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UNIÃO AFRICANA

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

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PROGRESS REPORT ON THE IMPLEMENTATION OF THE COMMITMENTS OF THE MAY 2006 ABUJA SPECIAL SUMMIT ON HIV/AIDS, TUBERCULOSIS AND MALARIA (ATM)

(Disease Specific Reports are each presented separately)

DRAFT PROGRESS REPORT ON THE IMPLEMENTATION OF THE COMMITMENTS OF SPECIAL SUMMIT ON HIV/AIDS, TUBERCULOSIS AND MALARIA (ATM) - ABUJA, NIGERIA, 2-4 MAY 2006:

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

b) Africa's Common Position to the UN General Assembly Special Session on AIDS (June 2006) (with the Brazzaville Commitment on Scaling Up Towards Universal Access to HIV/AIDS Services in Africa.)

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

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The Progress Report on the implementation of the 2006 Abuja commitments towards universal access to HIV/AIDS, Tuberculosis and Malaria Services, together with the disease specific Reports on each of the three diseases are a culmination of the efforts by the WHO, especially the Regional Offices for Africa and Eastern Mediterranean, UNAIDS, RBM, Stop TB Partnerships and UNICEF, working in close collaboration with the AU Commission, under the leadership of the Commissioner for Social Affairs.

The Bureau of the 3rd. Session of the AU Conference of Ministers of Health under the Chairmanship of the Minister of Health of South Africa has also played an important role in coordinating the follow up on the implementation of the outcome of the May 2006 Abuja Special Session.

With the collective efforts and commitment of partnerships at National, Regional, Continental and International levels, Africa can very confidently work towards achieving universal access to HIV/AIDS, TB and Malaria Services by 2010, and indeed the MDGs by 2015.

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS:	Acquired Immuno-deficiency Syndrome
ATM:	AIDS, Tuberculosis and Malaria
AU:	African Union
HIV:	Human Immuno-deficiency Virus
ORID:	Other related infectious diseases
TB:	Tuberculosis
NEPAD:	New Partnership for Africa`s Development
UNGASS:	UN General Assembly Special Session
UN:	United Nations
MDGs:	Millennium Development Goals
CAMH:	Conference of AU Ministers of Health
GFATM:	Global Fund to Fight AIDS, TB and Malaria
WHO:	World Health Organization
UNECA:	United Nations Economic Commission for Africa
UNFPA:	United Nations Population Fund
UNICEF:	United Nations Children Fund
UNAIDS:	United Nations Programme pm HIV/AIDS
CSOs:	Civil Society Organizations
NGOs:	Non-governmental Organizations
PLWH/A:	People Living with HIV and AIDS
PMTCT	Prevention Mother to Child Transmission
EU:	European Union
ACTs:	Artemisinin Combination therapy
ART:	Anti-retroviral therapy
ARV:	Anti-retroviral
ITNs:	Insecticide treated nets
RBM	Roll Back Malaria
RECs	Regional Economic Communities
ANC	Absolute Neutrophil Count
NTP	National Toxicology Program
IRS	Indoor Residual Spraying
HMIS	Hazardous Materials Identification System

EXECUTIVE SUMMARY

In May 2006 at Abuja, Nigeria, the AU Heads of State and Government held a Special Summit on HIV/AIDS, TB and Malaria (ATM) on the theme: "***Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by a United Africa by 2010".*** The main objective of the Special Summit was to review the status of implementation of the Declarations and Plans of Action on the 2000 Abuja Summit on Roll Back Malaria (RBM) and the 2001Abuja Summit on HIV/AIDS, TB and Other Related Infectious Diseases (ORID). This would in turn enable them review the status of implementation of health-related MDGs, particularly no. 6: Combat HIV/AIDS, Malaria and other Diseases. After due deliberations including review of the challenges and opportunities, the African Leaders re-dedicated themselves to scaling up efforts towards universal access to HIV/AIDS, TB and Malaria Services by 2010 and adopted the following commitments:

a) Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services in Africa;
b) Africa's Common Position to the UN General Assembly Special Session on HIV/AIDS (June 2006), together with the *Brazzaville Commitment on Scaling Up Towards Universal Access to HIV/AIDS Services in Africa*.
c) The Continental Framework for Harmonization of Approaches and Policies on Human Rights and People Infected and Affected by HIV/AIDS.

The roles Member States and other stakeholders were to play in the implementation of the outcome of the Special Summit were clearly spelt out. The AU Commission, in collaboration with RECs and Development Partners, was requested to coordinate the preparation of a 2-year Progress Report on the status of implementation in 2008. The Report, which is a result of collective efforts by the AU Commission, WHO, UNAIDS and UNICEF comprises a summary covering the three diseases together, complemented by three disease-specific Reports. The Progress Report is timely in view of the 30th. Anniversary of the Alma Ata Declaration on Health For All through access to Primary Health Care, and the June 2008 schedule by the UN General Assembly to consider the Progress Report on the Political Declaration on HIV/AIDS, which was adopted in 2006.

The Report has, as much as possible, tried to focus on addressing the 12 Priority Areas of the Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis and Malaria services by 2010, namely**:** Leadership at National, Regional and Continental levels; Resource mobilization; Protection of Human Rights; Poverty Reduction, Health and Development; Strengthening Health Systems; Prevention, Treatment, Care and Support; Access to Affordable Medicine and Technologies; Research and Development; Implementation; Partnerships; and Monitoring Evaluation and Reporting.

Between 2006 and 2008, member States have sustained the pace and in some instances scaled up efforts to implement national and regional Strategic Plans on HIV/AIDS, TB and Malaria, in the framework of the Abuja commitments towards universal access to comprehensive services by 2010. Political will, commitment and

leadership have ensured better implementation, advocacy and mobilization of resources. Concerning the burden of disease, HIV/AIDS is still more prevalent in countries South of the Sahara, and TB is more uniformly spread but influenced by prevalence of HIV/AIDS; while Malaria affects mainly tropical and sub-tropical countries. Prevalence rates for HIV/AIDS have, in general been reduced due to multi-sectoral interventions and also because of better monitoring and data collection tools. The malaria burden has declined due to efforts by Member States and international partners. Prevalence, incidence and death rates of TB continue to increase in many countries, partially due to inadequate or delayed notification. However, drug and multi-drug resistant and extensively drug resistant TB is more prevalent than generally indicated, this may be due to weak laboratory and human resources capacity.

All countries have separate coordinating bodies and/or programmes for each of the three diseases. Since all interventions depend on strong health systems, emphasis has been laid on this strategy all round. The chronic shortage of health workers is, timely and still a thorn in the flesh of development of health systems in Africa. Thanks to the increased support by the international community, access to funding for prevention, treatment care and support has improved significantly. However, financing needs to be more predictable and sustainable. As a long-term strategy to promote access to affordable medicines and commodities, Member States, RECs and Regional Health Organizations should collaborate in the implementation of the Pharmaceutical Manufacturing Plan for Africa. Adoption of combination therapies as first line of treatment for the three diseases for efficacy and to prevent the development of resistance to medicines is a positive strategy, although not yet universally utilized. Poverty reduction and the need to address these diseases as a human rights issue need more attention. Partnerships at all levels have been further developed but require better coordination and harmonization of programmes. Research, Monitoring, Evaluation and Reporting are areas that need serious attention.

In conclusion, although a lot has been achieved to implement the 2006 Abuja commitments towards on universal access to HIV/AIDS, TB and Malaria Services in Africa, “much more remains to be done”. The collective efforts of all stakeholders should be scaled up. There is no room for complacency, otherwise the achievements of the past few years will be forfeited, with dire consequences.

INTRODUCTION

On 2-4 May 2006, in Abuja, Nigeria, the AU Heads of State and Government held a Special Summit on HIV/AIDS, TB and Malaria (ATM). Their deliberations focused on the theme: "***Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by a United Africa by 2010".*** The main objective of the Special Summit was to review the status of implementation of the Declarations and Plans of Action on the 2000 Abuja Summit on Roll Back Malaria (RBM) and the 2001Abuja Summit on HIV/AIDS, TB and Other Related Infectious Diseases (ORID). The specific objectives included the following:

- To review the achievements made to attain the targets of the 2000 and 2001 Abuja Summits, in the framework of the Millennium Development Goals (MDGS).

- To identify gaps, constraints and challenges to the achievement of the Abuja and MDGs targets;

- To identify new strategies that would enable Africa to chart a new and more realistic course towards achieving these targets.

- To obtain renewed commitment by African Leaders for addressing these disease; and promoting health and well-being in Africa.

- To strengthen the efforts of the New Partnership for Africa's Development (NEPAD) towards poverty reduction and measuring progress towards achieving socio-economic development.

- To prepare Africa's Common Position to global forums such as World Health Assembly and the UN General Assembly Special Session (UNGASS) and High Level Meetings on HIV/AIDS.

The African Leaders noted that in spite of commendable efforts and achievements, HIV/AIDS, TB and Malaria continue to be the leading causes of morbidity and mortality in Africa. Additionally, the three diseases contribute to considerable social-economic stagnation on the continent, hence exacting an ever-increasing burden to the population, especially the poor and vulnerable. In this regard, Heads of State and Government still considered HIV/AIDS, TB and Malaria as a State of Emergency in Africa. They underscored the challenges and obstacles as well as opportunities for accelerated action towards universal access to comprehensive health services. Consequently, they individually and collectively re-dedicated themselves to scale up efforts towards universal access to HIV/AIDS, TB and Malaria Services when they adopted the following commitments:

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

e) Africa's Common Position to the UN General Assembly Special Session on AIDS (June 2006), together with the *Brazzaville Commitment on Scaling Up Towards Universal Access to HIV/AIDS Services in Africa*.

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

The Outcomes of the Special Summit focused on the following priority areas for action with targets to be met by 2010:

- Practical Leadership at National, Regional and Continental levels;
- Resource mobilization;
- Protection of Human Rights;
- Poverty Reduction, Health and Development;
- Strengthening Health Systems;
- Prevention, Treatment, Care and Support;
- Access to Affordable Medicine and Technologies;
- Research and Development;
- Implementation;
- Partnerships whereby the roles of each stakeholder were clearly spelt out
- Monitoring Evaluation and Reporting.

In conclusion, the Heads of State and Government then requested the AU Commission together with RECs and development partners to coordinate the following activities during 2008:

i. Carry out a Consultative Review on the Status of Implementation of the Abuja "Call for Accelerated Action Towards Universal Access to HIV/AIDS, TB, and Malaria by 2010", the African Common Position on HIV/AIDS and of the MDGs and report to the AU Organs and the UN General Assembly.

ii. Intensify collective advocacy and action towards Malaria Elimination in Africa, especially around Malaria Control Day (25 April 2008), aimed at eventual eradication.

iii. Accelerate efforts to reverse and contain the challenges posed by the emergency due to Tuberculosis on its own and as a complication of advanced HIV infection. In this connection, the Conference of Ministers of Health requested for a Status Report on Tuberculosis, among others, indicating the TB multi- and extremely multi-drug resistance situation, and how it should be addressed.

BACKGROUND

In acknowledgement of the high and increasing widespread poverty, high death rates, ill-health and low social welfare services that still prevail in the world and

particularly in developing countries, world leaders adopted the Millennium Development Goals (MDGs) at their 2000 World Summit, with targets to be achieved by 2015. The MDGs focus on some very critical health and social areas such as poverty reduction, eradication of hunger, improving literacy, promoting the health of vulnerable groups as well as fighting communicable disease epidemics and protecting the environment. Regrettably Africa still faces many challenges related to widespread poverty, underdevelopment, other social determinants of health that include inadequate water and sanitation, gender inequities as well as natural and man-made disasters. The continent is particularly prone to civil strife and armed conflicts, which negatively affect health and development. In the face of such challenges, the continent might not attain the MDG targets unless drastic steps are taken to implement appropriate strategies.

Other factors which hamper the effective promotion of health and development in Africa include: weak health systems and inadequate or unpredictable financing. Furthermore, the burden of communicable and non-communicable disease continues to increase. The shortage of trained health professionals is also of serious concern and should be addressed more effectively.

As specifically concerns HIV/AIDS, TB and Malaria and as was noted at the Special Summit, effective implementation requires overcoming the following gaps and challenges:

- Coordination and harmonization of National and Regional Partnerships remains weak;
- Most countries have not adopted legislation to protect Human Rights of PLWA and TB;
- Health systems still face inadequacies in human resources characterized by low numbers, migration, mix of skills, motivation and retention.
- The poor face many hurdles accessing health services, including for HIV/AIDS, TB and Malaria;
- Inadequate and sometimes irregular supplies of medicines and commodities, which are still inaccessible by many due to high costs;
- Monitoring, evaluation and reporting are weak;
- Domestic resource mobilization is still insufficient. Only 33% of the countries have allocated 10% or more of the national budget to Health sector.
- Collaboration between Public and Private Sector at national level, in tackling HIV/AIDS, TB and Malaria is still weak – yet it has high potential in galvanizing the whole society against the three diseases and in reducing prices of medicines and commodities;
- Slow progress in provision of tax incentives to and removal of tariffs on all materials (including vaccines) necessary to fight against HIV/AIDS, TB and Malaria

It is encouraging to note that 2000 was a turning point for health promotion in Africa. In this connection and further to being party to the Millennium Summit, the African Leaders convened at Abuja in April 2000 in order to address Malaria which had

resurged and was posing a continental crisis. They declared 25 April as Africa Malaria Day to intensify advocacy. After one year, they again held a Special Summit and adopted the Abuja Declaration and Framework for Action on HIV/AIDS, TB and ORID. Compared to previous years, these commitments were followed by more political commitment and more effective implementation at Member State level. The international community also provided unprecedented technical and financial support, including the establishment of the Global Fund to Fight AIDS, TB and Malaria (GFTAM), which has ensured that financial resources for disease specific programmes are available. All stakeholders should scale up and sustain these efforts to move Africa closer to meeting the 2010 and 2015 Abuja and MDG targets respectively.

The AU Conference of Ministers of Health (CAMH) has also advanced significantly in collective efforts to improve health at continental level. In addition to coordinating the implementation of the commitments of Heads of State and Government, they have adopted the following Policy Frameworks which are also relevant to the control of HIV/AIDS, TB and Malaria and development of health systems in general:

- The Revised Africa Regional Nutrition Strategy 2005-2015
- The Continental Policy Framework and Maputo Plan of Action on Sexual and Reproductive Health and Rights
- Africa Health Strategy for strengthening Health Systems for Equity and Development
- Pharmaceutical Manufacturing Plan for Africa to promote access to affordable generic medicines. This was in accordance with the request by the Assembly of Heads of State and Government (January 2005)
- The Plan of Action on Violence Prevention, particularly as pertains to violence and health
- Other relevant policy frameworks and plans of action on peace and security and promotion of the welfare of women, youth, children and other vulnerable groups.

At continental and regional levels, a lot of action was also undertaken, and regional strategies developed which are at different levels of implementation. HIV/AIDS, TB and Malaria have been kept high on the AU Agenda and those of regional groupings. The AU in collaboration with WHO, UNAIDS, UNICEF, ECA and other partners, launched the campaign on 2006 as “the Year for Accelerating HIV Prevention in Africa”. The theme of the launch was: ”S*tep Up the Pace of HIV Prevention in Africa”*. At the 3rd Session of CAMH, a **Malaria Elimination** Campaign was launched, among other actions.

OVERVIEW ON PROGRESS IN IMPLEMENTATION OF COMMITMENTS ON HIV/AIDS, TB AND MALARIA

(Disease Specific Reports are each presented separately)

Implementation of the outcomes of the Abuja Special Summit on ATM was in the framework of ongoing national programmes for disease control in general and HIV/AIDS, TB and Malaria in particular. In recent years, bilateral and multilateral organizations have increased their support to national and regional programmes for the fight against HIV/AIDS, TB and Malaria as well as health and development in general. The Global Fund to Fight AIDS, Tuberculosis and Malaria currently provides significant funding for HIV/AIDS, TB and Malaria programmes, in supplementation to national efforts and other international support.

Building from the opportunities available for action, the following achievements were recorded, among others:

a) Sustained political commitment and leadership at highest level
b) Increased availability of financial resources, both from national and international sources
c) Effective combination therapies are available for the three diseases
d) Procurement or local production of affordable generics and commodities is improving and promoting access to services
e) Progress has been made in coordination and harmonization of partnerships at national, regional and international levels
f) The roles of Civil Society and Private Sector more evident
g) Many Member States have recorded reduced or stable prevalence rates, of especially HIV and Malaria.

Implementation has been hampered by the following, among other challenges and gaps:

a) Weak Health systems including shortage of human resources
b) Funding remains mainly external and can be unpredictable
c) Resistance to mono-therapies or first line affordable medicines
d) Challenges related to supply and distribution of medicines and commodities especially in rural settings
e) Limited inter-country or regional cooperation
f) Research, Monitoring and Evaluation are some of the areas to be addressed urgently
g) Sharing of information is inadequate and sometimes information has to be solicited. Monthly reporting of notifiable diseases is not done regularly as required. This can result in old records being utilized, for future reporting.

