

Abuja +12

Shaping the future of health in Africa

RECOMMENDATIONS

- 1. Unite leadership for a healthy Africa**
- 2. Generate innovative financing solutions**
- 3. Make smart investments for greater health returns**
- 4. Strengthen Africa's human health resources**
- 5. Leave no one behind**

Twelve years ago, African nations gathered to issue the ground-breaking Abuja Declaration. It was a historic moment, as Africa pledged to band together to eliminate the health crises devastating the continent. In July 2013, African Union (AU) Member States once again will convene in Nigeria for the Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria (Abuja +12). It will be an opportunity to review how far countries have come since Abuja and to chart a course for the work still to come.

To inform preparations for the Summit, this report reviews the purpose and objectives of the 2001 Abuja Declaration, summarizes achievements against these objectives and describes the current state of public health in Africa. In looking forward to 2030, this report identifies five priority health recommendations for the AU, and the specific activities to improve health and well-being in Africa over the next generation.

Overview of the Abuja Declaration

The 2001 Abuja Declaration was a historic milestone for Africa.

For the first time, the nations of Africa declared that the AIDS epidemic was a full-fledged emergency on the continent. In response, AU Member States offered unprecedented commitments to strengthen their responses not just to AIDS, but also to Tuberculosis (TB) and Malaria. Most importantly, the Abuja Declaration made it clear that words were not enough. To truly transform the continent's future, African nations needed to take decisive action.

As they left the summit, the signatories of the Abuja Declaration pledged to allocate at least 15% of their national budgets to public health by 2015. They also promised to remove all taxes, tariffs and other economic barriers that hindered the AIDS response. They pledged to support vaccine development, to make medical commodities and technologies more available, and to intensify their efforts to mobilize AIDS-fighting resources.

Perhaps most importantly, the assembled African leaders made a promise that they would assume full responsibility for—and ownership of—the AIDS response.

Figure 1

Timeline of African Union 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.



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.

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.

2000

2001

2002

2003

2004

2005

Significant progress has been made on the Abuja commitments, although that progress remains partial and uneven.

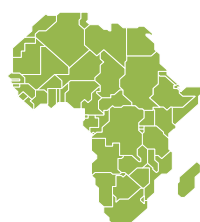
Since the Abuja Declaration, national governments have taken ownership of Africa's health challenges. They have established dedicated offices, coordination mechanisms and national strategic plans for all major diseases—especially AIDS.

- The AU Commission developed both strategic plans for HIV from 2005–2007 and the AIDS Watch Africa strategic framework to better harmonize the continent's intensified efforts to respond to the AIDS epidemic.
- Health funding has risen in Africa since 2001, but it still has not reached the level that the Abuja Declaration promised. From 2001 to 2011, health budgets in AU Member States increased from 9% to 11% of public expenditures. Six AU Member States (Liberia, Madagascar, Malawi, Rwanda, Togo and Zambia) have achieved the Abuja target of allocating 15% of public expenditure to health, and a number of other countries (e.g. Djibouti, Ethiopia, Lesotho and Swaziland) are within reach of the 15% target. Still, the vast majority of African nations have not met this essential commitment.
- In 2012, AU Member States built on this progress by adopting a historic Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa. Under this roadmap, the Member States pledged concerted action to strengthen and diversify health funding, strengthen health leadership and governance, and enhance access to affordable and quality-assured medicines.
- Affordable and quality-assured medicines are much more accessible today. This is especially true for AIDS—millions of people have received HIV treatment in the last decade. This is, in part, thanks to a combination of sharp price reductions, national leadership and international solidarity. TB and Malaria medicines are also much more widely available today.



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

African Union Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB 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 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. This includes partnerships with people living with HIV and other 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 maximize opportunities to diversify funding sources in order to increase domestic resource allocation to AIDS, TB and Malaria.

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 three 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*.

Africa and the Millennium Development Goals

With the Millennium Development Goals (MDGs) due to expire in less than 1000 days, African countries urgently need to articulate future aims for efforts to improve health outcomes. Africa's future priorities and directions need to be clarified now to expedite momentum—that is the best way to drive further progress after 2015.

Right now, Africa is on track to meet MDG targets regarding universal primary education, gender parity at all levels of education, lower HIV prevalence among 15–24 year olds and increased access to antiretroviral drugs. Africa, however, is not on pace to meet a broad range of health-related MDGs, including those pertaining to child mortality, maternal health and key aspects of efforts to respond to HIV, TB, Malaria and other diseases.

The MDGs have helped catalyse unprecedented efforts to improve health outcomes, but progress to date is incomplete. This fact only underscores the urgent need to renew commitments and strategic actions to improve the health and well-being of Africa's people.

Health in Africa

AIDS response: Major progress has been made regionally in reducing new HIV infections and AIDS-related deaths, although alarming trends remain in many areas.

In 2011, an estimated 34 million people worldwide were living with HIV. Sixty-nine percent of the people lived in Africa, where nearly one in every 20 adults is HIV-positive. Even more striking is the fact that, in the same year, more than 90% of all pregnant women and children living with HIV throughout the world were in Africa.

Clearly, Africa remains the most affected region of the epidemic. It has, however, made historic progress in its AIDS response. In 2011, the number of people newly infected with HIV in Africa South of Sahara was 25% lower than in 2001, while AIDS-related deaths declined by 32% from 2005 to 2011. Among 21 priority countries in Africa, the number of children newly infected with HIV has fallen by 38% since 2009. That number is even higher in some places. Seven countries—Botswana, Ethiopia, Ghana, Malawi, Namibia, South Africa and Zambia—have reported declines of at least 50% in new HIV infections among children.

The dramatic expansion of antiretroviral therapy has transformed the regional AIDS response. In 2001, when the Abuja Declaration was issued, it was still extremely difficult to access HIV treatment in Africa. Just 11 years later, 7.5 million people in Africa were receiving antiretroviral therapy. All told, scaled-up antiretroviral treatment has saved millions of lives in Africa South of Sahara since 1995.

