African health services to effectively use these tools (Gleneagles, 2005) G8 annual total commitments for health of US\$ 13 billion (collective results of individual country budgetary processes) | <ul style="list-style-type: none"> 15% of government budgets allocated to health (Abuja, 2000) AU commits to diversify funding through country-specific financial sustainability plans, ensure predictable funding from development partners, and expand funding sources for AIDS, TB and Malaria (AU Roadmap on Shared Responsibility and Global Solidarity, 2012) | <ul style="list-style-type: none"> Among AU member states, six have met the 15% benchmark: <ul style="list-style-type: none"> Rwanda (24%); Liberia (19%); Malawi (19%); Zambia (16%); Togo (15%); and Madagascar (15%) AU government expenditures allocated to health increased, on average, from 9% to 11% between 2001 and 2011 Globally, domestic investments in AIDS activities accounted for a majority of AIDS expenditure for the first time in 2011 G8 provided US\$ 12.2 billion to the Global Fund (78% of Global Fund funding) G8 funding increased by US\$ 10 billion between 2005 and 2010 80% of G8 AIDS financial commitments disbursed G8 bilateral AIDS funding increased from US\$ 2 billion in 2005 to US\$ 4.2 billion in 2010 | <ul style="list-style-type: none"> 47 AU member states have not reached the Abuja target of 15% public funding allocation for health 32 AU member states invest less than US\$ 29 per capita on health G8 funding for AIDS, TB and Malaria has declined since 2008 Global funding gap for AIDS exceeds US\$ 5 billion annually Funding gap for TB in Africa is US\$ 900 million annually Funding gap for malaria in Africa is estimated at US\$ 3.8 billion to 2015 Global Fund needs US\$ 15 billion in 2014–2016 to accelerate progress on AIDS, TB and Malaria |
| Prevention, treatment, care and support | | | |
| <ul style="list-style-type: none"> Reduce the number of young people living with HIV by 25% by 2010; reduce TB deaths and prevalence of the disease by 50% by 2010; reduce the burden of disease associated with Malaria by 50% by 2010 (Okinawa, 2000) Universal access to HIV prevention, treatment, care and support in Africa (Gleneagles, 2005) Support life-saving antiretroviral treatment for approximately five million people (Heiligendamm, 2007); later extended and expanded to 15 million people by 2015 (2011 Political Declaration of Commitment) 50% reduction in TB deaths by 2015 (MDG 6) 50% reduction in sexual transmission by 2015 (2011 Political Declaration on HIV/AIDS) Elimination of new HIV infections among children by 2015 (2011 Political Declaration of Commitment on HIV/AIDS) | <ul style="list-style-type: none"> Universal access to prevention, treatment and care by 2015 through the development of an integrated health-care delivery system based on essential health package delivery (Gaborone, 2005; Kampala, 2010) 75% reduction in Malaria deaths and cases by 2015 (AU Africa Malaria Elimination Campaign) 50% reduction in TB deaths by 2015 (MDG 6) 50% reduction in sexual HIV transmission by 2015 (2011 Political Declaration on HIV/AIDS) Elimination of new HIV infections among children by 2015 (2011 Political Declaration on HIV/AIDS) Provide antiretroviral therapy to 15 million people worldwide by 2015 (2011 Political Declaration on HIV/AIDS) | <ul style="list-style-type: none"> By 2012, antiretroviral therapy reached more than seven million people in Africa, with five African countries achieving universal access to HIV treatment 25% reduction in the annual number of new HIV infections from 2001 to 2011 33% reduction in malaria mortality from 2000–2010 The percentage of households owning at least one bednet in Africa has risen from 3% in 2000 to 53% in 2012 Between 2000 and 2011, 12.7 million people in Africa were treated for TB 10% decline in TB deaths in Africa from 2009 to 2011 | <ul style="list-style-type: none"> In 26 of 31 African countries with generalized epidemics, less than 50% of young women have accurate and comprehensive knowledge about HIV Sexual risk behaviour is increasing in some African countries No progress globally has been reported in reducing the number of new HIV infections since 2007 Some African countries are not on track to achieve the 2015 target of reaching 80% of men with voluntary medical male circumcision Substantial access gap exists for male and female condoms 41% of pregnant women living with HIV did not receive antiretroviral prophylaxis in 2011, and the number of new infections among children are on the rise in at least four African countries Africa only region not on track to achieve global target of reducing TB deaths by 50% by 2015 Drug-resistant TB on the rise in Africa Number of bednets purchased for Malaria control fell by more than half from 2010 to 2012 |