SUMMARY STATUS ON IMPLEMENTATION OF HIV AND AIDS STRATEGIES

Due to political commitment and increased funding, a lot has been achieved although there are gaps that should be addressed. The following is a summary of the findings recorded for the period under review:

i. The Global Fund to Fight AIDS, Tuberculosis and Malaria currently provides 20% of all funding for HIV/AIDS. The success rate of Round 7 proposals for HIV about 60% (10 out of 17).

ii. Of the 35 countries that responded, 31 (90%), 28 (80%), and 21 (60%) reported of having policies or guidelines on ART, PMTCT, and HTC—respectively.

iii. Almost two-thirds (63%) of the countries reported setting national targets for HTC, PMTCT, and ART. Over three quarters (77%), have set national PMTCT targets, while 70% (24 countries) have set for HTC and ART

iv. Of the 35 countries that reported, 18 (46%) have a policy that allows lower level health workers—once trained—to provide second-level services, such as managing patients with HIV and ADIS

v. Among 35 countries in the Africa region, one in every five facilities provide HTC services—ranging from less than 1% in Liberia to 100% in Botswana

vi. In 2007, over 470,000 HIV positive pregnant women reportedly received ARVs for PMTCT purposes —over 50% increase from 2006 figure of slightly over 300,000.

vii. In 2007, over 2.1 million people received ART in countries of this region. This represents a 60% increase in just one year—as 1.3 million people received ART in 2006.

viii. Among the 35 countries that reported, 7 (20%) experienced stock outs of ARVs in part or all facilities that provide ART.

ix. Of the 35 countries that submitted the Universal Access (UA) reporting form, 80% implement ANC surveillance by using the WHO-recommended HIV 2nd generation surveillance protocol.

x. 77% of the countries have policies in place for HIV and AIDS and only 50% have developed HIV/AIDS guidelines in line with WHO recommendations.

xi. Most countries have not developed or implemented Legislation on human rights and PLWA and TB; and to protect vulnerable groups against HIV/AIDS and TB.

The African countries of Eastern Mediterranean (except Sudan, Djibouti and parts of Somalia) continued to estimate low HIV prevalence in the general population although three countries confirmed concentrated epidemics among injecting drug users. Several countries made progress in assessing and mapping risk and vulnerability. The momentum for scaling up antiretroviral treatment (ART) created through the 3 by 5 Initiative was followed by a global commitment to bring the world as close as possible to ensuring universal access to HIV prevention, treatment, care and support by 2010. Funding for HIV programmes increased, bearing fruit in terms of progress in technical capacity-building in HIV interventions and HIV service provision. The vast majority of PLWH do not know their HIV status and do not come forward for HIV testing, counseling and treatment, resulting in the lowest coverage of estimated numbers of PLWH in need of treatment world-wide (below 5%). The coverage of known PLWH in need of ART reached approximately 80%.

Member States are commended for the giant steps taken towards Universal Access for HIV prevention, care, and treatment. The documented achievements include: increased access to ART, PMTCT and HTC as well as care and support. In some African countries, the numbers of reported HIV cases remain small, although they are slowly increasing, partially due to expanding testing efforts. However, efforts towards prevention, treatment and support should be in place to stabilize and reverse the situation, or reduce prevalence and incidence rates further where applicable.

International Development Partners, private sector, CSOs, NGOs, are commended for their untiring efforts and supports to Africa in its fight against HIV/AIDS. These partnerships, however, require better coordination, and need to harmonies their efforts.

To achieve universal access to prevention, treatment, care and support for HIV/AIDS, the following recommendations are made:

- HTC coverage is relatively low—compared to ART and PMTCT. Provider-initiated testing and counseling (PITC) should be expanded to all public health facilities of every country
- Countries should not lose the momentum of prevention, PMTCT and ART scale up and have to continue or even increase the level of efforts till Universal Access targets are fully achieved.
- Infant diagnosis and care & treatment for infected children should be expanded.
- Investment and strengthening of strategic information should be undertaken, particularly in methods of understanding the dynamics of specific country epidemics and its drivers
- Even countries with low prevalence rates or where success has been reported, should avoid complacency.

- Member States are urged to monitor implementation and submit reports regularly.
- Partners at national, regional and international level should sustain their technical and financial support as well as advocacy

SUMMARY STATUS ON IMPLEMENTATION OF TUBERCULOSIS STRATEGIES

Tuberculosis control in Africa has progressed in the last decade but the continent still lags behind on major TB Control targets. Estimated TB prevalence, incidence and death rates all continue to increase in most countries. Notification rates have risen from 82 per 100,000 population in 1990 to 160 in 2006. Despite an apparent stabilization and decline in overall TB cases globally and in the African Region, at this rate, the MDG targets for TB incidence and prevalence are unlikely to be achieved at regional level. In Eastern Mediterranean Region, incidence rates are higher for Djibouti, Somalia and Sudan than in the other countries in northern Africa.

Political leadership has been demonstrated through the commitments of African Leaders and the declaration of TB as national emergencies by at least 18 countries in the African Region. Financial resources, traditionally a bottleneck for NTPs till the 2000s, is no longer a major factor as GFATM grants, GDF grants (for standard TB treatment), GLC support (for drug resistant TB), bilateral donors support and several Partnership mechanisms provide technical and financial assistance to cover most needs.

Drug resistant TB, especially multi-drug resistant TB, is widely prevalent than previously known and poses a serious challenge. Twenty-six countries from the region reported a total of 8,624 multi-drug resistant TB (MDR-TB) cases during 2007 while four countries (Botswana, Lesotho, Mozambique and South Africa (99.1% of the cases)) reported a total of 541 Extensively Drug Resistant TB cases (XDR-TB) during the same period. In terms of capability to diagnose MDR TB, there were still 10 Member States without this capability by the end of 2007. Of the 26 countries that reported at least a case of MDR or XDR-TB during 2007, only 17 countries (65.4%) have an organized treatment programme for these cases. Despite the availability of a Stop TB Partnership global facility for accessing concessionary priced second line drugs by DOTS based TB Control programmes, only 9 countries had successfully applied to this facility by February 2008.

In order to achieve Universal Access by 2010 and the MDG targets by 2015, much remains to be done, especially to:

- Increase treatment success rate for smear positive TB cases
- Increase case detection rates
- Detect, treat and prevent Drug resistant TB

- Scale up the linkage of TB/HIV country programme activities

- Strengthen Health Systems Components that affect TB Control

The following recommendations are made:

i. All countries to periodically review their TB Control performance with regard to the WHA, MDG and Abuja targets and develop strategies to accelerate their attainment

ii. Member states to decentralize and strengthen TB laboratory services in the public and private sectors in order to improve case detection and ensure quality assured laboratory services in pursuit of Universal Access to such services.

iii. The African Union to advocate to national governments in the 10 countries without local capability for TB culture and drug susceptibility testing for first line anti-TB drugs to establish this capacity in order to facilitate diagnosis and treatment of MDR-TB cases

iv. National TB Control Programmes to prioritize implementation of strategies to expand DOTS diagnosis and treatment services with a view to rapidly move towards the WHA, MDG, Abuja and Regional Committee targets for treatment success and case detection. This includes strengthening the capacity of the Health Systems to suspect and diagnose Tuberculosis, and to reduce treatment failures, treatment defaulters and transfer outs.

v. All countries with generalized HIV epidemic (5% or higher) in the general population to programme and implement in full the Regional Strategy for controlling TB-HIV with particular emphasis on universal access to HIV testing for TB patients, ART for eligible HIV positive patients and other interventions to reduce the burden of TB on People Living with HIV & AIDS, and reduce the burden of HIV &AIDS on dually infected TB patients.

vi. Member states to allocate sufficient resources to ensure uninterrupted supply of first line anti-TB drugs at central and peripheral levels, including adequate buffer stocks at the various levels.

vii. For drug resistant TB cases, national programmes to determine the burden of MDR-TB and initiate treatment programmes for all confirmed cases. National programmes should also mobilize sufficient quality assured second line drugs including concessionary priced drugs through the Stop TB Partnership Green Light Committee

viii. Member States to respect the pledge to allocate at least 15% of the national budget to health development and allocate a sufficient amount of that for delivery

for TB control interventions. Further, Member States to timely expend approved GFATM grants and submit proposals for more funding to meet funding gaps for scale up of activities towards universal access.

Despite the progress in tuberculosis control, the African countries in EMRO have failed in achieving the global targets for tuberculosis control. While DOTS has expanded, covering 94% of the regional population and treatment success is high (82%), the case detection rate is only 44%. To improve case detection, the regional plan to Stop TB was developed as part of the global plan 2006–2015. The budgetary need for the period of 2006 to 2015 indicated in the Plan is US$ 3.1 billion in the Region. Support to countries was enhanced and partnership development promoted.

SUMMARY STATUS ON IMPLEMENTATION OF MALARIA STRATEGIES

The Africa Malaria Elimination Campaign takes into account the variation in the burden and epidemiology of malaria in the different regions of the continent. The general direction to move from malaria control to elimination through incremental programming:

a) High Transmission Areas (referred to as Group 1)
b) Low Transmission Areas (referred to as Group 2)
c) Transmission has been interrupted (referred to as Group 3)

The strategic plan for malaria control and elimination for 2006–2010 was finalized and endorsed by Member States and strategic plans were updated in all malaria endemic countries. Requirements for certification of malaria-free status in the United Arab Emirates were finalized and the number of countries that are malaria-free or implementing successful malaria elimination strategies increased.

All countries in Africa have established RBM coordinating bodies and, developed Malaria Strategic Plans (MSPs). By 2004, only 4 nations had achieved the goal of devoting 15% government expenditure to health with a regional average of 8.8 %. Several initiatives to increase funding for malaria control have emerged and include the Global Fund (GFATM), World Bank Booster Programme (WBB), the Presidents' Malaria Initiative (PMI) and The Islamic Development Bank. To date, the GF has committed 1.7 billion US $ to malaria control in Africa and about US $ 645 million form various sources was spent on malaria control in Africa.

To increase access to malaria control interventions, 74% of countries have waived taxes on anti-malarials, 64% have removed taxes or introduced waivers on ITNs while about half have waived taxes and tariffs on nets, netting materials and insecticides. In 2006-2007, over 33 million ITNs were distributed through campaigns in 22 countries. About 25% of households own at least one mosquito net of any type, while 12 % own at least one ITN. By 2007, 7 countries had achieved more than 40% household owning at least 1 ITN. On average, 8% of children under-five sleep under an ITN. However, ITN use by children under five has exceeded 40% in Rwanda, the

Gambia, Guinea Bissau, Sao Tome and Principe and Guinea Bissau. Use of ITNs by pregnant women is even lower at 5%.

All the 35 countries where IPTp is recommended have adopted the policy but only 20 countries are implementing countrywide. Coverage with IPT is less than 10%. However, some countries like Zambia 61%, Malawi 45% and, the Gambia 33% have achieved higher IPT coverage.

All countries except 2 have adopted ACTs as 1st line treatment for malaria, with 25 already implementing the policy. Across the region, 34% of children with fever received an antimalarial treatment. However, in the Gambia (52%), Tanzania (51%), Ghana (48%) and Sierra Leone (45%) received antimalarial treatment within 24 hours mostly with chloroquine which is no longer effective. Use of ACT is very low; in some 14 countries with 2005-7 data, the median proportion of children under five years with fever receiving an ACT was only 2%.

By end of 2007, 25 out of the 42 malaria endemic countries in the region had included IRS in their national strategy. Of these, 17 routinely implement IRS as a major malaria control intervention while six are piloting IRS in a few districts. In the 2006-2007 malaria season a total of about 5 million units/structures were sprayed with an operational coverage in target areas of about was 83% protecting about 21 million people.

Several initiatives to increase access to malaria control commodities have emerged. The Affordable Medicines facility for Malaria (AMFm) was established to bring down the cost of ACTs and help phase out the monotherapies to avoid the development of resistance. The Global RBM partnership was established in 1998. Consequently, all countries in the African region have established partnerships at the country level. Also, sub-regional RBM partnerships networks (SRNs) have been established that bring together all key partners in the sub-region to consolidate support for malaria control in the respective countries.

Since 2000, 25 April has been commemorated as Africa Malaria Day. Regional events have been held across the sub-region and nationally. The commemoration of Africa Malaria day has firmly place malaria on top of the agenda in many countries. In 2007, 25 April was also declared World Malaria Day.

Data from over 25 household surveys conducted in 2005-2007 has been used to compile this report. All the countries in the sub-region have functional HMIS although interpretation of the trends in malaria cases and deaths is difficult due to incomplete reports, non-standardized reporting and reliance mostly on clinical diagnosis. However, in selected countries that have scaled up interventions but also have more consistent and complete data, such as Eritrea, Kenya, Rwanda, Sao Tome and Principe, South Africa, Swaziland and Zanzibar Island in the United Republic of Tanzania, there have been reductions in malaria cases and deaths at health facility level.

Most countries in the region are moving towards universal access to malaria prevention and control among all at risk of malaria. Malaria Elimination has been discussed in several AU sessions but much needs to be done before any country is ready for malaria elimination.

In conclusion, Member States have made moderate progress towards achieving targets set at the Abuja 2000, 2001, RBM and MDGs. Great political commitment, adoption of better policies as well as increased funding for malaria control from governments, development agencies and funding initiatives. However, few governments have achieved the target of devoting at least 15% government expenditure on health. Coverage of key malaria control interventions has increased in several countries. Slow production, supply and re-fill of ITNs and other preventive services; as well as monitoring of actual use. In spite of these laudable achievements, there is a lot more required if the set targets are to be achieved. Currently very few of these countries are likely to achieve the RBM, Abuja or MDG targets. A major constraint to achieving these targets has been weak health systems characterized by inadequate human resources, poor infrastructure as well as failure to implement a comprehensive package of interventions in the same geographical area for impact.

Note should be made that a few countries in Africa do not have the Malaria burden. However, they need to be very vigilant as Malaria can easily be re-introduced.

To enhance scaling up towards Malaria Elimination in Africa, the following recommendations are made:

i. Countries should increase funding for the health sector and in particular malaria control and prevention.
ii. Partnerships at country level should be strengthened to optimize utilization of resources while avoiding duplication
iii. Investment should be made in strengthening health systems without which scaling up malaria control will not happen.
iv. Expansion of access to ACTs, ITNs and other malaria control interventions to all at risk of malaria should be undertaken.
v. Procurement and supply chain management infrastructure should be strengthened to enhance access to malaria control and prevention services.
vi. Surveillance, Monitoring and Evaluation should be ensured to monitor progress and prevent re-introduction.

THE ROLES OF PARTNERS IN THE FOLLOW UP AND MONITORING OF THE IMPLEMENTATION OF ABUJA COMMITMENTS TOWARDS UNIVERSAL ACCESS TO HIV/AIDS, TB AND MALARIA SERVICES

African Union and its Organs

As had been requested, the then Chairperson of the African Union, H E President Dennis Sassou Nguesso of Congo presented Africa`s common Position to the 2006 UNGASS and High Level Meeting on HIV/AIDS which adopted the Political Declaration. This year, a Progress Report on its implementation is to be presented to the Assembly in June 2008.

Both the Chairperson of the AU and of the Commission have undertaken advocacy at the G8 and EU Summits, and intensified collaboration with other continents and sub-continents. In these endeavours, issues relating to the fight against HIV/AIDS, TB and Malaria are regularly included.

The 3rd. Session of the AU Conference of Ministers of Health (CAMH) was held in Johannesburg, South Africa in April 2007 on the theme: *"Strengthening of Health Systems for Equity and Development in Africa".* They adopted the Africa Health Strategy as a framework for comprehensively addressing the disease burden; and the Pharmaceutical Manufacturing report for Africa, to promote access to affordable medicines. The Bureau of the 3rd. Session of CAMH had been very active in coordinating the implementation of the adopted strategies, among many other activities.

Coordination and harmonization of Partnerships, among others through Inter-Agency Consultations with the UN and other International partners, RECs and Regional Health Organizations and Regional Civil Society Organizations, on coordination and harmonization of HIV/AIDS, TB and Malaria (ATM) Strategies and actions. The AU is collaborating more closely with international and regional partners as well as CSOs; while efforts to mainstream HIV/AIDS into other programmes of the AU are improving.

Regional Economic Communities (RECs) and Regional Health Organizations

Regional Strategies and Plans of Action on HIV/AID, TB and Malaria have been developed and are being implemented. Progress is variable but significant. Programmes with Member States and cross-border activities are undertaken in this in this connection. These Agencies are working more and more with the AU. These bodies also benefit from the support and collaboration of international development partners.

NGOs and CSOs

During preparation for and after the 2006 Abuja Special Summit, the CSOs undertook unprecedented advocacy to ensure the success of the Summit, incorporation of the recommendations in Africa`s Common Position into the conclusions of the UNGASS on HIV/AIDS. The CSOs have organized coalitions which have promoted

coordination and harmonization of their activities. During the period under review, more and more CSOs for Malaria and TB control are emerging, as compared to those for HIV/AIDS which are more prevalent. The CSOs have continued to provide direct support to communities, particularly vulnerable groups, as well as to Government institutions.

UN and Other International Partners

The UN and other development partners have continued to avail Member States immense technical and financial support for country programmes, each according to the respective mandate. Coordination and harmonization of their efforts is receiving more attention which improves partnerships and results in more rational utilization of the support.

International mobilization of resources has ensured that more and more people in need have access to prevention, treatment, care and support.

The International partners have also continued to lead in advocacy for action, resources and results.

CONCLUSIONS

The Progress Report on the implementation of the May 2006 Abuja continental commitments on universal access towards universal access to HIV/AIDS, TB and Malaria Services indicates satisfactory performance in some priority areas, while efforts need to be scaled up in others. Better access for funding has enabled more access to prevention, treatment, care and support. An integrated and multi-sectoral approach to the management of these diseases should be ensured as it is more cost-effective. Planning, Coordination, Research, Monitoring, Evaluation and Reporting are areas in need of more attention.