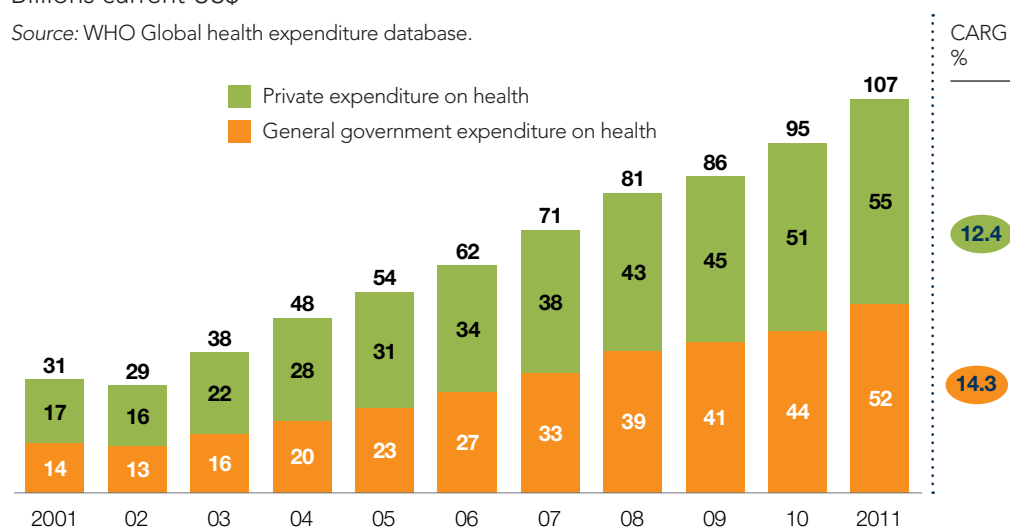
Figure 2

Africa Union expenditures on health

General government and private expenditure on health in the AU member states, 2001–2011.

Billions current US\$

Source: WHO Global health expenditure database.



The region reached another milestone in 2011, when domestic financing accounted for the majority of global AIDS spending for the first time. This reflects a larger trend among many low- and middle-income countries that have increased their domestic investments for HIV treatment. Although the degree of domestic AIDS spending varies across the region, a number of countries—including Kenya, South Africa, Togo and Zambia—have substantially increased domestic allocations for AIDS treatment in the last several years.

Figure 3

Number of new HIV infections in Africa, 2001–2011

(in millions)

Source: UNAIDS

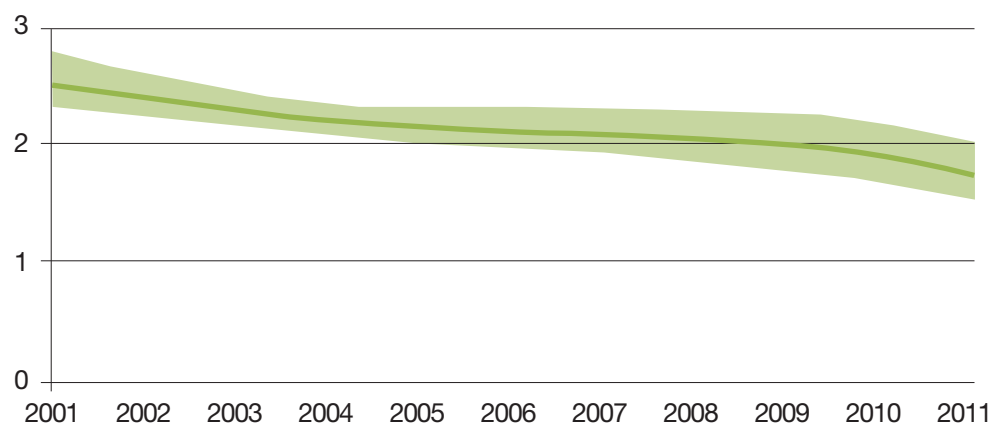


Figure 4

Domestic Spending on the AIDS response in the African Union by sub-regions, 2006–2011

(in US\$ Billions)

Source: UNAIDS (data reported by countries and modeling trends by replacing missing data and making projections with estimates based on epidemiological, demographic and income level data)