| G8 commitment | AU commitment | Progress | Gaps |
|--|---|--|---|
| Health systems strengthening | | | |
| <ul style="list-style-type: none"> Improve technical capacity, including disease surveillance (Kananaskis, 2002) Strengthen health systems as a framework for increasing access of the neediest populations of developing countries to health care, drugs and treatments (Evian, 2003) Build sustainable health systems in order to deliver effective disease interventions (Heiligendamm, 2007) Strengthen training facilities for the recruiting and training of health professionals (St. Petersburg, 2006; Tokayo, 2008) | <ul style="list-style-type: none"> Accelerate health sector reform with a focus on all epidemics, and AIDS in particular (Lomé, 2000) Strengthen key elements of health systems (e.g. financing, infrastructure, workforce, etc.) (Abuja, 2006) | <ul style="list-style-type: none"> 47 member states of the African Union have developed a plan to strengthen health systems Services to prevent children from acquiring HIV infection have been integrated into maternal and child health services in all 22 priority countries Of 36 eligible African countries, 22 have had Global Fund health systems strengthening proposals approved for > US\$ 300 million Global Fund has supported 14 million person-episodes of training for health and community workers worldwide from 2002 to mid-2012 African countries have extensively implemented task-shifting in health settings | <ul style="list-style-type: none"> Human resource challenges persist, as Africa accounts for 24% of the global disease burden, but has only 2% of the world's physicians and accounts for 1% of health spending |
| Access to affordable medicines and technologies, and R&D | | | |
| <ul style="list-style-type: none"> Begin to address substantial gaps in knowledge about how to manage, organize and deliver health care in Africa Support efforts to deliver affordable medicines to those who need them (Genoa, 2003) | <ul style="list-style-type: none"> Urge member states to take the lead in TRIPS negotiations and in implementing measures identified for promoting access to affordable generic drugs (Abuja, 2005) Ensure access to affordable and quality-assured medicines (AU Roadmap, 2012) | <ul style="list-style-type: none"> 99% reduction in the price of antiretrovirals from US\$ 10 000 per person in 2000 to less than US\$ 116 in 2010 Pharmaceutical Manufacturing Plan for Africa (PMPA) Business Plan adopted and African Medicines Regulatory Harmonization initiative established Malaria Partnership for Product Development is expected to significantly contribute to development of a Malaria vaccine Price reductions achieved for Malaria drugs and Xpert MDR/RIF technology | <ul style="list-style-type: none"> Local production of essential medicines is hindered by unfavourable international trade policies and a lack of support to benefit from TRIPS flexibilities Prices for second-line antiretrovirals remain highly prohibitive Additional progress needed towards establishment of common regulatory approach |
| Human rights and gender equality | | | |
| <ul style="list-style-type: none"> Counter any form of stigma, discrimination and human rights violation, and promote the elimination of travel restrictions on people living with HIV (L'Aquila, 2009) Support a gender-sensitive response and address gender-based violence (Heiligendamm, 2007) | <ul style="list-style-type: none"> Implement comprehensive multisectoral strategies for HIV, TB and other infectious diseases that involve all appropriate development sectors, and that also mobilize community level organisations, civil society, NGOs, the private sector and people living with HIV (Abuja, 2001) | <ul style="list-style-type: none"> Among AU member states: <ul style="list-style-type: none"> 48 report full participation of civil society in the development of their national HIV strategy 47 have a mechanism to promote interaction between government, civil society organizations and the private sector for implementing HIV strategies and programmes; and 47 have representation of people living with HIV in national AIDS coordinating bodies Since the Abuja Declaration on Roll Back Malaria in 2000, all endemic countries in Africa have established country-based RBM partnerships. Global Fund Country Coordinating Mechanisms have served as a key platform to engage diverse stakeholders in planning for responses to AIDS, TB and Malaria | <ul style="list-style-type: none"> G20, BRICS and other emerging economies should be engaged in the AU-G8 partnership in support of health-related hard-to-reach MDGs and beyond Greater involvement of all stakeholders in the policy planning and responses to AIDS, TB and Malaria at all levels Appropriate linkages between Africa and low- and middle-income countries to further South-South Cooperation and the Busan Global Partnership for Effective Development Cooperation |
| Partnership for implementation | | | |
| <ul style="list-style-type: none"> Commitment to strong partnership with African governments and diverse stakeholders (Okinawa, 2000) | <ul style="list-style-type: none"> Implement comprehensive multisectoral strategies for HIV, TB and other infectious diseases that involve all appropriate development sectors, and that also mobilize community level organisations, civil society, NGOs, the private sector and people living with HIV (Abuja, 2001) | <ul style="list-style-type: none"> Among AU member states: <ul style="list-style-type: none"> 48 report full participation of civil society in the development of their national HIV strategy 47 have a mechanism to promote interaction between government, civil society organizations and the private sector for implementing HIV strategies and programmes; and 47 have representation of people living with HIV in national AIDS coordinating bodies Since the Abuja Declaration on Roll Back Malaria in 2000, all endemic countries in Africa have established country-based RBM partnerships. Global Fund Country Coordinating Mechanisms have served as a key platform to engage diverse stakeholders in planning for responses to AIDS, TB and Malaria | <ul style="list-style-type: none"> G20, BRICS and other emerging economies should be engaged in the AU-G8 partnership in support of health-related hard-to-reach MDGs and beyond Greater involvement of all stakeholders in the policy planning and responses to AIDS, TB and Malaria at all levels Appropriate linkages between Africa and low- and middle-income countries to further South-South Cooperation and the Busan Global Partnership for Effective Development Cooperation |
| Monitoring, Evaluation and Reporting | | | |
| <ul style="list-style-type: none"> Improve monitoring of emerging infectious diseases (L'Aquila, 2009) Develop well-functioning information systems (L'Aquila, 2009) | <ul style="list-style-type: none"> African heads of state and government lead a social movement, from 2006 to 2010, in their respective countries, to provide accurate and reliable information (Brazzaville, 2006) Develop an accountability framework (Abuja, 2001) | <ul style="list-style-type: none"> Global AIDS progress reporting response rates in Africa increased from less than 60% in 2004 to 100% in 2012 76% of countries in the most affected regions of Africa reported on AIDS spending in 2012 37 out of 44 African countries have benefited from Malaria-specific Malaria indicator surveys (MIS) or multiple indicator cluster surveys (MICS) in the last four years AIDS Watch Africa established as accountability mechanism ALMA scorecard for accountability and action established | <ul style="list-style-type: none"> Reporting far less robust for TB and Malaria than for AIDS, though the quality of routine collection of data for all three diseases remains an issue Inability to assess overall progress on Malaria health indicators due to weaknesses in surveillance systems Substantial discrepancies in data reporting on TB |