RECOMMENDATIONS

In order to achieve the 2010 Abuja targets as well as the MDGs, Member States in collaboration with NGOs and CSOs, are urged to:

a. Increase and sustain advocacy for prevention, treatment, care and support for HIV/AIDS, TB and Malaria programmes, even where success has been registered;

b. To accelerate access to affordable medicines and commodities, the Pharmaceutical Manufacturing Plan for Africa should be implemented through the close collaboration of Member States, Regional Communities, the Private Sector and International Development Partners;

c. Sustain political will and commitment of Africa's Leaders, as well as the participation of communities;

d. Within the framework of Africa Health Strategy strengthen the Health systems in order to Scale up access to affordable services by all;

e. Accelerate efforts towards adequate human resources for health service delivery, and support the global health workforce alliance and other partnerships;

f. Sustain efforts to mobilize from national and international financial resources, including from the Global Fund and other bilateral and multilateral donors to Fight HIV/AIDS, TB and Malaria. In this connection, a Joint Session of AU Ministers of Health, and Ministers of Finance and Economic Planning should be held before 2010;

g. An integrated and multi-sectoral approach and community involvement should be mainstreamed into all programmes of HIV/AIDS, TB and Malaria;

h. Surveillance, Monitoring, Evaluation and Reporting should be a priority in national programmes;

i. Coordination and harmonization of Partnerships at all levels should be developed in the framework of the Three Ones Principles.

j. The African Union, Regional Economic Communities and Regional Health Organizations are requested to coordinate and harmonize regional and continental strategies, including inter-country programmes;

k. The Development Partners and International Community. They are called upon to continue to support Member States and to mobilize additional resources, through a well coordinated and harmonized approach, based on assessed need.

WAY FORWARD

The Special Session of the AU Conference of Ministers of Health, the Progress Report and Recommendations on the Implementation of commitments towards *Universal Access to HIV/AIDS, TB and Malaria Services by 2010*:

i. It was submitted to the UN General Assembly High Level Session on the Progress Report on the 2006 Political Declaration on HIV/AIDS as Africa's Common Position. In this connection, the African Group in New York was appraised and urged to promote Recommendations during the High Level Meeting.

ii. In order to achieve universal access to HIV/AIDS, TB, and Malaria Services by 2010, stakeholders at national, regional, continental and international levels

should double their efforts, with the aim of attaining the 2015 MDG targets. In this connection, monitoring of the actions should be priority.

iii. Furthermore, preparations for the 2010 five-year review of the commitments of the May 2006 Abuja Assembly of Heads of State and Government on Universal Access to HIV and AIDS, TB and Malaria Services should be initiated in time. In this regard, the 4th Session of the AU Conference of Ministers of Health scheduled to be held in April 2009 in Zimbabwe will consider this matter.

iv. The Report and Recommendations were submitted to the Assembly of AU Heads of State and Government for consideration.

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P. O. Box 3243, Addis Ababa, ETHIOPIA Tel.: (251-11) 5525849 Fax: (251-11) 5525855
Website: www.africa-union.org

ASSEMBLY OF THE AFRICAN UNION
Eleventh Ordinary Session
30 June – 1 July 2008
Sharm EL-Sheikh, EGYPT

Assembly/AU/4 (XI)
Annex I

PROGRESS REPORT ON THE IMPLEMENTATION OF THE COMMITMENTS OF THE MAY 2006 ABUJA SPECIAL SUMMIT ON HIV/AIDS, TUBERCULOSIS AND MALARIA (ATM)

ANNEX I

STATUS REPORT ON HIV/AIDS IN AFRICA

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EXECUTIVE SUMMARY

At their May 2006 Special Summit, AU Heads of State and Government recommitted their countries to accelerate the implementation of the 2000 and 2001 Abuja Declarations and Plans of Action on HIV/AIDS, TB and Malaria. Their deliberations focused on accelerating action towards universal access to HIV/AIDS, TB and Malaria Services by 2010. It is required that regular progress reports be submitted to the AU Organs and the UN General Assembly on the status of implementation of the commitments.

The report covers the main priority interventions undertaken by Member States, such as program policy and management, advocacy, HIV testing and counseling (HTC), prevention of mother-to-child transmission (PMTCT), and access to anti-retroviral therapy (ART).

The main source of data for this report (HIV section) is country reports based on a WHO framework on monitoring the health sector response towards Universal Access for HIV prevention, care, and treatment, as well as from UNAIDS and other reports. The reports also draw from progress report on the implementation of the Political Declaration of the 2006 UN General Assembly Special Session and High Level Meeting on HIV/AIDS.

Findings:

The following findings are recorded for the period under review:

ii. In recent years, bilateral and multilateral organizations have increased their HIV support. The Global Fund to Fight AIDS, Tuberculosis and Malaria currently provides 20% of all funding for HIV/AIDS. The success rate of Round 7 proposals for HIV about 60% (10 out of 17).

iii. Of the 35 countries that responded, 31 (90%), 28 (80%), and 21 (60%) reported having policy or guidelines on ART, PMTCT, and HTC—respectively.

iv. Almost two-thirds (63%) of the countries reported setting national targets for HTC, PMTCT, and ART. Over three quarters (77%), have set national PMTCT targets, while 70% (24 countries) have set for HTC and ART

v. Of the 35 countries that reported, 18 (46%) have a policy that allows lower level health workers—once trained—to provide second-level services, such as managing patients with HIV and ADIS

vi. Among 35 countries in the Africa region, one in every five facilities provide HTC services—ranging from less than 1% in Liberia to 100% in Botswana

vii. In 2007, over 470,000 HIV positive pregnant women reportedly received ARVs for PMTCT purposes —over 50% increase from 2006 figure of slightly over 300,000.

viii. In 2007, over 2.1 million people received ART in countries of this region. This represents a 60% increase in just one year—as 1.3 million people received ART in 2006.

ix. Among the 35 countries that reported, 7 (20%) experienced stock outs of ARVs in part or all facilities that provide ART.

x. Of the 35 countries that submitted the Universal Access (UA) reporting form, 80% implement ANC surveillance by using the WHO-recommended HIV 2nd generation surveillance protocol.

In conclusion, countries in Africa took giant steps towards Universal Access for HIV prevention, care, and treatment. Among documented achievements include: increased access to ART, PMTCT and HTC.

As concerns African countries under the WHO Eastern Mediterranean Region, the overall numbers of reported HIV cases remain small except in (Sudan), although they are slowly increasing partially due to expanding testing efforts. Access to prevention, treatment, care and support tends to be more easily available except in countries under special circumstances such as conflicts.

Way Forward:

As a way forward, the following recommendations are made:

- HTC coverage is relatively low—compared to ART and PMTCT. Provider-initiated testing and counseling (PITC) should be expanded to all public health facilities of every country
- Countries should not lose the momentum of prevention, PMTCT and ART scale up and have to continue or even increase the level of efforts till Universal Access targets are fully achieved.
- Infant diagnosis and care & treatment for infected children should be expanded.
- Investment and strengthening of strategic information should be undertaken, particularly in methods of understanding the dynamics of specific country epidemics and its drivers

- Even countries with low prevalence rates or where success has been reported, should avoid complacency.
- Member States are urged to monitor implementation and submit reports regularly.
- Partners at national, regional and international level should sustain their technical and financial support as well as advocacy

1. BACKGROUND

In April 2001, African leaders met in Abuja to address the challenged posed by HIV/AIDS, Tuberculosis, and other related infectious diseases. The primary objective of the declaration was to arrest and reverse the frightening rate at which these priority diseases are depleting the gains made in combating communicable diseases in the continent. They adopted the related Abuja Declaration and Framework for Action, and declared HIV/AIDS an emergency and a threat to security. The Abuja Declaration and Framework for Action was Africa's contribution towards the 2001 United Nations General Assembly Special Session (UNGASS) on HIV/AIDS.

In May 2006, the Heads of State and Government again held a Special Summit on HIV/AIDS, TB and malaria to review the status of implementation of their previous commitments on these diseases. They reviewed the continental status report on the implementation of the Abuja Plans of Action and adopted commitments to promote Universal Access to HIV/AIDS, TB and Malaria Services by 2010. The African leaders highlighted a Framework for Action, which requested for implementation and reporting on the following 12 priority areas:

- Leadership
- Resource Mobilization
- Partnership
- Enabling Environment and Protection of Human Rights
- Information, Education and Communication
- Poverty, Health and Development
- Strengthening Health Systems
- Prevention
- Access to Care and Support
- Access to Affordable Drugs and Technologies
- Research and Development
- Monitoring and Evaluation

The Leaders also requested for progress reports on the 2006 commitments in 2008 and 2010.

2. INTRODUCTION

As of December 2007, UNAIDS and WHO estimated over 33 million people were living with HIV worldwide—of which about two-thirds live in African countries south of the Sahara. In addition, an estimated 2.5 million people were newly infected in 2007, and 2.1 million died of AIDS.[1] The numbers for northern African countries are still low although slowly increasing.

In 2001, the United Nations convened a special session on HIV/AIDS (UNGASS) and has agreed to a set of global targets in response to the growing public health threat against all nations, particularly in middle and low income countries[2]. In 2006, at the second United Nations General Assembly High Level Meeting on HIV/AIDS, the world leaders committed their nations to work towards the goal of "universal access" for comprehensive HIV prevention, care, treatment, and support" by 2010."[3] This commitment, and others like the Abuja Declarations, complements the health-related UN Millennium Development Goals, which establish targets on reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria and other major diseases by 2015[4].

Although Africa especially the countries south of the Sahara seems to be lagging behind on most of the global targets, the increased global and national commitments, as well as financial investments towards combating HIV and AIDS, have produced tangible progress that can motivate politicians and public health workers to accelerate their efforts towards above targets and goals. A rapidly growing number of people have access to HIV prevention, care and other interventions. Available data indicate that in Africa, access to HIV testing and Counseling (HTC), Prevention of Mother-To-Child-Transmission (PMTCT) and antiretroviral therapy (ART) is increasing substantially. Furthermore, there is evidence that prevention programs are paying off dividends since behavior change and declining HIV prevalence in some high-burden countries have been documented in recent years[5].

2.1 PURPOSE

The main purpose of this progress report is to give account of progress made by Member States since 2006 towards Universal Access for HIV prevention, care, and treatment. The report covers the main priority interventions, such as program policy and management, HIV testing and counseling (HTC), prevention of mother-to-child transmission (PMTCT), and access to anti-retroviral therapy (ART).

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[1] 2007 AIDS Epidemic Update. Geneva, UNAIDS/WHO, December 2007.
[2] United Nations General Assembly Special Session on HIV/AIDS, 25-27 June 2001. Declaration of Commitment on HIV/AIDS.
[3] United Nations General Assembly Sixtieth Session. Political Declaration on HIV/AIDS. (UN General Assembly document 60/262). 15 June 2006.
[4] http://www.un.org/millenniumgoals/ accessed on 25 March 2008.
[5] 2007 AIDS Epidemic Update. Geneva, UNAIDS/WHO, December 2007.

2.2 METHODS

The main source of data for this report (HIV section) is country reports based on the WHO and UNAIDS frameworks on monitoring the health sector response towards Universal Access for HIV prevention, care, and treatment. Of the 46 countries in the WHO African Region, 35 have submitted a standard reporting form for monitoring the health sector response. These data will be validated and reconciled with other global reporting mechanisms, such as UNGASS. Additional source of information is the PMTCT card (UNICEF/IATT)

The WHO reporting form is designed to collect 27 indicators which cover availability, coverage and outcome/impact, of priority HIV interventions. Since a global report on health sector response will be launched during the World Health Assembly in May 2008, this progress report will not discuss all indicators but rather highlights important milestones since May 2006 on priority interventions in HIV and AIDS.

3. FINDINGS

3.1 Leadership, Partnerships, and Resource Mobilization

In response to adopted Resolution AFR/RC55/R6, under the auspices of the African Union, the member states launched the campaign to accelerate the HIV prevention strategies and interventions in Addis Ababa in April 2006. Consequently, countries responded by putting in place a number of initiatives, based on their local context. This initiative catalyzed important HIV prevention achievements in many countries in the region. Interventions that received substantial boost from this initiative are HTC and PMTCT.

In recent years, multilateral organizations have increased their HIV support. The Global Fund to Fight AIDS, Tuberculosis and Malaria currently provides 20% of all funding for HIV/AIDS. The success rate of Round 7 proposals for HIV in this region was about 60% (10 out of 17)—which is considered to be the best year in this region. It has continued to expand grants allocated for HIV prevention, care and treatment programmes in recent years, and was successful in securing commitments for increased investment from donor countries in 2007

Through a CIDA grant of about 30 million (Canadian $), WHO is supporting 10 high HIV prevalence countries in the region to scale up PMTCT services to selected districts. This grant is intended to supplement the ongoing efforts to improve access of PMTCT services within the context of the broader family health domain.

Besides the global partnerships, such as GFATM and PEPFAR, several smaller partnerships are mushrooming at country levels. A good example of this is the UNITAID's partnership with African countries to contribute to scaling up access to treatment for HIV/AIDS, malaria and tuberculosis by leveraging quality drug and diagnostic price reductions and accelerating the pace at which these are made

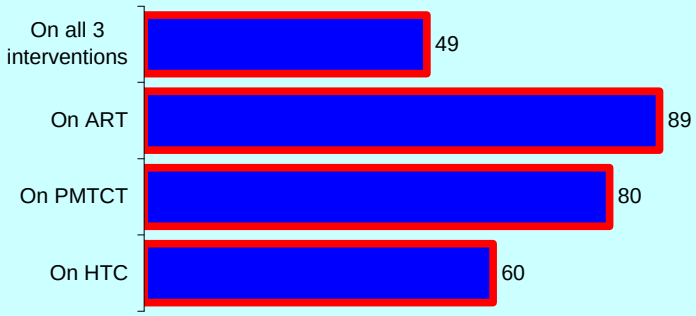
available to patients in need of them. With UNITAID partnership, partner countries are receiving price reductions of up to 40% for 1st and 2nd line ARVs and diagnostic facilities[6].

The United States remains the largest bilateral donor, contributing more than half of total bilateral aid to HIV since 2006—mainly through the US President's Emergency Plan for AIDS Relief (PEPFAR). Early this year, the US Congress has debated and passed the reauthorization, with possibility to more than double the current level of funding over the next five years[7]. Other major bilateral funding sources include the United Kingdom, whose share in the total represents 12%; and the Netherlands, Germany, France, Sweden and Canada, whose contributions together represent another 20% of the total contribution from OECD DAC members. As at the end of 2006, a total of US$5.56 million was committed, of which US$3.9 million was disbursed (bi-laterals accounted for 76%, while GFTATM 24.2% of these disbursements)[8]

3.2 STRENGTHENING HEALTH SYSTEMS

As the overwhelming majority of the HIV and AIDS services are planned and executed within the health sector, the health systems of low and middle income countries are outstretched and are unable to cope with the additional burden—unless additional resources are allocated to them. With HIV and AIDS care and treatment services comes a huge price tag in strengthening capacity for new and expensive diagnostic tools as well as treatment regimens.

Figure 3.1: % of countries reported having policy/guidelines on HTC, PMTCT and ART, in WHO African Region, 2007



Major global stakeholders are beginning to realize the importance of health systems strengthening within the context of the Universal Access approach. For this reason, major global funding mechanisms for HIV/AIDS, such as GFATM and PEPFAR, are encouraging low/middle income countries to place health systems strengthening on the top of their health agenda.

3.2.1 National Policy/Guidelines for Priority HIV Interventions

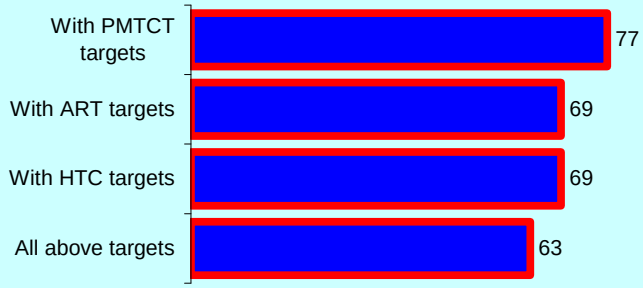
[6] About UNITAID. http://www.unitaid.eu/en/UNITAID-budget.html
[7] The Global AIDS Fight. Editorial. *The New York Times*. February 29, 2008.
[8] Financial resources required to achieve universal access to HIV prevention, treatment, care and support. UNAIDS, Geneva: pg. 3 Additional information can be found at: *http:data.unaids.org/pub/presentation/2007/20070605 unaids kff ppoint en.pdf*

Access to HIV interventions first and foremost requires availability of clear policies to guide which approaches to take and how to deliver the services. All countries are usually expected to have adequate policy document, as well as appropriate guidelines, for health workers to use during service delivery. Of the 35 countries that responded, 31 (90%), 28 (80%), and 21 (60%) reported having policy or guidelines on ART, PMTCT, and HTC—respectively. Only 17 countries—almost half—reported having such documents for all three interventions (Figure 3.1)

3.2.2 Setting National Targets for Universal Access

There is no global target for Universal Access in HIV prevention, care, and treatment. Each country, based on its resources and work environment, is expected to set its own targets toward the Universal Access for HIV prevention, care and treatment. As countries develop their national strategic plans (NSPs), the expectation is for them to develop national targets for priority HIV interventions.

Figure 3.2: % of countries that reported having national targets for HTC, PMTCT, and ART, WHO African Region, 2007
n=35



Almost two-thirds (63%) of the countries reported setting national targets for HTC, PMTCT, and ART. Over three quarters (77%), have set national PMTCT targets, while 70% (24 countries) have set for HTC and ART (Figure 3.2).
Meanwhile in Libya and Tunisia the target is 34% of infected men and women to receive ART. In other countries i.e. Egypt, Somalia and Sudan, the focus is on pregnant women and other infected women- the target ranges from 1.0% in Sudan to 7.3% in Egypt.