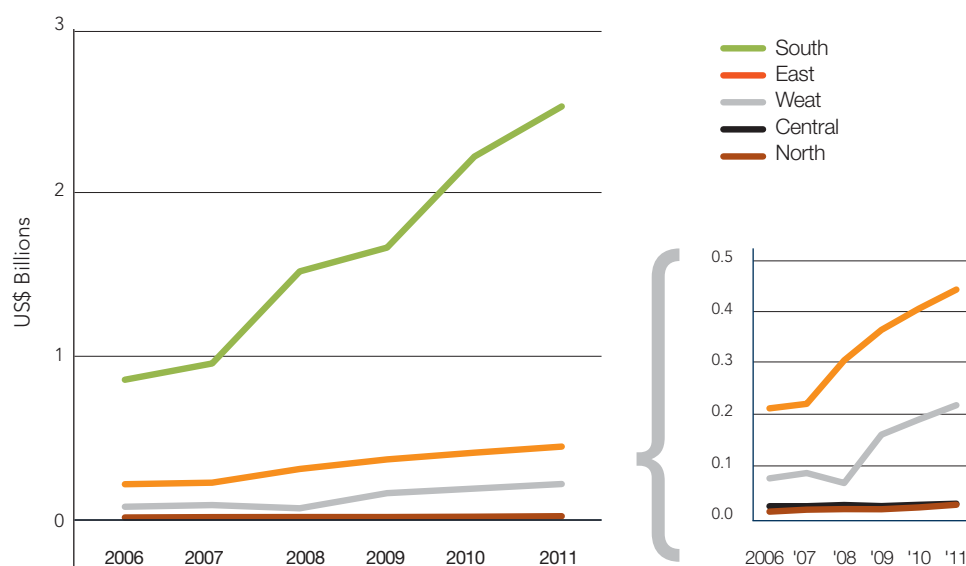
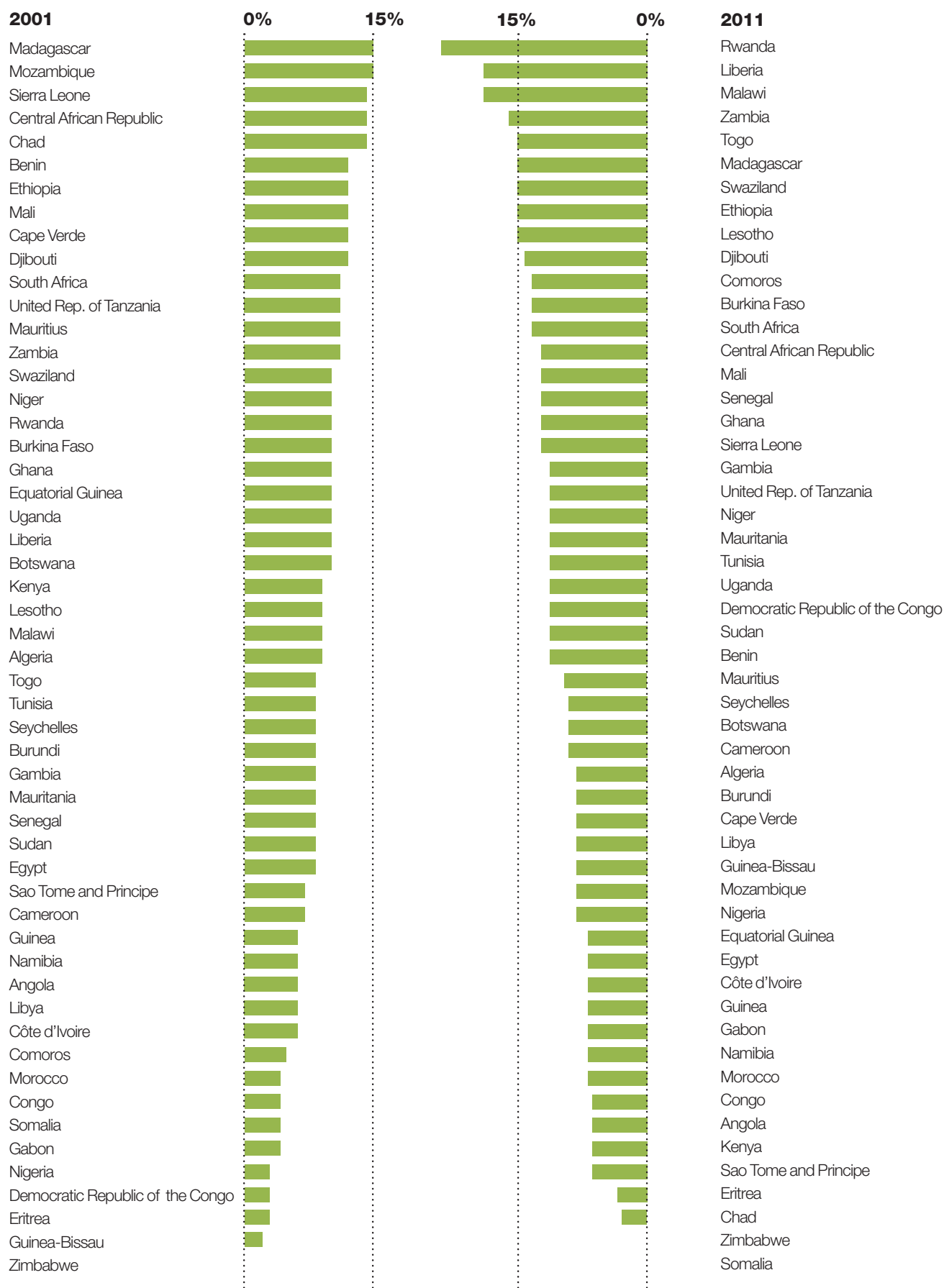


Figure 5

Abuja Declarations: Promises of commitment and solidarity

Government health expenditure as a % of Government expenditure by country, 2001 to 2011

Source: WHO Global health expenditure database



Tuberculosis (TB): Great progress has been made worldwide and in Africa, but much more progress is needed.

The world is winning the fight against TB, but the path to victory is much less certain in Africa. Worldwide, the global TB epidemic is on track to be reversed by 2015, just as envisioned in the Millennium Development Goals. Yet even as the world makes great strides, Africa remains the only continent on the globe that is not yet on track to achieve a 50% reduction in TB mortality by 2015.

Africa has seen real progress, however, including a 10% reduction in TB incidence from 2009 to 2011. Since 2000, 12.7 million people in Africa were treated for TB, and the number of TB patients tested for HIV rose from just 3% in 2004 to 69% in 2011. Today, countries are working to roll out Xpert MTB/RIF, a WHO-endorsed rapid molecular test that can diagnose TB and rifampin resistance within 100 minutes.

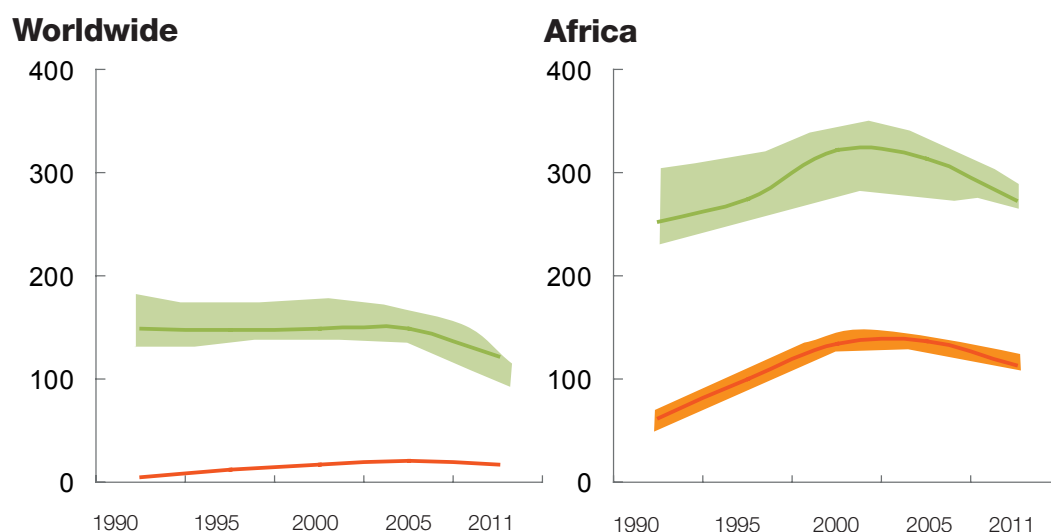
Nonetheless, Africa still accounts for 24% of the world's TB cases, and it is home to nearly 80% of TB cases among people living with HIV. As of 2011, almost four in 10 TB cases in the region remained undetected. If the world hopes to celebrate victory over TB, these persistent problems must be solved.