Section 4: Addendum

Acronyms

| | |
|--------------------|--|
| ACT | artemisinin-based therapy |
| AIDS | acquired immunodeficiency syndrome |
| ALMA | African Leaders Malaria Alliance |
| AMREF | African Medical & Research Foundation |
| AMRH | African Medicines Regulatory Harmonization |
| AMFm | Affordable Medicines Facility–Malaria |
| APRM | African Peer Review Mechanism |
| ART | antiretroviral therapy |
| AU | African Union |
| AUC | African Union Commission |
| AWA | AIDS Watch Africa |
| BRICS | Brazil, Russia, India, China and South Africa |
| FHI 360 | Family Health International |
| G8 | Group of Eight |
| G20 | Group of Twenty Finance Ministers and Central Bank Governors |
| Global Fund | The Global Fund to Fight AIDS, Tuberculosis and Malaria |
| GNI | Gross National Income |
| HIV | human immunodeficiency virus |
| HSGOC | Heads of State and Government Orientation Committee |
| IRS | indoor residual spraying |
| ITN | insecticide-treated net |
| M&E | monitoring & evaluation |
| MDGs | Millennium Development Goals |
| MDR-TB | multi-drug-resistant Tuberculosis |
| MICS | multiple indicator cluster surveys |
| MIS | Malaria indicator surveys |
| NEPAD | New Partnership for Africa's Development |
| NGOs | Non-Governmental Organizations |
| ODA | Official Development Assistance |
| OECD | Organization for Economic Co-operation and Development |
| PMPA | Pharmaceutical Manufacturing Plan for Africa |
| RBM | Roll Back Malaria Partnership |
| RDTs | rapid diagnostic tests |
| RECs | Regional Economic Communities |
| SADC | South African Development Community |
| TB | Tuberculosis |
| TRIPS | Agreement on Trade-Related Aspects of Intellectual Property Rights |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| WHO | World Health Organization |

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