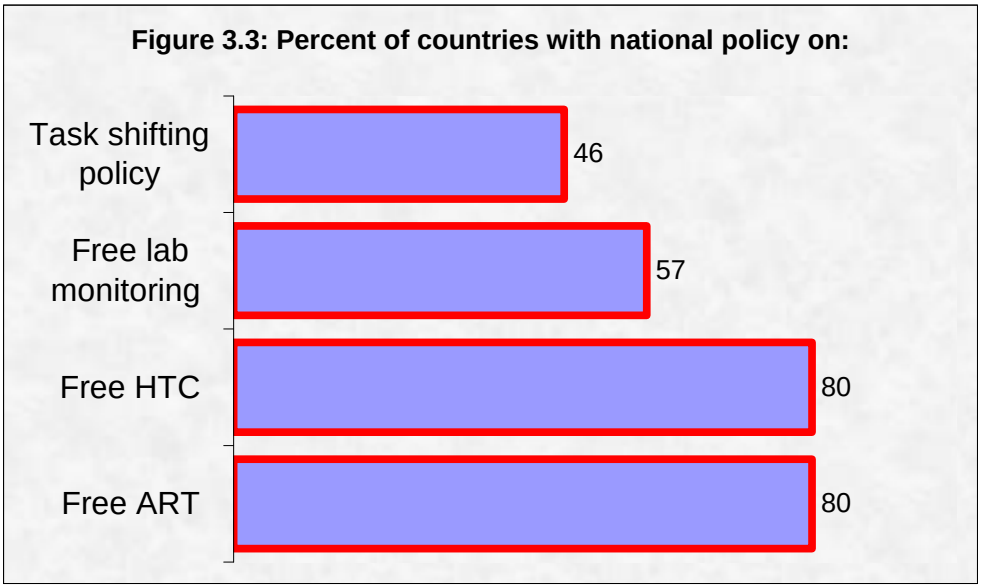
3.2.3 National Policy for Task Shifting and Free HIV Care and Treatment Services

Human resource constraints represent the main health systems challenge facing most of the countries in the region to reach the global and national targets on Universal Access for HIV prevention, care, and treatment. In 2007, WHO, in collaboration with health development partners and national authorities, developed a plan to tackle the health workforce problems through a new initiative, which commonly known as “Treat Train Retain” or TTR. The TTR is based on three principles: I) Treat health workers by providing comprehensive care and treatment packages; II) Train, including task shifting to lower level health workers; III) Retain, through improving work environment, financial and non-financial incentives to motivate health workers to remain in country and

serve those who need care most. Task shifting happens when lower level health workers are trained and given tasks, which are normally reserved for highly trained workers, such as doctors.

Although TTR is a new concept, some of its elements, such as task shifting, are already operational in a number of countries in the region. Of the 35 countries that reported, 18 (46%) have a policy that allows lower level health workers—once trained—to provide second-level services, such as managing patients with HIV and AIDS (Figure 3.3).

Figure 3.3: Percent of countries with national policy on:



Although the cost of HIV care and treatment services is gradually becoming affordable, these are still beyond the means for millions of poor people infected or affected by the epidemic. As part of the Abuja and UNGASS commitments, African leaders resolved to make these life-saving interventions free for those who cannot afford.

About one third of reporting countries (57%) indicated to have a national policy which offers free laboratory monitoring services for patients on ART. Such services include CD4 count or viral loads, which otherwise cost more than the treatment.

An equal number of countries (28) reported having a policy of free HIV testing and counseling as well as ART services for their citizens. In other countries such as Sudan, a high rate of turn-over of staff limits the ability to meet the long-term requirements of policy response. In Tunisia the emphasis is on information, education and communication as a policy strategy. Whereas in Egypt, HIV-related activities have been mainstreamed into and initiated within programmes addressing people most likely to be exposed to HIV. In Somalia, the continuing humanitarian crisis, conflict and emergencies directly affect sustainability of any policy for an effective long-term response.

Such leadership qualities are likely to foster a favorable environment for the expansion of services all the way to Universal Access.

3.3 SCALING UP PRIORITY SERVICES

WHO provides guidance to countries to develop comprehensive packages which are tailored to local needs, including on how the different interventions can be integrated into various service delivery models. The package consists of an array of services that are usually facility based—and sometimes community-based—from HTC to treatment of opportunistic infections to infection control. However, this report covers the three main interventions, which are: HIV testing and counseling, Prevention of Mother to Child Transmission (PMTCT), and anti-retroviral therapy (ART.

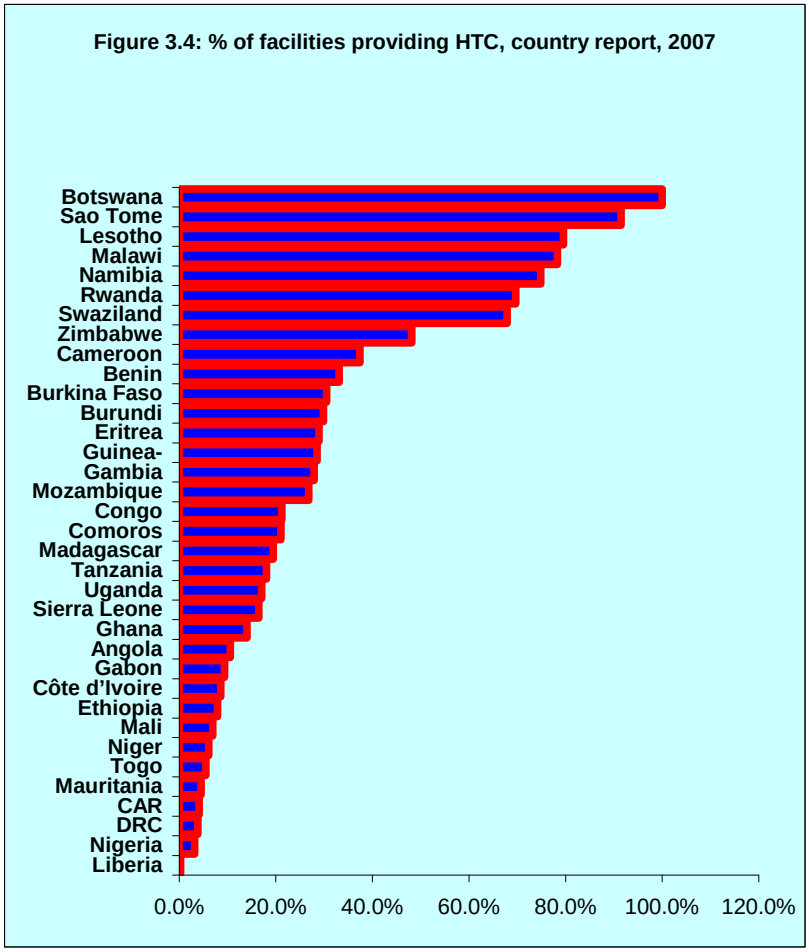
3.3.1 HIV TESTING AND COUNSELING (HTC)

Scaling up access to HIV testing and counseling is the gateway to prevention, care, and treatment services. For HIV-infected individuals, HIV testing is the first step towards early care and treatment services. On the other hand, for those who are not infected with HIV, it provides an opportunity to have appropriate tools and information to reduce the risk of HIV transmission. HIV testing and counseling is therefore very critical to the achievement of universal access to HIV prevention, care and treatment.

Countries are implementing various models of HTC, from the traditional voluntary counseling and testing (VCT) to the new concept of provider initiated HIV testing and counseling.

In 2007, WHO and UNAIDS issued new guidance on HIV testing and counseling in health facilities to increase uptake of HIV testing and counseling and improve

Figure 3.4: % of facilities providing HTC, country report, 2007

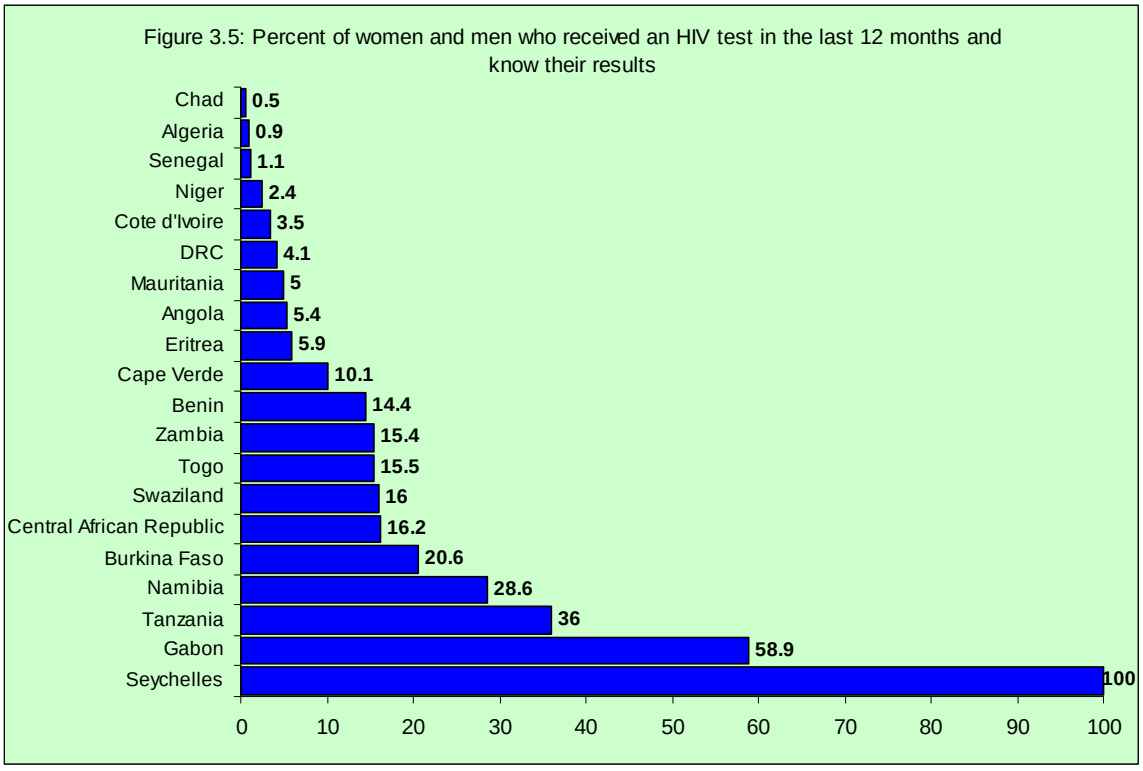


access to health services for people living with HIV[9].

Among 35 countries in the WHO Africa region, one in every five facilities provide HTC services—ranging from less than 1% in Liberia to 100% in Botswana (Figure 3.4, adjusted the scale to reflect a maximum of a 100%). In 2007, the total number of health facilities that provided HTC services ranged 1 in Liberia to 1,107 facilities in Cameroon. Tanzania reported second in the term of available HTC facilities with 1,035. The median number of the HTC facilities per country is 164. In the EMRO region, Somalia is scaling up integrated prevention, treatment, care and support aligning ART, voluntary counseling and testing with the support of the Global Fund. In Sudan there is very limited access to prevention, testing, treatment, care and support, especially in rural areas.

A more compelling statistic is the actual uptake of VCT (ie. percentage of people who take an HIV test and receive the results compared to the targets of respective countries – where these are available).

Fig 3.5 shows the percent of men and women who received an HIV test in the last 12 months and know their results in selected countries. The figure shows the variability in progress in the countries. HTC coverage remains low in Africa.



Source: 2007 UNGASS Country Reports

[9] Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities. WHO, UNAIDS. Geneva, 2007.

The figures 3.7 and 3.8 below for Southern and East Africa show percent of women and men who received an HIV test in the last 12 months and know their results.

Fig.3.7 **PREVENTION: HIV Testing (Southern Africa)**

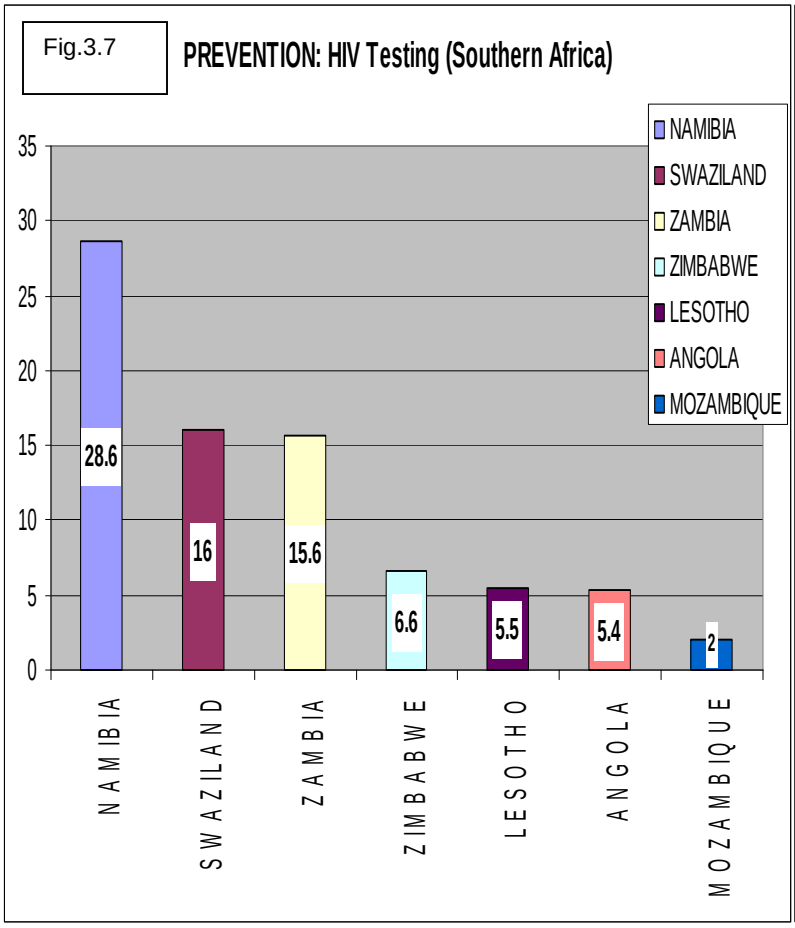
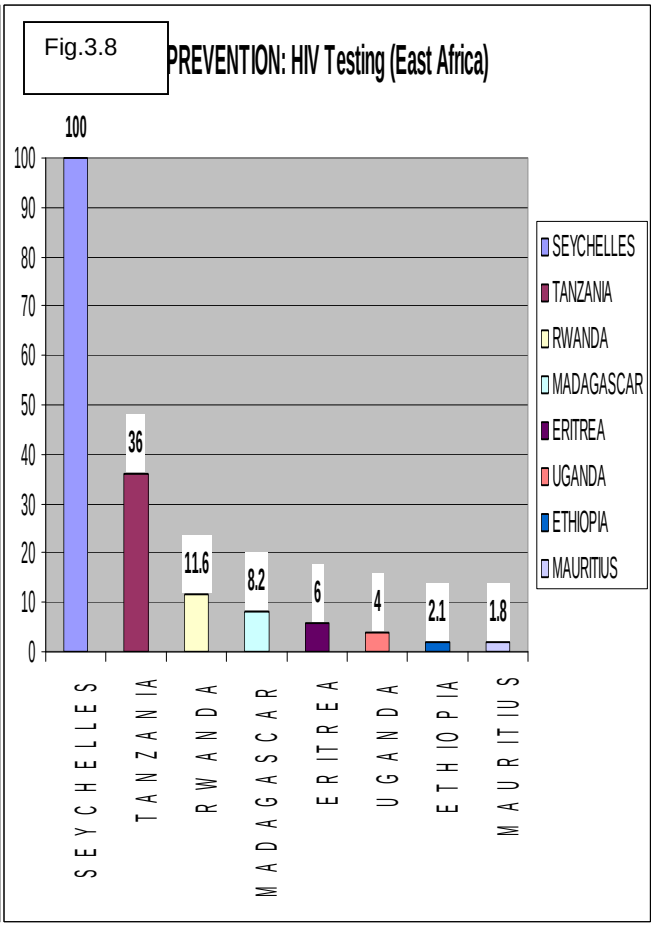


Fig.3.8 **PREVENTION: HIV Testing (East Africa)**



Source: 2007 UNGASS reports or go to: http://www.unaids.org/en/KnowledgeCentre/HIVData/CountryProgress/2007CountryProgressAllCountries.asp

Data from 2006-2007 population-based surveys conducted in some countries of the region indicates that the proportion of men and women who received HIV test and counseling within the past 12 months preceding the survey increased to 7% each—from 3% range in similar surveys conducted earlier. With the expansion of HTC and ART sites, similar coverage rates are expected in coming years.

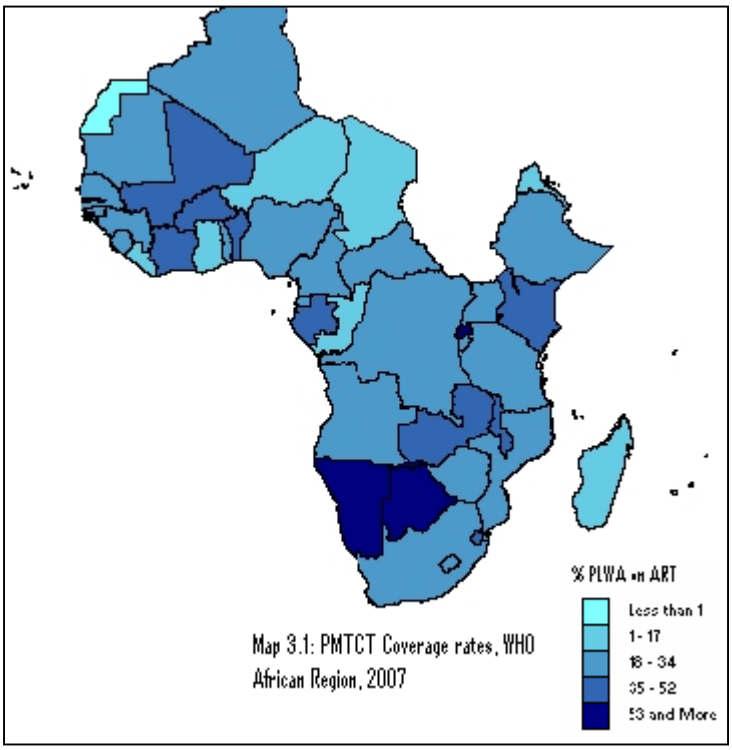
3.3.2 PREVENTION MOTHER TO CHILD TRANSMISSION (PMTCT)

The 2001 UNGASS Declaration committed to reduce the proportion of infants infected with HIV by 50 per cent by 2010, and to ensure 80 % of pregnant

women attending antenatal care (ANC) have access to essential services to reduce MTCT.