Figure 6

Trends in estimated TB incidence rates (green) and estimated incidence rates of HIV positive TB (red). Shaded areas represent uncertainty bands

Source: WHO Global Tuberculosis report 2012

Rate per 100 000 population per year



Malaria: Africa remains the continent most heavily affected by Malaria, with particularly severe effects on maternal and child health

Malaria has been eradicated from most places on Earth, yet this disease remains a devastating daily reality for too many people in Africa. An estimated 80% of the world’s Malaria cases and 90% of Malaria-related deaths occur in Africa South of Sahara. In 2010, there were 174 million estimated cases of Malaria on the African continent, resulting in approximately 600 000 deaths. Many of these deaths were children under five years old or pregnant women—the most vulnerable populations, who bear an outsized burden of this disease’s deadly toll.

Still, there are bright spots in this story. There have been exponential increases in funding and implementation for Malaria control programmes over the past decade. International disbursements for Malaria control have significantly increased, rising from less than US\$ 0.5 per case (US\$ 100 million total spend) in 2000 to more than US\$ 8 per case in 2012 (US\$ 1.84 billion total spend). These increased funds have been focused on Africa, countries with the lowest gross national income (GNI) per capita and countries with the highest Malaria mortality rates.

This investment has substantially improved the outlook for Malaria control in Africa. Today more households than ever own at least one insecticide-treated bed net (ITN). Excluding North Africa, 53% of African households owned at least on ITN in 2012, up from only 3% in 2000. Even more importantly, surveys indicate that as many as 90% of households with an ITN are actually using it.

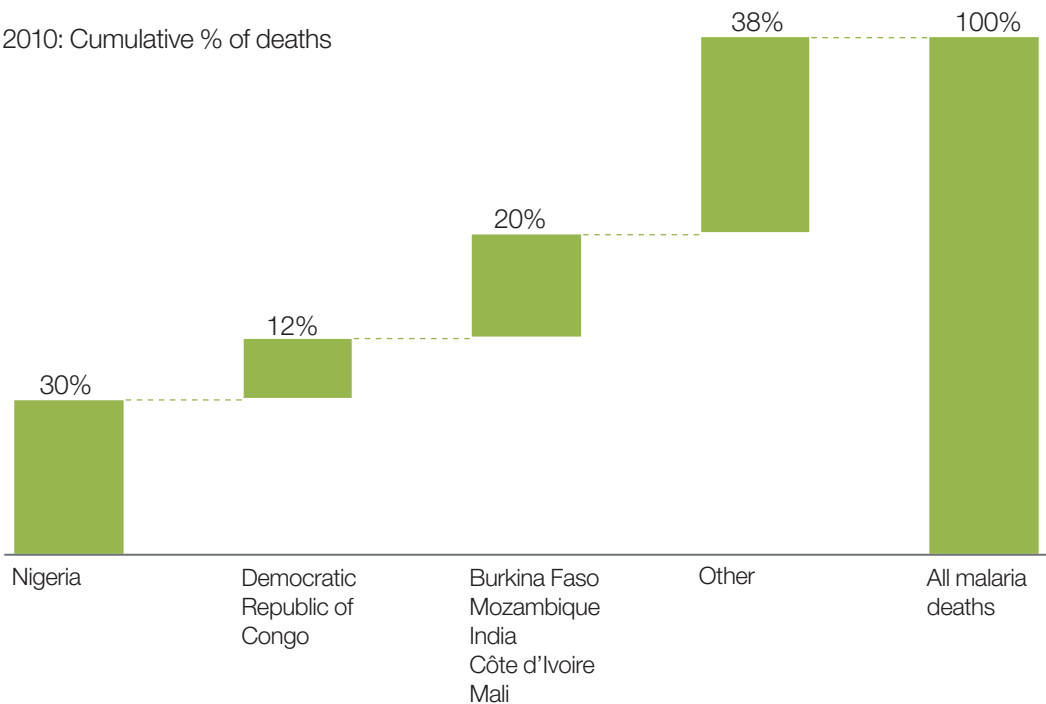
The progress is equally encouraging for households protected by indoor residual spraying. In 2005, fewer than 5% of homes were protected by indoor spraying. In 2011, that number had more than doubled to 11%. Procurement of rapid diagnostic tests and artemisin-based combination therapies has also surged as a result of increased funding. A multi-sectoral approach to Malaria like that of the HIV response could reap similar benefits. Thus, even as Africa remains the most affected region of the Malaria epidemic, there is reason for hope on the horizon.

Figure 7

Cumulative proportion of the global estimated deaths accounted for by the countries with the highest number of deaths

Source: WHO estimates

2010: Cumulative % of deaths



Maternal health: Important gains and continuing challenges.

In an age where no woman should have to fear childbirth, African women remain 100 times more likely to die from pregnancy-related causes than women in developed countries. Women in Africa South of Sahara accounted for 56% of global maternal deaths in 2010. That said, there has been some progress on this front. Most notably, the maternal death rate in Africa South of Sahara fell by 41% from 1990 to 2010. Maternal health, however, is still a critical challenge in Africa.

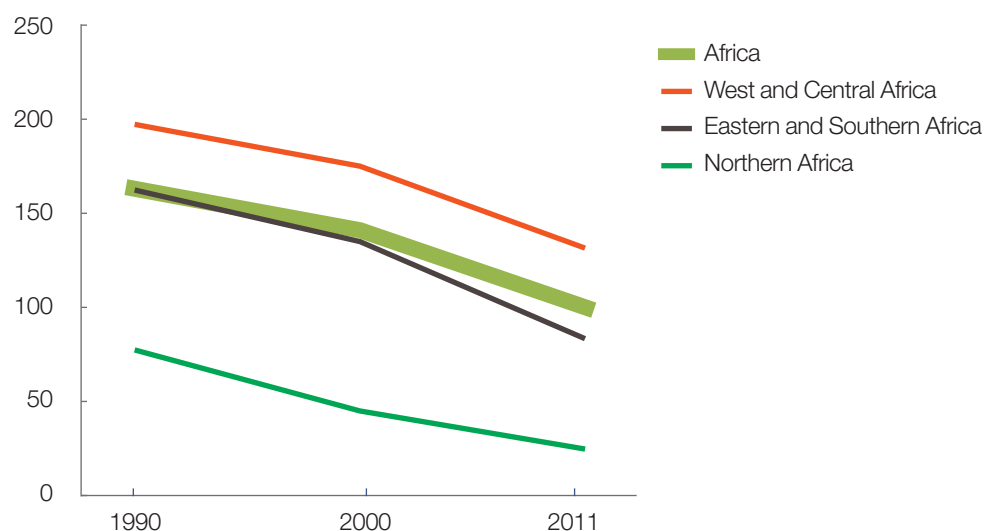
One way to accelerate results is through integrated sexual and reproductive health (SRH) services delivery. Studies have shown that the scale-up of integrated SRH and HIV services contribute to the reduction of maternal mortality and an increase in family planning.

One of the most effective ways to save lives is to focus on maternal health. If maternal mortality continues to decline at the same pace as it did between 1990 and 2010, an additional 125 000 lives will be saved each year. In 12 years, the region's maternal mortality rate would be in line with other low- and middle-income countries.

Figure 8

Under-five mortality rate (deaths per 1,000 live births), Africa and by sub-regions*

Source: Levels & Trends in Child Mortality, Report 2012. UNICEF, WHO, the World Bank, United Nations, 2012



* Africa, Eastern and Southern Africa, and West and Central Africa are grouped according to UNICEF regions; and, Northern Africa according to Millenium Development regions.

Child survival: All children should have the opportunity to grow, develop and reach their full potential.

Today, a child in Africa is more likely to die than a child in any other part of the world. Again, advances have been made, but they are not nearly enough. From 1990 to 2011, the mortality rate among children under five years old in Africa South of Sahara declined by 39%. Even with such encouraging progress, however, the region is still not on track to meet the MDG goal of reducing the under-five mortality rate by two-thirds by 2015.

Even as the rest of the world makes gains, African children continue to die at much higher rates than children in other parts of the globe. In Africa South of Sahara, one in nine children die before age five—a rate more than 16 times higher than in developed countries. In 2011, a child born in Africa south of Sahara was 1.8 times more likely to die by age five than was a child born in Southeast Asia, and more likely to die than a child in Latin America and the Caribbean.

In Africa, children usually die because of pneumonia (18% of all under-five deaths), preterm birth complications (14%), diarrhoea (11%), intrapartum-related complications (complications during birth—9%) and Malaria (7%). These deaths are almost entirely preventable.

Many nations have made progress against child mortality with vaccinations, family planning, improved nutrition, Malaria prevention and treatment, and better case management of pneumonia and diarrhoea. Nonetheless, progress is still slow in improving child survival because too many newborns are still dying in the first 28 days of their lives. Those deaths alone account for as many as 40% of African children who die before their fifth birthday. Thus, any solution to the problem of child mortality must include action to address this tragic trend.

Going beyond the Abuja commitments

The Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria occurs at a pivotal moment for the continent. Critical gains have been made, and there is the will to cement even greater gains in the near future. If Africa leverages the achievements made in the last 12 years, it can lay the foundation for a healthier, more prosperous and more just continent in the decades to come. The nations that gather in Abuja this year must seize the opportunity at hand.

Improving health will sustain and accelerate the continent's economic growth and development.

Africa's strong economic growth is an encouraging trend in the continent's broader story. Africa has the second highest rate of economic growth in the world. The region's economy grew 5.1% in 2011, and growth is projected to accelerate to 5.8% in 2014. In this decade alone, Africa is expected to add 122 million people to its labor force.

This economic growth could be game-changing for the continent. A stronger economy means more resources to combat disease. As Africa becomes healthier, even more economic growth will be possible. More people will be pulled out of poverty, and health outcomes will rise accordingly. Ultimately, economic growth can create a virtuous cycle that leads to a stronger, healthier and wealthier Africa.

When considering life expectancy, the potential for a trend like this is clear. Right now, Africa has the lowest life expectancy in the world: 54.4 years. As life expectancy rises, however, every additional year of life expectancy will raise the region's GDP by an estimated 4%. Thus, an investment in health is an investment in economic growth and a stronger continent in every imaginable way.

About 65% of the total population of Africa is under the age of 35, and some 10 million young people enter the job market every year. Health, education and employment opportunities increasingly will be entwined.

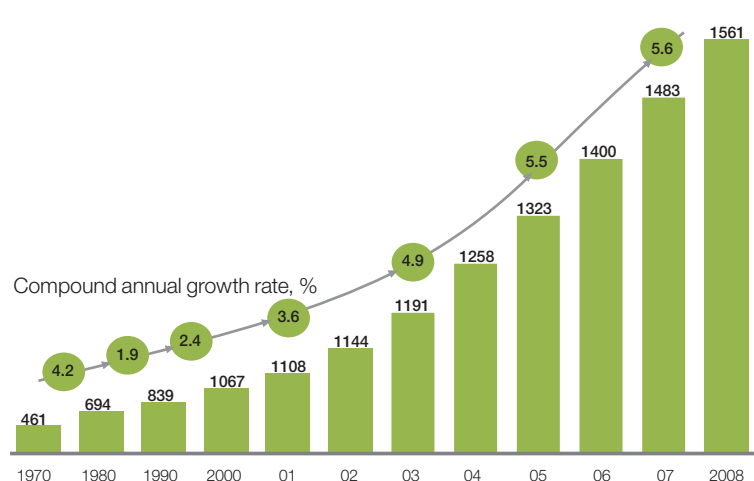
Investments in health can also create jobs in more direct ways. According to an economic assessment in South Africa, when investments were made to scale-up HIV treatment, those investments returned three times as much economic activity.

Figure 9

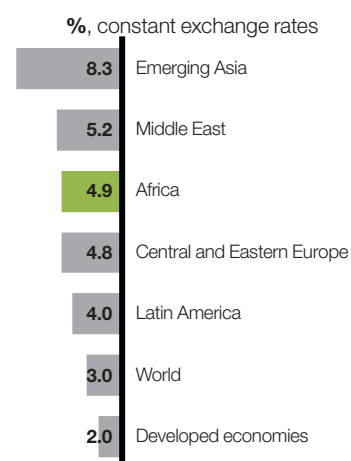
Africa's economic growth accelerated after 2000, making it the world's third-fastest growing region

Source: International Monetary Fund; World Bank World Development Indicators; McKinsey Global Institute

African annual real GDP, 2008



Compound annual real GDP growth, 2000–08



As these examples demonstrate, investments in health don't just save lives—they change them. They create jobs and foster economic activity across Africa. For these reasons and many more, these investments must continue in the coming years.