Effective PMTCT programs consist of the following elements: primary prevention of HIV infection among women of childbearing age, prevention of unintended pregnancies among HIV-infected women, and prevention of mother to child transmission.

In 2007, over 470,000 HIV positive pregnant women reportedly received ARVs for PMTCT purposes —over 50% increase from 2006 figure of slightly over 300,000. This figure, despite representing commendable progress, it is estimated to represent only about one third of those in need of the service. Map 3.1 (on the right) shows the distribution of PMTCT coverage rates (%) in WHO African Region for 2007.



Map 3.1: PMTCT Coverage rates, WHO African Region, 2007

The median percentage of ANC facilities in 23 countries offering PMTCT services is 31—ranging from 0 to 100% (Figure 3.9). Among these countries, the total number of ANC facilities offering PMTCT services is over 8,200, with a median of 129 per country—ranging from 0 in Comoros to 1,311 in Tanzania. In Egypt, 7.3% of pregnant women receive treatment in order to reduce mother-to-child transmission, whereas the percentage is 3.3 in Somalia.

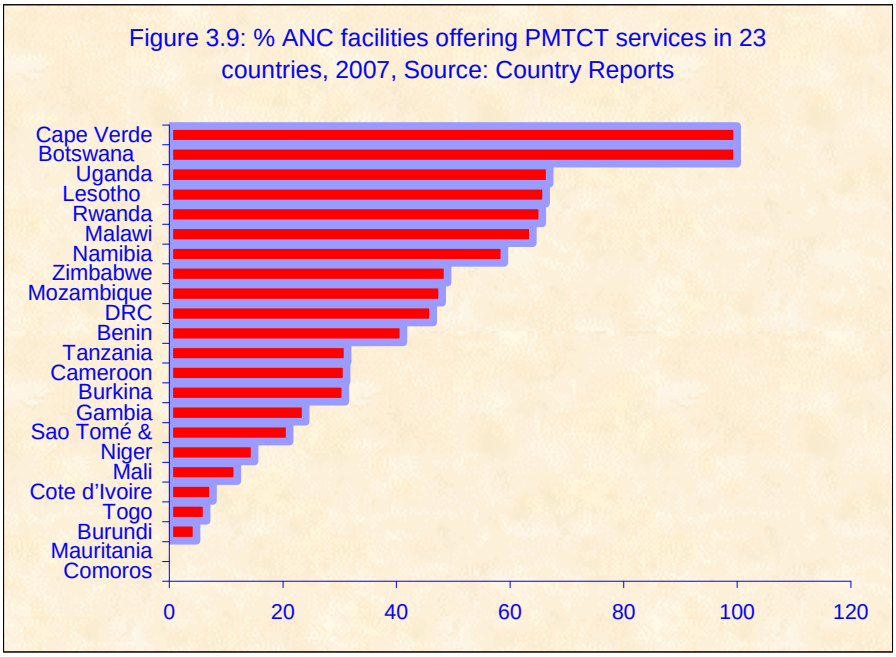
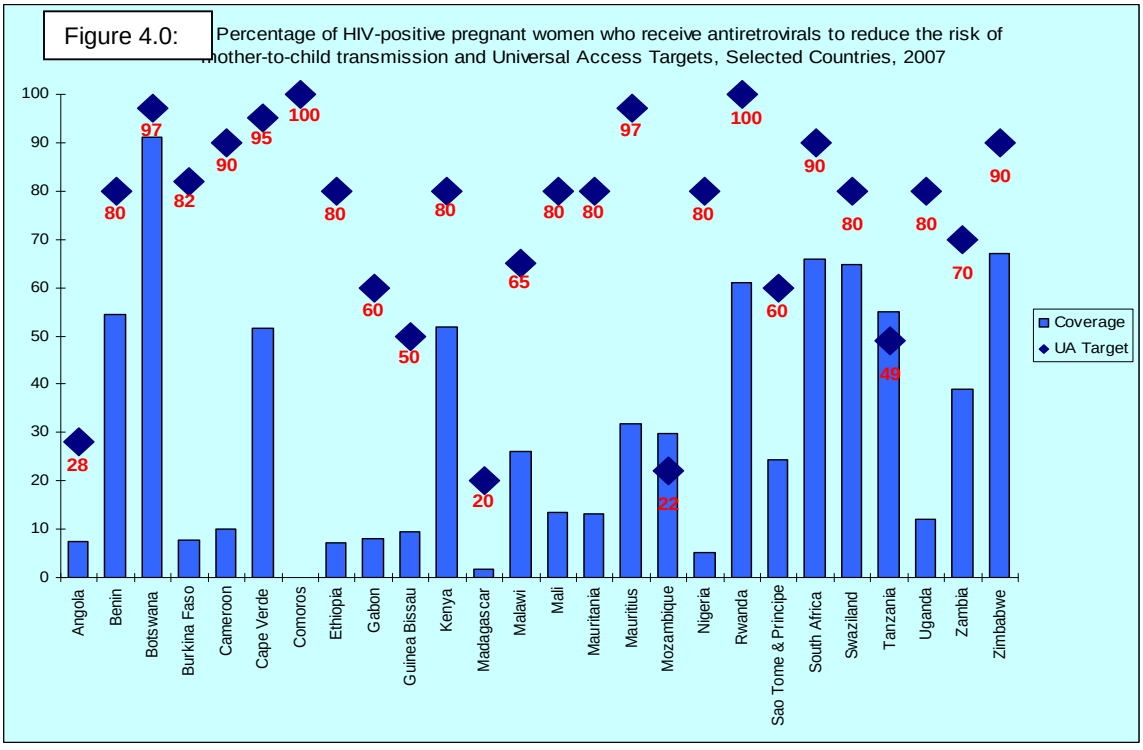
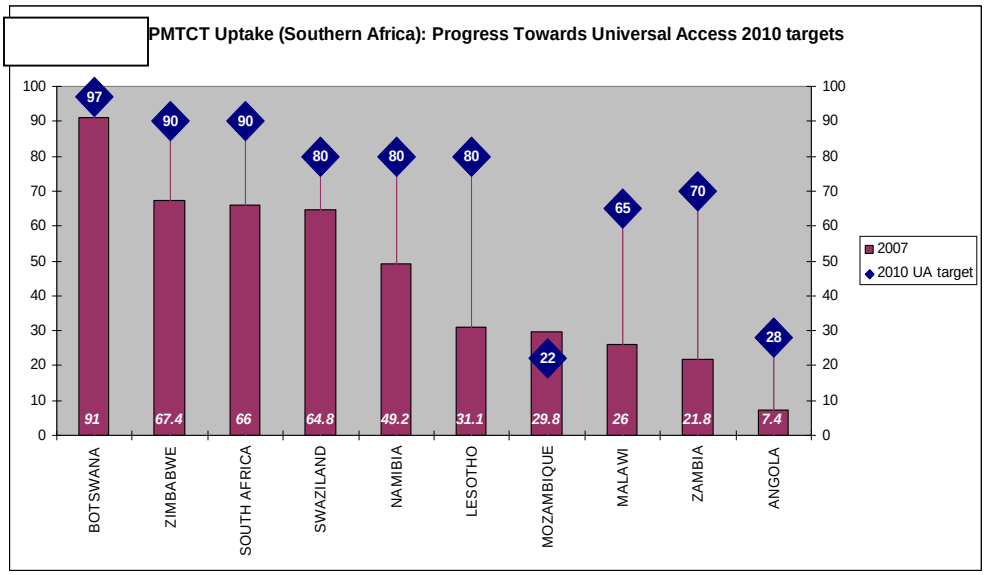


Figure 4.0 shows the progress towards the UA targets in selected countries in the region. Most countries are still quite below the target and will need to accelerate progress to reach these targets. Targets have been achieved mostly in countries with conservative targets



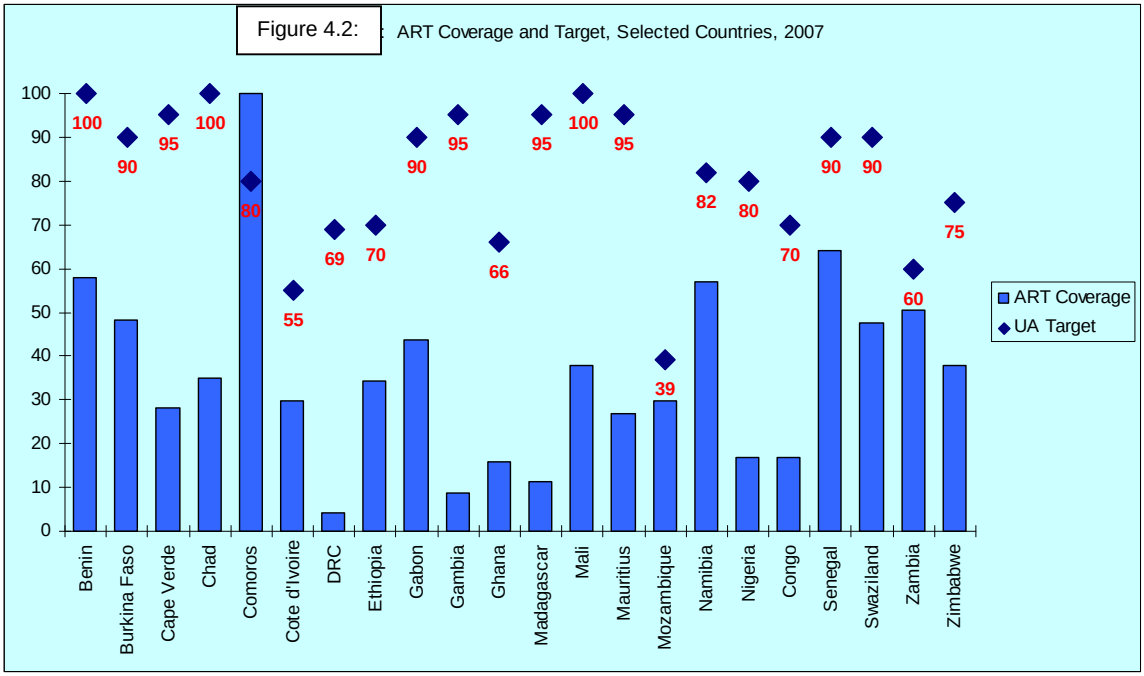
Source: 2007 UNGASS Country Reports

The chart below shows the progress East and Southern African countries are making towards universal access targets set in their respective countries (note: the figures in the diamond shape are the targets, while the bars depicts the current PMTCT uptake as reported in 2007 UNGASS reports)



3.3.3 CARE AND TREATMENT

By the end of 2007, an estimated 3 million people received ART worldwide—over 70% of these are from sub-Saharan Africa. Across the world, the number of people accessing ART has grown more than 7 times in 4 years. The bulk of this increase comes from sub-Saharan Africa, where almost 2.1 million people were receiving ART by the end of 2007. This represents a 60% increase in just one year—as 2006 saw about 1.3 million on ART.



Source: 2007 UNGASS Country Reports

WHO recommends a simplified public health approach, known as the integrated management of adult and adolescent illnesses (IMAI), to scale up anti-retroviral therapy (ART) in resource limited countries—to reduce morbidity and mortality among people living with HIV/AIDS. By the end of 2007, half of the countries in the region, were implementing IMAI, and in the process trained thousands of various health workers to manage patients with HIV/AIDS and related illnesses. Consequently, ART services have expanded to sub-district levels.

Another factor that contributed to increasing ART coverage in the region is the falling prices of ARVs and other HIV-related commodities. However, almost two thirds of people in the region who are in need of antiretroviral therapy have no access yet.

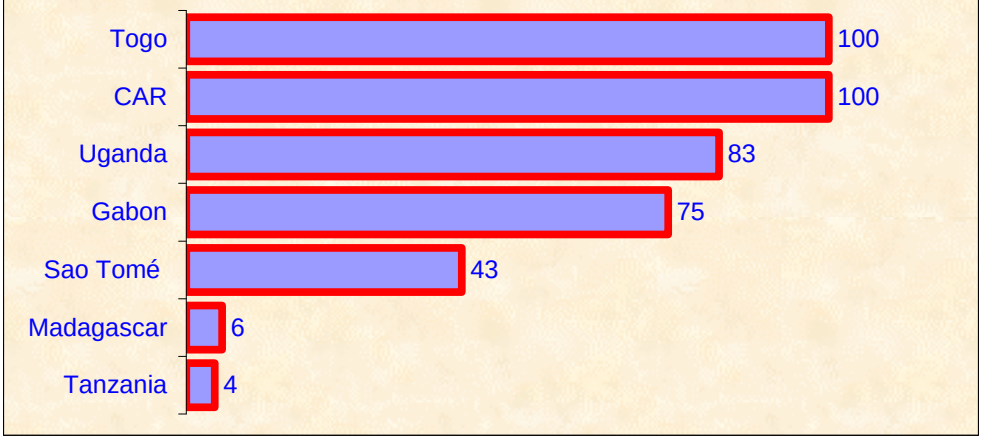
One way of measuring the level of effort countries are placing on care and treatment scale up, is the equitable expansion of ART outlets. In 2007, a total of 3,393 facilities providing ART services were reported in 35 countries—but this figure can easily exceed 4,000 if facilities in remaining 11 countries are included. Table 4.2 shows the distribution of number of people on ART in 2006 and 2007, percentage increase, and number of ART sites in 2007, by country. Women receiving ART in Somalia and Sudan is 1.0%. In Tunisia the figure for all women receiving ART is 34%.

3.4 ACCESS TO AFFORDABLE MEDICINE AND TREATMENT

The Global Price Reporting Mechanism (GPRM) on Antiretroviral Drugs, established in 2004, provides information on transaction prices of anti-retroviral (ARVs) medicines purchased in developing countries.

The price of first-line ARVs is continuing to fall—up to 40% in 2007. Further reductions are expected to occur in coming years as the ART scale up effort reaches the poor and disadvantaged population groups and local production of ARVs increases. Currently, up to 6 plants in the region are producing generic ARVs—mainly for local consumption, but some, like the South African plant (Aspen) has WHO pre-qualification for exports to other countries. The other 5 plants are in: Zimbabwe, Nigeria, Kenya, Benin, and Uganda.

Figure 4.3: Percent of ART sites experiencing ARVs stock outs during the past 12 months, 2007



Among the 35 countries that reported, 7 (20%) experienced stock outs of ARVs in part or all facilities that provide ART. Figure 4.3 shows proportion of ART sites that experienced stock outs of one or more ARVs during 2007. Six out of these 7 countries, reported not having provisions to address stock outs or shortages of ARVs and commodities, including test kits. Overall, half of all reporting countries (35) have procedures, which allow them to tackle such shortages or stock outs. In most of the EMRO region countries, the bulk of the costs of medicines is by the governments. Whereas in Sudan limited absorption capacity for Global Funds grants and other available financial resources may be an indicator of drugs not being available rather than affordability.

Figures 4.4 and 4.5 show progress ART uptake towards Universal Access by 2010 in Southern and Eastern Africa.