Lessons learned through the AIDS response can help improve the return on health investments.

Now in the fourth decade of the AIDS epidemic, Africa has gained a great deal of insight into what works and what does not. As the AU strives to maximize the impact of health investments, these important lessons offer guidance on the best steps forward.

The latest models project that it is possible to avert 12.2 million new HIV infections and 7.4 million AIDS-related deaths during the current decade, while also bending down the long-term AIDS cost curve.

In this scenario, funding would prioritize high-impact, high-value interventions that focus on people most in need. These efforts would then be complemented by critical enablers and development synergies.

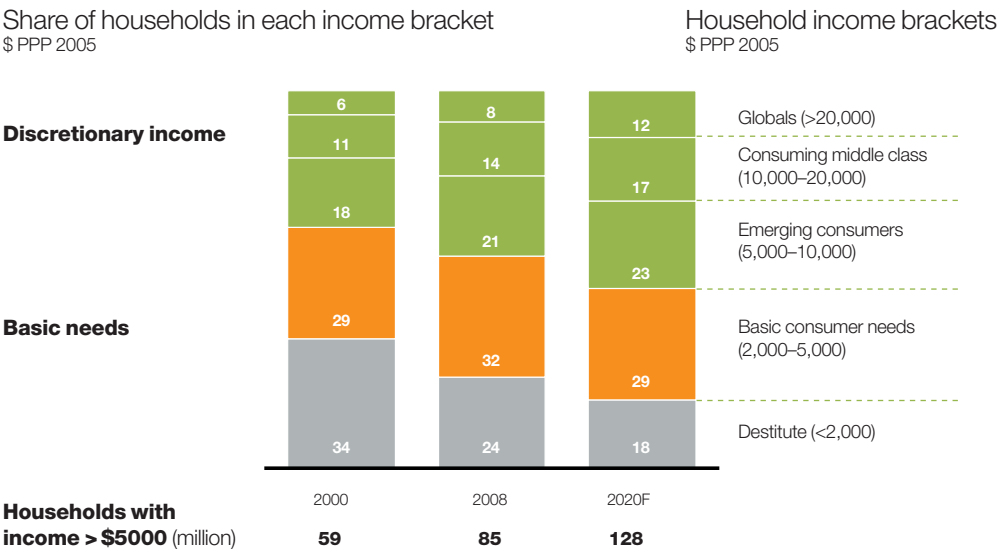
The AIDS investment frameworks have given countries useful lessons for addressing other health issues, including non-communicable chronic conditions. Ultimately, the efforts against HIV point the way towards strategies that can strengthen the efficiency, effectiveness and reach of health initiatives across a broad range of conditions. These lessons should be taken into account as plans for the future take shape at Abuja +12.

This is a moment to achieve unprecedented progress against major health threats.

This is a moment for optimism. As Africa continues the post-2015 conversation, nations have the opportunity and the responsibility to ensure the health of their citizens. Now is the time to commit to finishing the mandate of the MDGs. Now is the time to recommit to reach targets set forth in the original Abuja Declaration. Now is the time to signal—through a bold and thoughtful Abuja+12 Declaration—that health must remain a fundamental priority for Africa, both today and tomorrow.

Figure 10
By 2020, more than half of African households will have discretionary spending power

Source: Canback Global Income Distribution Database (C-GIDD); McKinsey Global Institute



Abuja +12

Shared core values

Recommendations

Shared core values

The Abuja +12 process is a historic opportunity for the region to begin focused, strategic actions to achieve real results. At every stage, the process can be guided by core values that recognize the social determinants of health—the very circumstances that citizens face—and how they are shaped by the distribution of opportunity, money, power and resources at regional, national and local levels.

In moving forward, AU Member States should unite around a set of shared core values.

Core values

1. People, especially women and children, should be at the centre of efforts to improve health.
2. Diverse cultures and communities have critical roles to play and need to be actively engaged in efforts to improve health outcomes.
3. Health architecture needs to be simplified and rationalized.
4. All stakeholders must be accountable for results.
5. Improving health in Africa is a shared responsibility that requires united action from all parts of society and partnerships with the broader international community.

Recommendations

The AU envisions an “integrated, prosperous and peaceful Africa, driven by its own citizens and representing a dynamic force in the global arena.” Achieving this vision is impossible without robust, sustained improvements in the health of Africa’s citizens.

Elevating health as a force for economic growth and social progress.

The AU has recognized this key fact and expressed a desire to renew its commitment on health issues. Going forward, the AU wants to enhance return on investment in health, while increasing African ownership of key health initiatives. At the same time, the AU aims to strengthen economic growth and development. Towards these ends, it is recommended that the AU pursue five key objectives.

1: Unite leadership for a healthy Africa

For these approaches to truly be effective, nations will need to partner across borders. The region has a tremendous opportunity to come together in order to work more effectively towards a common goal. Through better health, countries can lay the foundation for a more prosperous and more just future in the region.

This can be accomplished through several important steps.

- **Strengthen health governance in Africa.** Strengthened governance in Africa would improve coordination, facilitate rapid dissemination of innovation, enhance local commitment and ownership, and strengthen the region’s voice on health issues with international partners and donors. To that end, the AU should consider creating a governance mechanism across countries or Regional Economic Communities (RECs) that drives the overall health priorities

of the AU. This body could also potentially monitor and drive implementation of the Abuja +12 decisions and objectives. In this regard, African leadership advocacy and accountability platforms— such as AIDS Watch Africa— provide useful examples of how collective action generates synergies to address priority public health challenges.

- **Enhance regional integration.** Regional Economic Communities offer useful mechanisms that can improve coordination and planning of health interventions. Several RECs already have prioritized health care, the free transfer of skilled health-care professionals and the exchange of information. Looking towards 2030, the AU could further strengthen the role of the RECs in health care planning and delivery.
- **Make more of the medicine Africa needs in Africa.** Concerted action is urgently needed to reduce Africa's dependence on imported pharmaceutical and medical products. While Africa accounts for 69% of the world's 34 million people living with HIV, it imports more than 80% of its antiretroviral drugs. Increasing local manufacturing would increase self-sufficiency, relieve trade imbalances and exchange rate pressure, shorten supply chains (resulting in fewer stockouts and reduced inventory costs), generate new jobs and knowledge, and ensure production of drugs that the rest of the world does not supply for African diseases.