Figure 4.4: **ART Uptake: Progress towards Universal Access 2010 targets in Southern Africa**

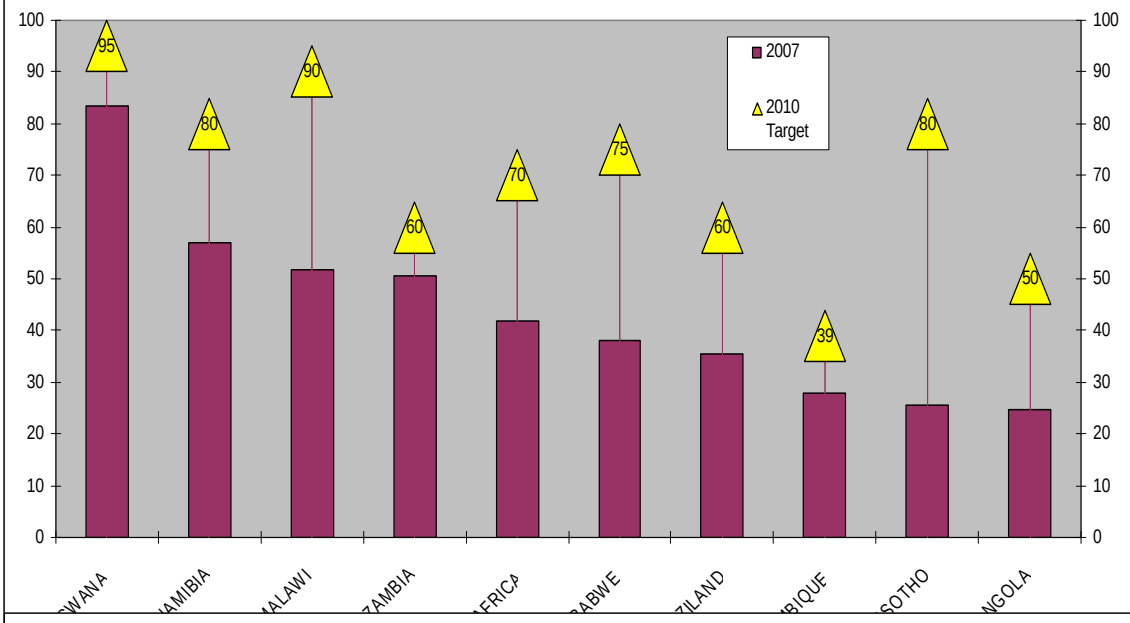
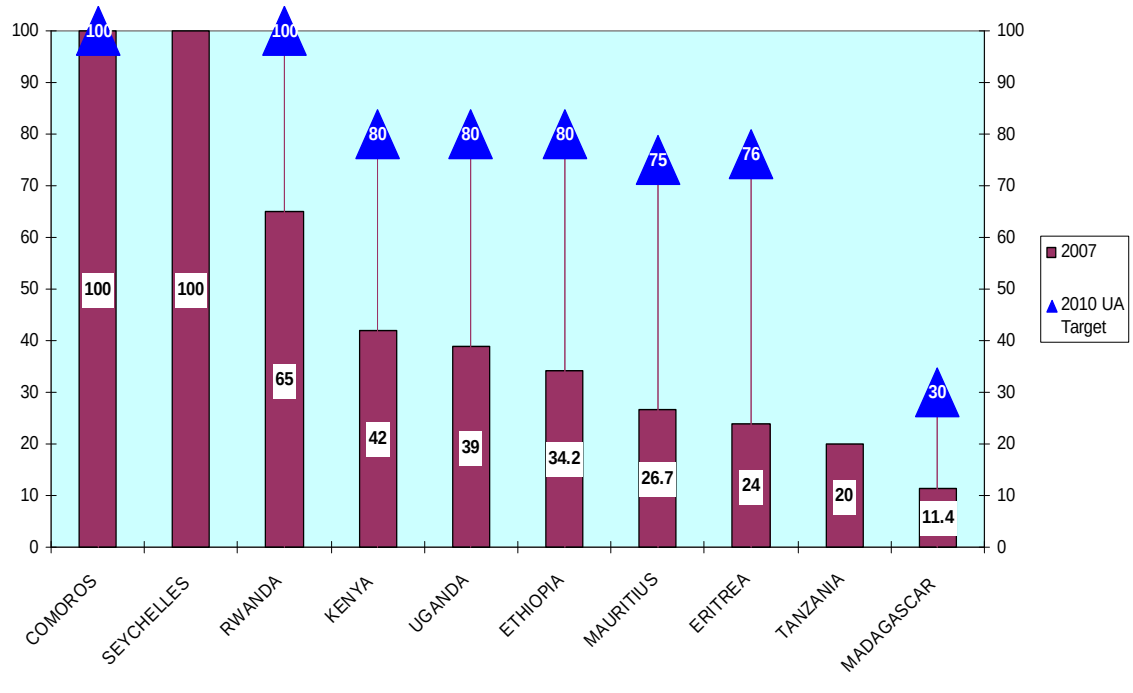
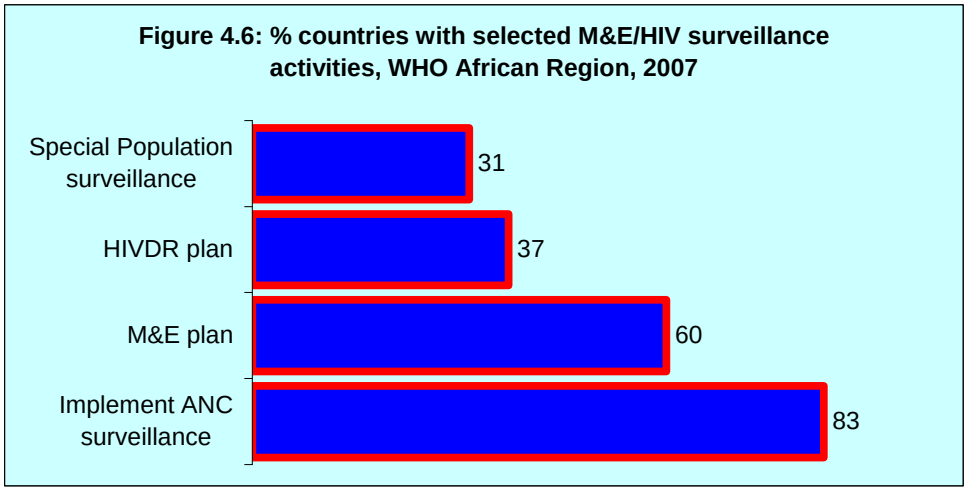


Figure 4.5: **ART uptake: progress towards Universal Access 2010 targets (East Africa)**



surveillance—mainly in low or concentrated HIV epidemic.



In this era of ART and PMTCT scale up, the development of HIV drug resistance (HIVDR) is inevitable. In collaboration with partners, WHO has developed a global HIV drug resistance network—known as ResNet—for monitoring the magnitude of HIVDR. As of 2007, 13 countries in the region have developed national HIVDR plans.

Monitoring and evaluation (M&E) is an area that received less attention and investment in the past. Since member states have committed themselves to several global resolutions and declarations that require proper planning, establishment of effective M&E systems is inevitable. Many countries are beginning to understand the importance of M&E for program planning and tracking of the level of implementation of key interventions. About 60% of countries reported having M&E plans—in order to track the health sector response toward Universal Access for HIV prevention, care, and treatment. Sudan is in the process of improving surveillance and M & E by developing a National Monitoring and Evaluation Framework with standardized HIV core indicators. Somalia on the other hand is boosting up M & E efficacy in the response within the context of the Global Fund sub-recipients and building up Regional Partnerships in order to address HIV vulnerability and cross-border mobility in the Horn of Africa.

4. CONCLUSION

Since 2006, Member States took giant steps toward the Universal Access for HIV prevention, care, and treatment. Among documented achievements include: increased access to ART, PMTCT and HTC.

In addition, national, bilateral, multilateral commitments have increased and therefore were contributing factors of the 2007 achievements. Despite these achievements, the coverage of priority intervention—HTC, PMTCT, and ART—is still low. The number of new infections is still high and in some countries increasing. Therefore, the fight against HIV/AIDS is far from over.

5. THE WAY FORWARD
MEMBER STATES

- HTC coverage is relatively low—compared to ART and PMTCT. Provider-initiated testing and counseling (PITC) should be expanded to all public health facilities of every country
- Countries should not lose momentum of ART and PMTCT scale-up and have to continue or even increase the level of effort until Universal Access targets are fully achieved.
- Expansion of infant diagnosis, care and treatment for infected children
- Invest and strengthen strategic information, particularly in methods of understanding the dynamics of specific country's epidemics and its drivers
- Develop strategies of scaling up male circumcision, particularly in Southern Africa
- Furthermore, promote coordination and harmonization of Programmes and Partnerships through multi-sectoral and integrated approach. Regional Economic Communities and Regional Health Organizations
- Development partners and International Organizations to continue and sustain their financial and technical support to countries in Africa in order to attain Universal Access
- Promote coordination, harmonization of Regional and Continental strategies including inter-country programmes

Annexes

Table 1A: Burden of HIV/AIDS in African countries in WHO EMRO Region

Country	Estimated HIV prevalence in adult pop. (%)	Estimated number of PLWH	Reported AIDS cases 2006	Estimated no. of adults needing ART	Reported no. of people receiving ART
Djibouti	3.1	15 000	NA	2 600	492
Egypt	<0.1	5 300	88	870	166
Libya	NA	NA	NA	500	217
Morocco	0.1	19 000	291	3 300	1 530
Somalia	0.9	44 000	NA	7 100	96
Sudan	1.6	350 000	418	56 000	986
Tunisia	0.1	8 700	24	346	298

Table 1: Availability of program policy/management, including M&E, WHO/AFRO 2007

Country	Have national targets for			Have updated national policy/guidelines for			Have task shifting policy for ART expansion	Have public sector policy for free ARVs	Have national HIV M&E plan	Have national HIV Drug Resistance Strategy	HIV survey-lance
	HTC	PMTCT	ART	HTC	PMTCT	ART					
Algeria											
Angola											
Benin											
Botswana											
Burkina Faso											
Burundi											
Cameroon											
Cape Verde											
CAR											
Chad											
Comoros											
Congo											
Cote d'Ivoire											
DRC											
Eq.Guinea											
Eritrea											
Ethiopia											
Gabon											
Gambia											
Ghana											
Guinea											
Guinea Bissau											
Kenya											
Lesotho											
Liberia											
Madagascar											
Malawi											
Mali											
Mauritania											
Mauritius											
Mozambique											
Namibia											
Niger											
Nigeria											
Rwanda											
Sao Tomé											
Sénégal											
Seychelles											
Sierra Leone											
South Africa											
Swaziland											

Country	Have national targets for			Have updated national policy/guidelines for			Have task shifting policy for ART expansion	Have public sector policy for free ARVs	Have national HIV M&E plan	Have national HIV Drug Resistance Strategy	HIV survey-lance
	HTC	PMTCT	ART	HTC	PMTCT	ART					
Togo											
Uganda											
Tanzania											
Zambia											
Zimbabwe											

Table 2: HTC and PMTCT indicators by country, WHO/AFRO 2007

Country	% HFs where HTC is available	Number of health facilities that provide HTC	% of ANC facilities that provide both HIV testing and ARVs for PMTCT	Number of ANC facilities that provide PMTCT	% of pregnant women who know their HIV status	% of HIV-infected pregnant women who received ARVs for PMTCT	Number of HIV-infected pregnant women who received ARVs during the last 12 months
Algeria		54				2.8	19
Angola	10.6	154		81	6.7	7.5	1,540
Benin	33.1	183	41.2	206	33.5	33.5	2,554
Botswana	100.0	634	100	634		89.0	12,419
Burkina Faso	30.5	454	31	400	8.1	7.7	1,426
Burundi	29.9	167	4.8	31	0.4	73.0	1,102
Cameroon	37.4	1,107	31.2	739	19.6	10.0	6,263
Cape Verde		32	100	27	68.0	47.3	9
CAR	4.1	24		62		5.1	1,867
Chad							
Comoros	21.1	4	0	0		0.0	0
Congo	21.3	54		28	4.0	2.2	175
Cote d'Ivoire	8.6	124	7.68	111		74.0	1,591
DRC	3.8	286	46.46	394	7.3	2.8	3,703
Eritrea	28.9	109			97.0	3.9	133
Ethiopia	7.9	1,005		408			5,304
Gabon	9.4	75				8.9	229
Gambia	28.0	26	24	22		100.0	350
Ghana	14.0	422		408	15.9		2,896
Guinea Bissau	28.6	34		1	34.6	12.0	430
Lesotho	79.5	163	66.34	136	91.0	31.0	3,966
Liberia	0.3	74		18			50
Madagascar	19.5	630			9.4	1.6	25
Malawi	78.3	504	64	349		45.0	10,715
Mali	7.0	58	12	103	2.0	61.1	1,151
Mauritania	4.5	22	0	0		6.0	45
Mozambique	26.8	359	48	384		7.0	12,150
Namibia	74.9	253	59	201		49.0	
Niger	6.1	145	15	129	4.0	57.0	234
Nigeria	3.2	736		253		5.3	10,500
Rwanda	69.6	312	65.66	285		73.8	5,945
Sao Tomé & Principe	91.4	32	21.21	7	88.4	24.4	22
Sénégal		190		85			264
Sierra Leone	16.5	165					919

Country	% HFs where HTC is available	Number of health facilities that provide HTC	% of ANC facilities that provide both HIV testing and ARVs for PMTCT	Number of ANC facilities that provide PMTCT	% of pregnant women who know their HIV status	% of HIV-infected pregnant women who received ARVs for PMTCT	Number of HIV-infected pregnant women who received ARVs during the last 12 months
Swaziland	67.9	110		110			10,428
Togo	5.5	51	6.6	41		6.7	697
Uganda	17.1	554	67	504	34.1	29.0	26,484
Tanzania	18.1	1,035	31.4	1,311	37.1	28.0	31,863
Zambia							306,000
Zimbabwe	48.1	791	49	771	68.0	47.0	15,381
		11,132		8,239			478,849

Table 3: ART Implementation and coverage—WHO AFRO 2007

Country	Number on ART 2006	Number on ART 2007	% increase	Number facilities providing ART
Algeria	588	993	69	7
Angola	6,514	11,540	77	56
Benin	7,634	9,765	28	47
Botswana	79,490	92,932	17	99
Burkina Faso	14,079	16,938	20	76
Burundi	8,048	10,894	35	43
Cameroon	28,403	45,817	61	109
Cape Verde	233	348	49	27
CAR	2,782	9,591	245	46
Chad	5,500	7,400	35	
Comoros	5	7	40	1
Congo	3,186	4,956	56	28
Cote d'Ivoire	36,348	67,680	86	104
DRC	17,561	28,925	65	209
Equatorial Guinea	414	985	138	
Eritrea	1,175	1,301	11	14
Ethiopia	53,720	90,212	68	272
Gabon	5,278	6,373	21	12
Gambia	400	431	8	8
Ghana	9,882	13,357	35	92
Guinea	4,699	5,660	20	
Guinea Bissau	349	890	155	12
Kenya	125,026	177,000	42	
Lesotho	17,667	21,710	23	110
Liberia	796	1,120	41	
Madagascar	92	138	50	18
Malawi	86,168	100,649	17	154
Mali	11,651	12,398	6	45
Mauritania	256	839	228	4
Mauritius	120	321	168	
Mozambique	40,891	89,592	119	211
Namibia	35,593	52,316	47	17
Niger	1,168	1,536	32	12
Nigeria	95,008	196,582	107	215
Rwanda	34,636	48,569	40	161
Sao Tomé & Principe	51	74	45	7
Sénégal	5,500	6,699	22	68
Seychelles	82	94	15	
Sierra Leone	1,416	2,649	87	81
South Africa	324,754	458,951	41	
Swaziland	18,493	24,535	33	22
Togo	6,993	7,980	14	105
Uganda	96,294	115,348	20	286
Tanzania	60,342	135,696	125	204
Zambia	82,030	151,199	84	322
Zimbabwe	66,920	103,692	55	89
	1,398,235	2,136,682	53	3,393

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ASSEMBLY OF THE AFRICAN UNION
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Annex II

PROGRESS REPORT ON THE IMPLEMENTATION OF THE COMMITMENTS OF THE MAY 2006 ABUJA SPECIAL SUMMIT ON HIV/AIDS, TUBERCULOSIS AND MALARIA (ATM)

ANNEX II

STATUS REPORT ON TUBERCULOSIS IN AFRICA

(Detailed Report is prepared at the request of the Conference of the Ministers of Health)

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EXECUTIVE SUMMARY

Referent TB control indicators and targets

A number of targets have been set and commitments made with direct relevance to TB Control in the African continent over the past 10 years.

In 1991, the World Health Assembly (WHA) adopted a resolution urging countries to detect 70% of new smear-positive TB cases arising annually, and successfully treating 85% of them by 2005. These targets remain relevant for all counties that have not yet attained these targets.

In 2000, World leaders established the Millennium Development Goals that seek to halt by 2015 and begin to reverse the incidence of HIV/AIDS, malaria and other major diseases. Incidence, prevalence and death rates associated with tuberculosis, and proportion of tuberculosis cases detected and cured under DOTS as specified by the WHA were re-iterated. By way of operationalising the TB related MDG targets, the Stop TB Partnership confirmed the WHA targets for case detection and successful treatment. In addition, it called for 50% reduction in global TB burden relative to 1990 levels by 2015, and elimination of TB by 2050.

In April 2001, the African Heads of State and Government adopted a declaration on HIV/AIDS, Tuberculosis and Other related Infectious Diseases (ORID) calling upon member states to strive to allocate 15% of national budgets to the improvement of the health sector, and to allocate appropriate and adequate portions of this amount for the fight against HIV/AIDS, TB and ORID.

Confirming the gravity of the TB epidemic in Africa, the 55th session of the Ministers of Health of the WHO African Region (2005) declared TB an emergency in the Region calling upon member states to implement urgent and extra-ordinary actions to rapidly improve tuberculosis case detection and treatment success-rates; and accelerate implementation of interventions to combat the TB/HIV epidemic, including increased access to ARVs by doubly-infected patients;

In May 2006, Heads of State and Government of the African Union held a Special Summit on HIV/AIDS, Tuberculosis and Malaria, to review the status of implementation of the 2000 and 2001 Declarations and Frameworks of action to Roll Back Malaria, and the 2001 Abuja Summit on HIV/AIDS, TB and ORID. They adopted the “Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, Tuberculosis and Malaria services” that pledged collective dedication to a comprehensive remedial effort anchored on an implementation mechanism that responds to the continent’s health and developmental challenges and imperatives. The Summit reaffirmed previous global and regional targets for TB control as well as called for universal

access to TB prevention, treatment, care and support services, including of key TB-HIV interventions.

Despite the progress in tuberculosis control, northern African countries have failed in achieving the global targets for tuberculosis control. While DOTS has expanded, covering 94% of the regional population and treatment success is high (82%), the case detection rate is only 44%. To improve case detection, the regional plan to Stop TB was developed as part of the global plan 2006–2015. The budgetary need for the period of 2006 to 2015 indicated in the Plan is US$ 3.1 billion in the WHO/EMRO Region. Support to countries was enhanced and partnership development promoted.

This Report is prepared at the request of the 2006 Special Summit and the AU Conference of Ministers of Health. It reviews the status towards achievement of the TB targets as specified in the Abuja commitments and the MDGs.

Status of TB Control indicators and targets

Leadership at National, Regional and Continental Levels

The 2006 Abuja Call for Universal Access to ATM services is the most recent indication of the continent's growing political leadership for TB Control in the Region. It builds on and creates a supportive political environment for the quantitative pursuance of the World Health Assembly, MDG, Abuja 2001, and Maputo 2005 TB control targets. Political leadership has also been demonstrated through declaration of TB as national emergencies by at least 18 countries in the African Region; the adoption of a Regional Strategy to combat the TB/HIV epidemic by the 57th session of the Regional Committee for Africa in 2007 and other related declarations by Regional Economic Communities (RECs), and Health Communities.

The stated commitment not withstanding, national financing of health and TB Control programmes remains insufficient. Only two countries have achieved the 2001 pledge to allocate at least 15% of national budgets to the improvement of the health sector. Furthermore, a later call to allocate 34USD per capita for health is yet to be adopted by the majority of countries.

Estimated Prevalence, incidence and death rates

Estimated TB prevalence, incidence and death rates all continue to increase in most countries. Notification rates have risen from 82 per 100,000 population in 1990 to 160 in 2006. Despite an apparent stabilisation and decline in overall TB globally and in the African Region, at this rate, the MDG targets for TB incidence and prevalence are unlikely to be achieved at regional level. In Eastern Mediterranean Region, incidence rates are higher for Djibouti, Somalia and Sudan than in the other countries in northern Africa.

However, according to the 2008 WHO Global TB Report, by the end of 2006, *Comoros, Ghana, Mali, Mauritius, Sao Tome & Principe and Seychelles* had

already halted and started to reverse overall and smear positive TB incidence as specified in the core MDG targets (without applying the reference to 1990 rates as specified by the Stop TB Partnership in quantifying the MDG targets).

A further 6 countries, namely, *Angola, Benin, Cape Verde, Eritrea, Guinea Bissau and Niger* had already halted and started to reverse estimated TB prevalence, while four countries, namely, *Angola, Comoros, Sao Tome & Principe and Seychelles* had already halted and started to reverse death rates.

Status of case detection and treatment success rates

Case detection rate:

While increasing overtime during the past five years, at 46%, new smear positive case detection rate for the African Region is significantly below the 70% target set by the WHA, MDGs and the Special Summit. The region is only achieving 65% of the target. Mediterranean countries of North Africa are also performing better.

However, according to the 2008 WHO TB Report, 12 countries[10] had met the 70% case detection target, and 8 countries[11] had achieved the 85% treatment-success target. Only 3 countries (Algeria, Benin and Tunisia) had met both targets.

Treatment Success Rates

Treatment success rate has been increasing progressively since 1999. Nevertheless, at 76%, it still falls short of the 85% target. The region's performance is only 89% of the set target. Based on treatment outcomes for patients enrolled in 2005, only eight countries from the Region[12] had reached the target. This compares to two countries for 2001 patient cohort, three countries for 2002 cohort, four countries for 2003 cohort and eight countries for 2004 cohort. A further four countries[13] were making good progress and had attained treatment success rates of 80% and above. In the EMRO African countries, success rates are generally above 76% except where records were not available.

Drug Resistant TB

Drug resistant TB, especially multi-drug resistant TB, is widely prevalent than previously known. Twenty-six countries from the region reported a total of 8,624 multi-drug resistant TB (MDR-TB) cases during 2007 while four countries (Botswana, Lesotho, Mozambique and South Africa (99.1% of the

[10] Algeria, Angola, Benin, Botswana, Cameroon, Kenya, Lesotho, Madagascar, Namibia, and South Africa
[11] Algeria, Benin, Comoros, DR Congo, Eritrea, Gambia, Mauritius and Sierra Leone
[12] Algeria, Benin, Democratic Republic of Congo, Eritrea, Gambia, Mauritius and Sierra Leone
[13] Kenya, Rwanda, United Republic of Tanzania and Zambia

cases)) reported a total of 541 Extensively Drug Resistant TB cases (XDR-TB) cases during the same period.

In terms of capability to diagnose MDR TB, there were still 10 Member States without this capability by the end of 2007.

Of the 26 countries that reported at least a case of MDR or XDR-TB during 2007, only 17 countries (65.4%) have an organized treatment programme for these cases despite the availability of a Stop TB Partnership global facility for accessing concessionary priced second line drugs by DOTS based TB Control programmes. Only 9 countries had successfully applied to this facility by February 2008.

Status of implementation of TB/HIV Interventions

During 2006 in the Africa Region, only 22% of notified cases were tested for HIV, compared to the 100% set by the Special Summit. However, this represents a 100% increase in coverage compared to 11.2% for 2005.

Of those who tested positive, 37.1% were started on Anti-Retroviral Therapy (ART), increasing from 27.3% in 2005. Again this is far less than the 100% target. At this rate, the region is unlikely to reach the 100% target for both indicators by 2010.

However, 11 countries[14] recorded significant gains in ART coverage compared to the previous year. The best results ranged from 30.8% in Rwanda to 56.9% in Malawi. Furthermore, overall, 89.1% of HIV positive TB patients were started on Co-trimoxazole preventive therapy (CPT), a 23.4% increase compared to 72.2% in 2005. At this rate, Universal Access to CPT for dually infected persons is likely to be achieved by 2010.

Access to essential anti-TB medicines

Availability of first line anti-TB drugs has improved tremendously. By the end of December 2007, all 36 eligible countries from the Africa region that applied to the GDF secured first line anti-TB drug grants, including pediatric formulations for some countries.

The increased availability notwithstanding, of the 42 countries that reported, only 69% maintained uninterrupted supply of first line anti-TB drugs at both the central and peripheral levels. As stated under drug resistant TB section above, only 65.4% of countries with reported MDR-TB cases had organized treatment programmes for those cases, and only 9 countries[15] had taken steps to access concessionary priced second line drugs from the global facility of the Stop TB Partnership for such programmes.

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[14] Benin, Cote D'Ivoire, DRC, Guinea Bissau, Kenya, Malawi, Mauritius, Mozambique, Rwanda, South Africa and Zambia

[15] Burkina Faso, DRC, Guinea Conakry, Kenya, Lesotho, Mozambique, Rwanda, Tanzania (pre-approval stage) and Uganda

Resource mobilization

It is not feasible to accurately determine levels of national financing for TB Control as TB funding is not earmarked within the general primary health care services. It is however evident that only two countries have attained the 15% allocation of national budgets to health as pledged in the 2001 Abuja declaration.

At the same time, external funding for TB control activities has increased significantly. The Global Fund to Fight AIDS, TB and Malaria (GFATM) has been the single most important source of additional funding for TB control. Approximately 953 million USD (37% of total approved GFATM grants) has been approved for TB Control in the region from 2002-2007.

However, the increased flow has not been marched by timely spending and increased case detection and treatment success rates in the majority of countries. Countries under emergency situations face extra challenges.

Conclusions

Tuberculosis control in Africa has progressed in the last decade but the continent still lags behind on major TB Control targets. Financial resources, traditionally a bottleneck for NTPs till the 2000's, is no longer a major factor as GFATM grants, GDF grants (for standard TB treatment), GLC support (for drug resistant TB), bilateral donors support and several Partnership mechanisms provide technical and financial assistance to cover most needs. In order to achieve Universal Access by 2010 and the MDG targets by 2015, much remains to be done, especially to:

- **Increase treatment success rate for smear positive TB cases:** through implementation of initiatives to reduce preventable unfavourable treatment outcomes such as patient default, transfer out and HIV/AIDS related TB deaths

- **Increase case detection rates:** through development and strengthening of laboratory infrastructure, public private partnerships in the delivery of TB services and expanded institutional and community DOTS services.

- **Detect, treat and prevent Drug resistant TB:** through surveillance, development of culture and DST capability for first line anti-TB drugs, and programmatic management of drug resistant TB cases as part of routine NTP activities

- **Scale up TB/HIV collaborative activities:** especially HIV testing among TB patients, Co-trimoxazole and other preventive therapy, and ART for eligible dually infected persons

- **Address Health Systems Components** that affect TB Control (laboratory networks, personnel, surveillance, supply systems and monitoring and evaluation.

Key Recommendations:

The following recommendations are made:

ix. All countries to periodically review their TB Control performance with regard to the WHA, MDG and Abuja targets and develop strategies to accelerate their attainment

x. Member states to decentralize and strengthen TB laboratory services in the public and private sectors to improve case detection and ensure quality assured laboratory services in pursuit of Universal Access to such services.

xi. The African Union to advocate with national governments in the 10 countries without local capability for TB culture and drug susceptibility testing for first line anti-TB drugs to establish this capacity in order to facilitate diagnosis and treatment of MDR-TB cases

xii. National TB Control Programmes to prioritize implementation of strategies to expand DOTS diagnosis and treatment services with a view to rapidly move towards the WHA, MDG, Abuja and Regional Committee targets for treatment success and case detection. This includes strengthening the capacity of the Health Systems to suspect and diagnose Tuberculosis, and to reduce treatment failures, treatment defaulters and transfer outs.

xiii. All countries with generalized HIV epidemic (5% or higher) in the general population to programme and implement in full the Regional Strategy for controlling TB-HIV with particular emphasis on universal access to HIV testing for TB patients, ART for eligible HIV positive patients and other interventions to reduce the burden of TB on People Living with HIV & AIDS, and reduce the burden of HIV &AIDS on dually infected TB patients.

xiv. Member states to allocate sufficient resources to ensure uninterrupted supply of first line anti-TB drugs at central and peripheral levels, including adequate buffer stocks at the various levels.

xv. For drug resistant TB cases, national programmes to determine the burden of MDR-TB and initiate treatment programmes for all confirmed cases. National programmes should also mobilize sufficient quality assured second line drugs including concessionary priced drugs through the Stop TB Partnership Green Light Committee

xvi. Member states to respect the pledge to allocate at least 15% of the national budget to health development and allocate a sufficient amount of that for delivery for TB control interventions. Further, Member States to timely expend approved GFATM grants and submit proposals for more funding to meet funding gaps for scale up of activities towards universal access.

STATUS REPORT ON TUBERCULOSIS IN AFRICA

1: BACKGROUND:

1.1 TB CONTROL TARGETS:

1.1.1 World Health Assembly target:

In 1991, all WHO member states adopted a World Health Assembly (WHA) resolution[16] setting two targets for global TB control to be reached by 2000: ***to detect 70% of new smear-positive TB cases arising annually, and to successfully treat 85% of these cases***. When it became apparent that the year 2000 targets would not be met on time, the WHA postponed the target date to 2005. By 2005 only a small number of countries had attained the targets. Nevertheless, the WHA recommended that all countries continue pursuing these operational targets as they are essential to achieve impact on TB epidemiology.

1.1.2 Millennium Development Goal targets and indicators for TB Control:

Responding to the world's main development challenges, World leaders established in 2000 the Millennium Development Goals with targets and indicators for 2015. MDG number 6, namely: Combat HIV/AIDS, malaria and other diseases includes TB. The target is “To have halted by 2015 and begun to reverse the incidence of malaria and other major diseases”. Two related TB specific indicators have been specified:

- Incidence, prevalence and death rates associated with tuberculosis
- Proportion of tuberculosis cases detected and cured under DOTS. This is similar to the WHA and Stop TB Partnership targets

1.1.3: Stop TB Partnership targets:

To operationalise the WHA and the MDGs targets, the Stop TB Partnership defined a quantitative framework for measuring reduction in TB prevalence and death rates. In addition, the Stop TB Partnership committed to eliminate TB as a public health problem by 2050. Three targets were set, namely:

[16] World Health Organization. Forty-Fourth World Health Assembly. Resolution WHA44.8. Geneva World Health Organization 1991. Report No.: WHA44/1991/REC/1

- *At least 70% of people with sputum-smear positive TB will be diagnosed and at least 85% cured by 2005. These are similar to the targets set by the WHA.*
- *By 2015, the global burden of TB (per capita prevalence and death rates) will be reduced by 50% relative to 1990 levels.*
- *The global incidence of TB disease will be less than 1 case per million population per year (definition for TB elimination) by 2050.*

1.1.4: Abuja Declaration and Plan of Action on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (ORID) [17]

In April 2001, the African Heads of State and Government met in Abuja at a special summit of the Organisation of African Unity (OAU) devoted specifically to address the exceptional challenges of HIV/AIDS, Tuberculosis (TB) and Other Related Infectious Diseases (ORID). At the end of the Summit, a Declaration was adopted that, among others, pledging to set a ***target of allocating 15% of national budgets to the improvement of the health secto***r, and that an appropriate and adequate portion of this amount is put at the disposal of authorities for the fight against HIV/AIDS, TB and ORID.

1.1.5: Declaration of TB as an Emergency in the African Region

In August 2005, recalling Resolution AFR/RC44/R6 of September 1994 on implementation of Short Course Chemotherapy by TB Control Programmes in the region; noting the increasing national and international commitments to fight AIDS, tuberculosis and malaria; and noting the increasing financial resources made available, among others, by the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Stop TB Partnership and bilateral partners; and convinced that unless extraordinary actions are undertaken to address the current trend the TB epidemic would only get worse; the 55th session of the Regional Committee of Ministers of Health of the WHO African Region declared TB an emergency in the Region[18] and called for urgent and extra-ordinary actions to rapidly bring the TB epidemic under control. Among other actions, the resolution requested Member States to:

- develop and implement with immediate effect emergency strategies and plans to control the worsening tuberculosis epidemic;
- rapidly improve tuberculosis case detection and treatment success-rates; and
- accelerate implementation of interventions to combat the TB/HIV epidemic, including increased access to ARVs by doubly-infected patients;

[17] African Summit on HIV/AIDS, Tuberculosis and other related infectious diseases. Abuja Nigeria. 24-27 April 2001. OAU/SPS/ABUJA/3

[18] Resolution AFR/RC55/R5, 25August 2005

1.1.6: Special Summit on HIV/AIDS, Tuberculosis and Malaria[19]

In May 2006, Heads of State and Government of the African Union, held a Special Summit on HIV/AIDS, Tuberculosis and Malaria, to review the status of implementation of Declarations and Frameworks for Action on the 2000 Abuja Summit on Roll Back Malaria, and the 2001 Abuja Summit on HIV/AIDS, TB and ORID. During the summit, the Heads of Sate and Government adopted the "Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, Tuberculosis and Malaria services"[20].

The Call collectively resolved dedication to a comprehensive remedial effort anchored on an implementation mechanism that addresses the following program areas:

i: Leadership at National, Regional and Continental Levels
ii: Resource mobilisation
iii: Protection of Human Rights
iv: Poverty Reduction, Health and Development
v: Strengthening Health Systems
vi: Prevention, Treatment , Care and Support
vii: Access to Affordable Medicines and Technologies
viii: Research and Development
ix: Implementation at national level
x: Partnerships
xi: Monitoring , Evaluation and Reporting

1.1.7 The 2007 WHO Regional Committee addresses TB and HIV

Noting that tuberculosis cases have more than trebled in many countries over the past 10 years, especially where HIV prevalence is high and recognizing the public health importance of the two epidemics, the 57th session of the Regional Committee for the African meeting in Brazzaville in August 2007 adopted a resolution calling for further strengthened and improved mechanisms of collaboration between the Tuberculosis and AIDS Control Programmes in order to increase prevention, case finding and treatment of TB among PLWHA, improve access to HIV Testing and Counselling among TB patients and infection control to reduce transmission.

2: Monitoring, Evaluation and Reporting mechanisms for the Call

The Third Session of the African Union Conference on Ministers of Health, held from 10-14 April 2007 in Johannesburg, South Africa, agreed on a Monitoring and Reporting Mechanism for the Implementation of the 2006 Abuja Commitments on HIV/AIDS, Tuberculosis and Malaria (ATM) services

[19] Special Summit of African Union on HIV and AIDS, Tuberculosis and Malaria (ATM). Abuja, Nigeria. 2-4 May, 2006. Sp/Assembly/ATM/2(I). Rev 3
[20] Abuja Call for Accelerated Action towards Universal Access to HIV and AIDS, Tuberculosis and Malaria services in Africa. Sp/Assembly/ATM/2(I). Rev 3

for the period 2007-2010[21]. The framework is based on the programme areas agreed by the Heads of State and Government as outlined in section 1.1.5.

2.1: Abuja targets to be met by a United Africa by 2010

Within the agreed monitoring and evaluation Framework for the implementation of the Abuja Call, Member States will intensify the fight against the three diseases and achieve other internationally agreed goals.

In addition to the WHA, MDG, Stop TB Partnership and Abuja 2001 targets outlined in sections 1.1.1-1.1.4[22], the Summit set the following Tuberculosis related specific targets to be achieved by a United Africa by 2010:

- *100% of TB patients have access to HIV Testing and counselling services*
- *100% of eligible HIV positive TB patients access anti-retroviral treatment*

3: Operating Definitions[23]:

3.1 Patient classification and categorisation

3.1.1 A case of tuberculosis: A patient in whom TB has been bacteriologically confirmed, or has been diagnosed by a clinician.

3.1.2 Pulmonary tuberculosis: Bacteriologically confirmed TB of the lungs (definite TB case**)** or a case of pulmonary tuberculosis that does not meet the bacteriological confirmation criteria but has at least two sputum smears negative for TB bacilli, no response to a course of broad spectrum antibiotics among those not used in the treatment of TB, radiological abnormalities consistent with active pulmonary TB, and a decision by a clinician to treat with a full course of anti-tuberculosis chemotherapy.

3.1.3 Extra-pulmonary tuberculosis: Tuberculosis of organs other than the lungs for example the pleura of the lungs, lymph nodes, abdomen, genitor-urinary tract, skin, joints and bones, brain meninges, etc. Diagnosis is based on at least one culture-positive specimen, or histological or strong clinical evidence consistent with extra-pulmonary tuberculosis, followed by a decision by a clinician to treat with a full course of anti-tuberculosis chemotherapy. A patient diagnosed with both pulmonary and extra-pulmonary TB is classified as a case of pulmonary TB.