The Business Plan for the Pharmaceutical Manufacturing Plan for Africa that is being launched at this Summit provides a coordinated approach to the provision of technical assistance and capacity building for those countries that wish to invest in their pharmaceutical manufacturing industries. Defragmentation of the market will be important for the long-term sustainability of the pharmaceutical industry in Africa, and Regional Economic Communities are encouraged to accelerate their work to harmonize and improve industry regulations. This will also enable those countries that choose not to develop a pharmaceutical industry to benefit from high quality, local production through improved access to medicines that are quality assured, safe, efficacious and affordable.

In addition, the AU might catalyze the formation of public–private partnerships focused on medical industry development. It could lead to high-level conversations to attract established and emerging markets.

- **Ensure probity and accountability.** Increase efficiencies and eliminate waste and corruption. Institute quality control for medicines. Make judicious use of resources to ensure more health for money. Platform for accountability at all levels with all stakeholders.
- **Include all partners in health.** As most people access health care at the community level, local organizations and partners must be part of the decision-making process. Work is needed to further clarify health-related roles, responsibilities and priorities to ensure that all collective resources are used for maximum impact.

2: Generate innovative financing solutions

There is a strong need to find new sources of revenues to complement the targeted 15% national health expenditure goal. Over the last five years, health spending in Africa has risen by about 10% annually. Health spending, however, is still nowhere near where it needs to be—just to meet the Abuja target, health spending needs to increase by US\$ 31 billion. Even more strikingly, 75% of that funding gap is concentrated in six countries: Algeria, Angola, Egypt, Libya, Nigeria and South Africa.

These nations—and all of Africa—need to find new, innovative ways to fund health spending. That is the only way to realize the health systems that Africa needs.

- **Drive funding innovation.** Africa is blessed with an abundance of natural and human resources that are in demand globally. As these are further developed, innovative strategies (e.g. taxation, health funds and appeals for corporate social responsibility) should be employed to ensure that an

appropriate share of this new wealth is invested in health-care services that benefit the African people. The creation of national trust funds, such as in Zimbabwe, have been successful through acquiring taxes from formal sector workers and their employers.

- **Strengthen taxation.** Africa is missing out on roughly US\$ 65 billion a year in tax revenues as the result of unfair taxation (either due to mispricing or illicit outflows).¹ Just by addressing these deficiencies, Africa could close a substantial portion of the current funding gap for health.
- **Increase private sector healthcare investment.** Energetic efforts can leverage private sector resources (such as contributions by those who can afford to pay) to help close the health care financing gap. Because of Africa's robust economic growth, there are more and more private sector actors with the capacity to invest in health care. To this end, the region should implement policies and tax mechanisms that encourage private sector investment in health-care services. However, even with increased private involvement, the public sector must remain the leader to ensure that evolving health-care systems offer value for money, are accountable for results, improve health outcomes and place people at the centre of their efforts.

3: Make smart investments for greater health returns

The AU should leverage the newest technology and models of health service delivery to deliver the best possible care to the greatest number of people.

It is now clear that smart investment, innovation and evidence-driven flexibility can reduce unit costs for health services – and they can do so while improving health outcomes.

Towards these ends, AU Member States should use investment tools to improve planning, overcome access barriers and focus services on populations in greatest need. In particular, member states should focus on improving maternal and child health.

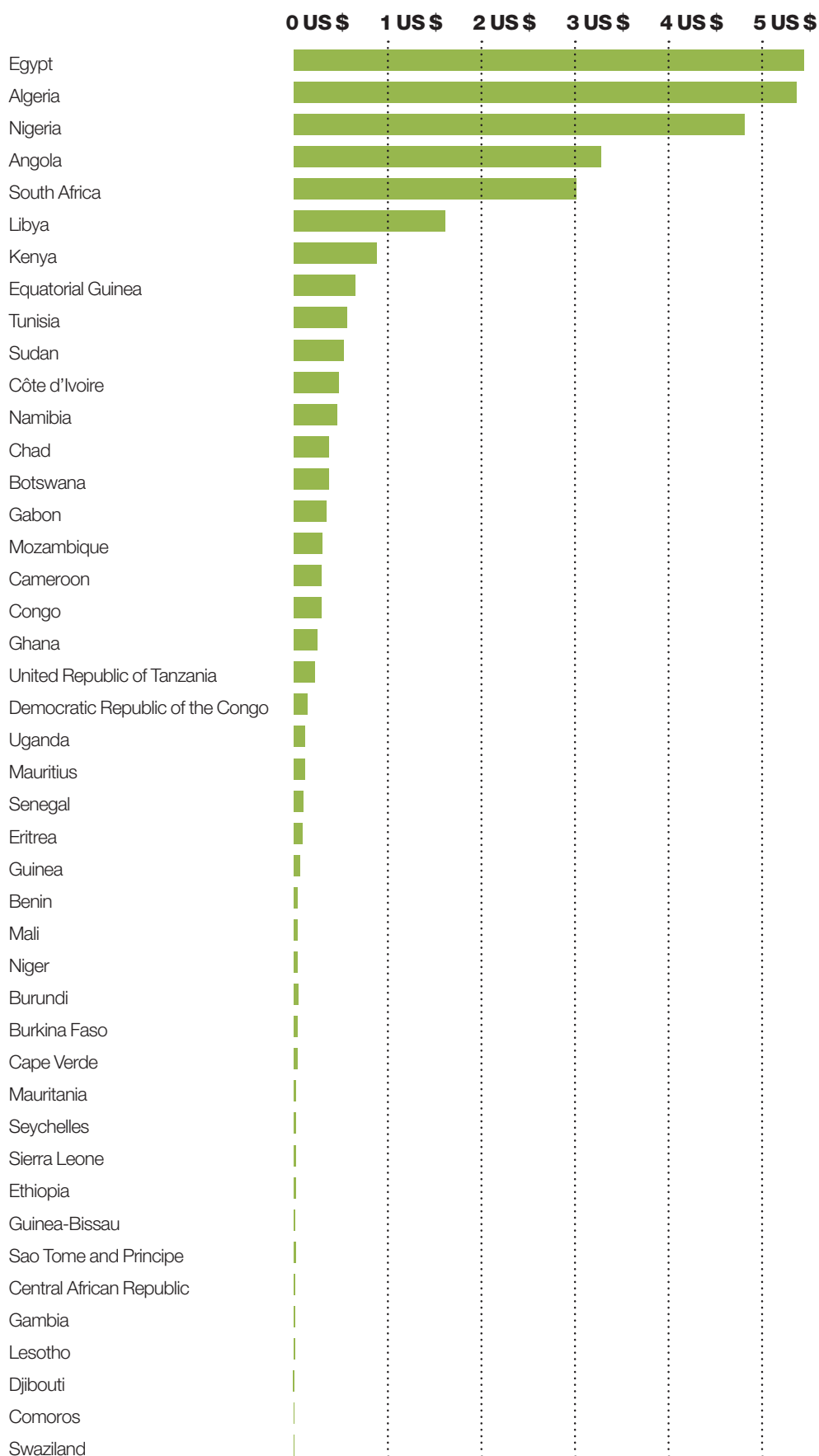
- **Leverage AIDS investment frameworks for all health priorities.** In order to ensure the right choices are made for the highest long-term impact, use of investment frameworks is encouraged. First, these frameworks should help prioritize spending on the most cost-effective interventions with the greatest health impact. Second, they should expand the time horizon of intervention planning to ensure that today's investments will reduce cumulative costs in the future.
- **Increase investment in key populations.** Disease burden and risk factors tend to vary by gender, geographic location, income quintile and other demographic variables. Even in generalized epidemics, the best return on investment comes when approaches target the populations most heavily affected. Investments, however, are consistently targeted poorly. For instance, there is a persistent under-investment in HIV prevention and treatment programmes for key populations at higher risk. These skewed resource allocations must be corrected before these diseases can ever be brought under control.
- **Make national health systems more efficient.** Focused efforts will be needed to reduce unit costs while enhancing the performance of health systems to produce measurable health outcomes. Rigorous tracking of inputs, costs and health outcomes is essential to greater efficiency.
- **Scale-up innovative delivery models.** In recent years, less expensive delivery models have emerged that reduce front-line service costs. Rather than sacrificing quality, these new models actually simplify and strengthen supply chain management, enhance programme oversight and extend limited human resources. These new models should be rapidly tested to uncover the best way to scale them. If the region widely implements best practices, it could greatly increase the impact of health investments.

¹ Africa Progress report 2013, p65. "Equity in Extractives: Stewarding Africa's natural resources for all", Africa progress panel.

Figure 11

US ~\$31 billion is required to close the gap; 75% of this gap occurs in 6 countries

Source: WHO Global Health Expenditure Database; expert analysis



4: Strengthen Africa's human health resources

Ultimately, a health system is only as strong as the men and women who implement it. Yet today, the human resources available for health efforts are insufficient. If the region is to achieve its health goals, it will need to greatly increase efforts to preserve and build human resources for health.

- **Train more health workers and train them better.** Current training capacity is insufficient to meet current need. At the same time, the growing demand for health-care services risks exacerbating the region's already acute human resource crisis. The AU Member States should take steps to significantly increase training capacity for health-care professionals, taking into account both the future demand for health-care services and the need to increase retention efforts.
- **Encourage South-to-South knowledge sharing.** The AU should strongly support the sharing of knowledge, expertise and talent across AU Member States, helping to bridge current knowledge gaps and equipping local leaders with broader experiences and exposure.
- **Create more health jobs and retain health workers.** To reduce incentives for out-migration of the limited number of trained health-care professionals, AU Member States should work to increase the number of local health-care jobs, and they also should work to improve the quality of these jobs and the retention of workers.
- **Leverage new technology.** New technologies can strengthen health systems and improve health outcomes. Innovative use of new technology is especially critical to efforts to enhance health-care services in rural areas (where technology offers new avenues to extend expertise in areas that have struggled with access). AU Member States should ensure funding for such initiatives and develop incentives to encourage entrepreneurs and institutions to expand use of innovative health and communications tools.

5: Leave no one behind

For Africa to secure the full benefits of better health, these services must reach all of its citizens. This can only happen through a people-centred approach that ensures everyone can access health services with dignity and without fear.

- **Include everyone, especially the most vulnerable.** A more inclusive approach ensures that attention and action is focused on the needs of the most affected, vulnerable and marginalized. An inclusive approach is needed at every stage, starting at the programmatic planning stage and following through to delivery and accountability.
- **Strengthen social protection and human rights.** There is a clear link between economic, social and health vulnerability. The most economically vulnerable are consistently people with the worst access to quality health care. Therefore, any efforts to improve the health and well-being of key populations must include strengthened social protections. Simply put, no one can fully realize their right to health without also realizing their right to a standard of living that is adequate to his or her health and well-being. This includes food, clothing, housing, education, social services, physical and mental health care and the right to security in the event of unemployment.
- **Enforce the laws that safeguard rights.** While AU Member States have adopted laws that prohibit discrimination and promote non-discrimination programmes, few enforce those laws. Few countries take their non-discrimination programmes to scale. This must change.
- **End gender inequality and gender-based violence.** Gender inequality and sexual and gender-based violence are not only morally abhorrent crimes, but they also diminish access to health care. The AU should take strong, concerted action to end this violence and inequality once and for all.

Conclusion

Abuja 2001 was a historic moment for Africa, the point at which the continent fully acknowledged the scale of the AIDS epidemic. Even more importantly, Africa pledged to take decisive actions to address that emergency. In the years since, the progress has been incredible, extensive and—sadly—incomplete.

Abuja +12 has the potential to be another decisive moment in Africa's history. If the will is there, Abuja +12 can be a tipping point in Africa's health crisis. It can be the moment when commitments are cemented, when action is taken and when success becomes inevitable.

The time is ripe for a decisive moment like this. The momentum is powerful. Political resolve is aligning with scientific breakthroughs like never before. In the foreseeable future, revolutionary treatments may be available for AIDS, TB and Malaria. That means fewer children will lose their mothers and fewer parents will face the heartbreak of losing a child.

All of this is possible, but it requires the determination of dedicated leadership to bring it into reality. It requires the action of bold individuals who will stand up, seize on this momentum and propel us to success.

In 2001, the men and women who assembled in Abuja envisioned a revitalized future for Africa. They looked forward to a future of peace, prosperity and health.

Today, that future is still within reach—and we must deliver it.

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