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[21] Strengthening of Health Systems for Equity and Development in Africa. Third session of the African Union Conference of Ministers of Health, Johannesburg South Africa. CAMN/MIN/9 (III)

[22] to detect 70% of new smear-positive TB cases arising annually, and to successfully treat 85% of these cases; to have halted by 2015 and begun to reverse the incidence of malaria and other major diseases; and WHA and MDG targets plus reducing per capita prevalence and death rates by 50% relative to 1990 levels, and reducing TB incidence to les than one case per million population per year by 2050

[23] Adapted from Global tuberculosis control: Surveillance, planning, financing: WHO report 2008. WHO/HTM/TB/2008.393

3.1.4 New TB case: A patient who has never been treated with anti-TB medicines before or who has previously taken anti-tuberculosis treatment for less than one month.

3.1.5 Relapse case: A patient previously treated for TB who was declared cured or treatment completed, but is diagnosed with bacteriologically confirmed TB again.

3.1.6 Treatment after Failure: A TB patient who is started on re-treatment anti-TB regimen after having failed on a previous treatment regimen.

3.1.7 Treatment after default: A TB patient who returns for treatment with positive bacteriology, following interruption of treatment for two months or more.

3.1.8 Other: All cases which do not fit the above standard definitions.

3.1.9 *Case detection rate*: proportion of identified TB cases relative to estimated existing cases in a referent population. Diagnosis is mainly among adults through sputum smear microscopy, culture or any other WHO recommended test for the diagnosis of TB.

3.2 Treatment outcomes of bacteriologically confirmed pulmonary TB patients:

3.2.1 Cured: A new or re-treatment TB patient who is sputum smear positive at the beginning of treatment and is sputum smear /or culture negative in the last month of treatment and on at least one previous occasion during the course of treatment.

3.2.2 Treatment completed: A patient who has completed treatment but who does not meet the criteria to be classified as a cure or a failure.

3.2.3 Treatment success rate: proportion of TB cases on treatment who are cured, plus those who have completed treatment but have no bacteriological evidence for cure relative to all those smear and or culture positive that started treatment during a specified time cohort.

3.2.4 Treatment Failure: A patient who, while on first line or re-treatment regimen, is bacteriologically positive at 5 months or later during the course of treatment or found to harbour MDR or XDR strain at any point of time during the treatment.

3.2.5 TB death: A known TB patient who dies from any cause whilst still on TB treatment.

3.2.6 Treatment Defaulter: A patient whose treatment was interrupted for two consecutive months or more.

3.2.7 Transfer out: A patient who has been transferred to another recording and reporting unit and for whom the treatment outcome is not known.

3.3 Drug resistant TB

3.3.1 Multidrug resistant TB (MDR-TB): TB caused by a strain resistant to, at least, Isoniazid (H) and Rifampicin ® at the same time.

3.3.2 Extensively drug resistant TB (XDR-TB) : TB caused by a strain that is resistant to at least Rifampicin and Isoniazid (i.e. MDR-TB), plus resistance to any medicine in the fluoroquinolone family such as Ciprofloxacin and Ofloxacin; and also resistance to at least one of the three second line injectable anti-TB drugs such as Capreomycin, Kanamycin and Amikacin.

4: Situation Analysis. Report on TB situation in the WHO African Region

4.1: Leadership at National, Regional and Continental Levels

Since TB was declared an emergency in the African Region, 18 countries[24] declared TB a national emergency /crisis and implemented special action plans to accelerate control.

In August 2007, the 57th session of the Ministers of Health of the African Region adopted a Strategy for control of the TB/HIV dual epidemic that highlights strengthening of mechanisms for collaboration between TB and HIV/AIDS control programmes, improving prevention, case finding and treatment of TB among people living with HIV and AIDS, improving access to HIV testing and counselling among TB patients, infection control to reduce transmission, advocacy, communication and social mobilisation, partnerships and resource mobilisation , and research.

During its 46th Conference, Health Ministers of the East, Central and Southern African (ECSA) health community in March 2008, adopted among others, a resolution on increasing access to medicines and medical supplies that urges all member states to develop and implement national medicines policies by 2009 and review essential drug lists and treatment guidelines at least every two years.

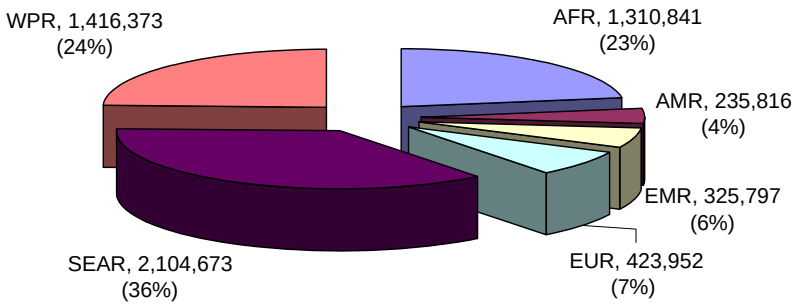
4.2 Prevention, Treatment, Care and Support

4.2.1 Trend of TB Notifications

Absolute TB cases notified in the Region have continued to increase every year. With approximately only 11% of the world population, the Region contributes at over 20% of the global TB burden (Figure 4.21).

Figure 4.2.1: Proportion of notified TB cases by WHO Region. 2006

[24] Botswana, Burkina Faso, Cote d' Ivoire, DRC, Guinea Conakry, Kenya, Lesotho, Malawi, Mali, Mozambique, Namibia, Nigeria, Senegal, Sierra Leone, South Africa , Tanzania, Togo and Zambia



Notification rates (per 100,000 population) for all forms of TB have risen from 82 in 1990 to 160 in 2006. For new smear positive cases, the rates have risen from 19 in 1993 to 72 in 2006. At this rate, the MDG targets relative to 1990 rates are unlikely to be achieved for the entire region (Table 4.2.1).

Table 4.2.1: Trend of TB notification rates by country. African Region

New smear-positive notification rates. African Region 1993–2006														
	Rate (per 100 000 population)													
	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Algeria		25	20	23	26	25	26	27	26	26	27	26	26	26
Angola	42	36	31	63	64	55	54	65	83	123	125	130	127	130
Benin	29	27	30	29	29	29	31	32		31	31	31	32	34
Botswana	101	109	122	158	172	186	161	179	174	188	170	172	173	175
Burkina Faso		6	10	13	10	12	12	13	12	12	13	14	16	19
Burundi	31	25	18	24	32	43	45		44	40	42	43	42	38
Cameroon	17	14	21	16	24	29	38	25	29	48	63	64	73	76
Cape Verde			28	28	25	24			30	23	34	34	27	25
Central African Republic			52	56	63	71	72		35	69	69	71	51	104
Chad			28	12			36			39	38	23	25	
Comoros			17	17	16	15	16	12	13	10	6	8	10	8
Congo		62	72	87	67	67	71	132	131	149	101	117	101	91
Côte d'Ivoire	50		55	58	57	61	60	50	63	62	64	67	67	68
DR Congo	35		46	52	52	69	71	71	81	83	97	109	111	105
Equatorial Guinea			57	53	56	69						86		
Eritrea					4	4	15	16	18	16	21	17	15	14
Ethiopia		10	15	21	25	29	32	44	46	50	53	54	49	45
Gabon		38	46	24	52	78	79		94	84	99	104	81	87
Gambia			67	62	66	70	64			70	68	64	70	73
Ghana		33	15	35	39	40	35	36	37	37	36	33	33	34
Guinea	31	30	31	38	39	43	44	48	49	51	52	57	61	64
Guinea-Bissau			80	75	68	42	53	38		62	64	77	71	63
Kenya	39	43	51	60	66	81	89	92	98	104	113	119	113	107
Lesotho	84	78	79	102	134	136	147	161		164	187	217	216	202
Liberia	75		54	29		44		33	29	61	40	74	63	81

Madagascar	52	54	58	59		63			67	66	73	75	70	81
Malawi	58	60	62	65	72	80	72	71	70	63	61	66	64	60
Mali		20	21	24	35	27	28	25		26	28	27	30	32
Mauritania			93		107	48	82	62				58	39	49
Mauritius			10	9	10	9	10	10	7	7	8	10	9	7
Mozambique	64	63	66	64	66	70	72	73	75	80	82	85	87	87
Namibia			42	167	184	200	204	213	237	241	279	259	259	262
Niger	5	21	16		35	31	25	27	30	29	36	34	38	38
Nigeria	2		9	10	10	11	13	14	18	17	21	24	25	28
Rwanda			33	35	44	63	56	45	38	45	52	46	45	45
Sao Tome & Principe							22	21	29	29	22	33	32	23
Senegal		52	60	64	57	56	50	56	57	53	59	56	57	
Seychelles	3		8	14	17	11	12	14	15	11	6	15	9	
Sierra Leone		34	35	54	54	53		55	57	60	60	69	78	81
South Africa			56	99	125	150	161	167	182	212	247	266	262	272
Swaziland			69	228			171	172	119	129	144	171	194	224
Togo	13		20	20	19	18	17	18		21	22	26	29	33
Uganda	60	72	64	70	76	78	77	70	68	73	75	75	71	68
UR Tanzania	55	59	67	70	70	74	73	71	71	68	68	69	66	63
Zambia		107	108	127			114	124	122	150	171	153	129	120
Zimbabwe	47		76	100	119	117	115	114	120	124	112	112	100	96
AFR	**19**	**21**	**36**	**44**	**45**	**51**	**54**	**54**	**59**	**65**	**71**	**75**	**73**	**72**

The increasing absolute notifications and rates notwithstanding, there is a tendency towards stabilization of overall rates and decline in new smear positive case notification rates since 2004 (Figure 4.2.2). These findings are consistent with apparent decline in TB cases globally[25].

4.2.2: Estimated Prevalence, incidence and death rates

Relative to MDG targets and basing on 1990 baseline as stipulated in the Stop TB Partnership operationalisation of the MDG targets, estimated regional TB prevalence, incidence and mortality rates have increased and are unlikely to be achieved by 2015 based on current trends (Figure 4.2.2)

However, according to the WHO Global TB Report for 2008, by the end of 2006, six countries[26] had already halted and started to reverse overall and smear positive TB incidence as specified in the core MDG targets.

A further 6 countries[27] had already halted and started to reverse estimated TB prevalence, while four countries, namely, Angola, Comoros, Sao Tome & Principe and Seychelles had already halted and started to reverse death rates (Table 4.2.2)

[25] WHO Global TB Report, 2008
[26] Comoros, Ghana, Mali, Mauritius, Sao Tome & Principe and Seychelles
[27] Angola, Benin, Cape Verde, Eritrea, Guinea Bissau and Niger

Figure 4.2.2: Trend of notification rates for total and smear positive cases, and absolute rate change for total cases. African Region 1990-2006

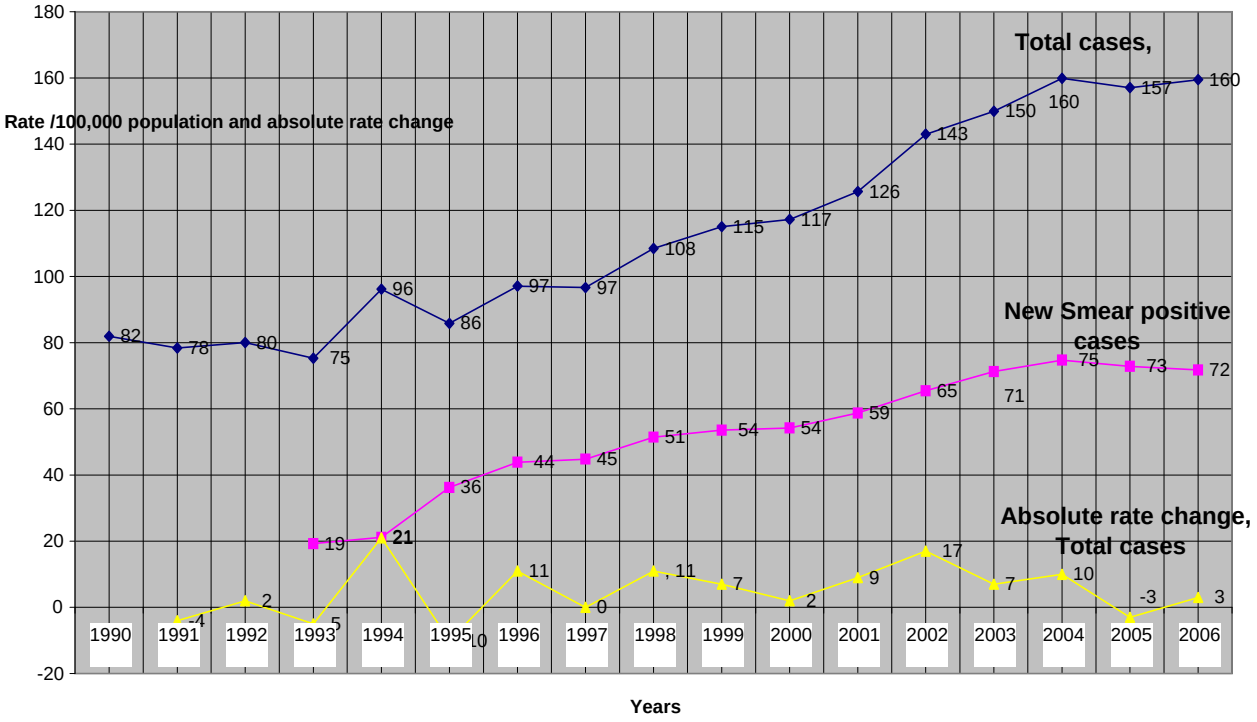


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Figure 4.2.2: Estimated TB prevalence, Incidence and death rates. African Region 1990-2006

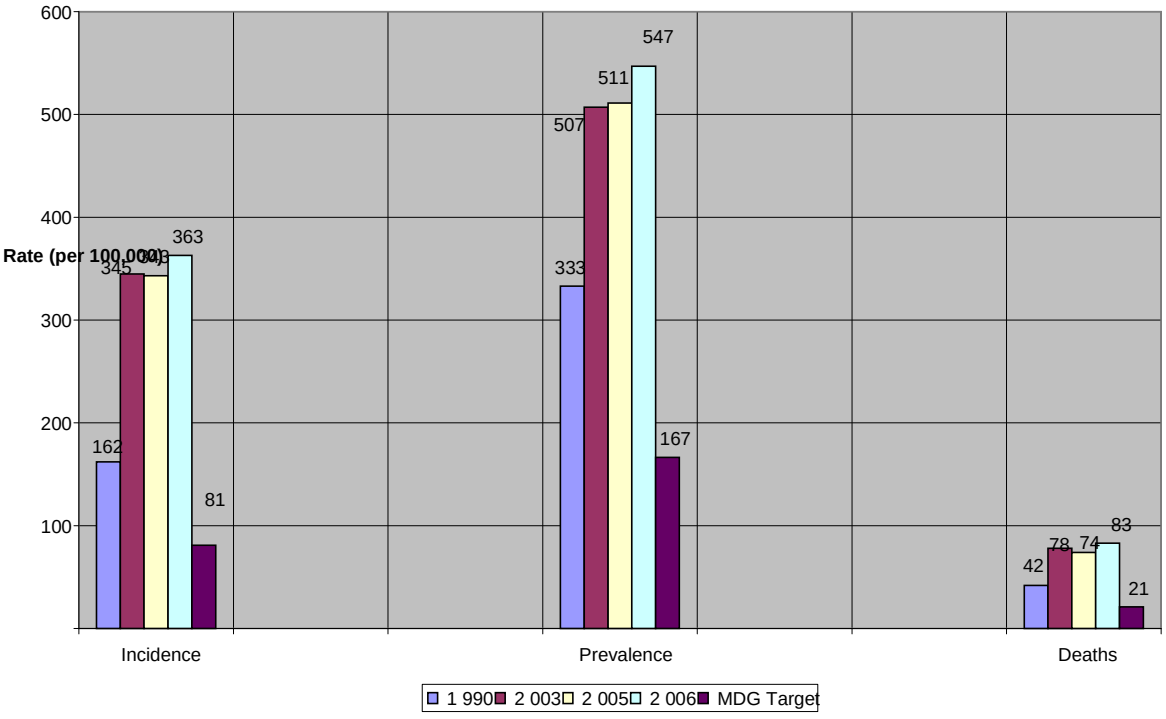


Table 4.2.2: ***Estimated Prevalence, Incidence and Mortality Rates (per 100,000)***

Associated with TB (Source: WHO TB Global Report 2008)

Country	Prevalence		Incidence				Mortality	
	All Forms		All Forms		Smear +ve		All Forms	
	1990	2006	1990	2006	1990	2006	1990	2006
Algeria	44	56	37	56	17	25	2	2
Angola	514	344	203	285	91	127	58	29
Benin	140	135	77	90	34	39	15	18
Botswana	294	454	240	551	98	218	34	91
Burkina Faso	337	476	159	248	69	108	50	71
Burundi	307	714	147	367	64	162	38	91
Cameroon	193	237	77	192	34	83	22	29
Cape Verde	413	324	162	168	73	76	46	36
Central African Republic	336	528	138	345	60	149	40	80
Chad	254	570	119	299	53	131	29	76
Comoros	186	86	85	44	38	20	15	7
Congo	251	566	161	403	70	177	36	80
Cote d'Ivoire	330	747	168	420	73	183	40	105
DR Congo	266	645	156	392	69	173	35	84
Equatorial Guinea	176	404	102	256	45	112	19	54
Eritrea	231	218	72	94	32	42	20	22
Ethiopia	307	641	151	378	67	168	37	83
Gabon	383	428	153	354	68	152	44	69
Gambia	347	423	183	257	82	114	38	53
Ghana	532	379	224	203	99	90	60	48
Guinea	254	466	122	265	55	118	29	56
Guinea-Bissau	403	313	156	219	70	97	39	40
Kenya	133	334	116	384	45	153	29	72
Lesotho	254	513	184	635	77	255	30	88
Liberia	333	578	132	331	59	147	37	70
Madagascar	365	415	176	248	79	111	38	45
Malawi	321	322	258	377	99	143	75	111
Mali	715	578	302	280	135	124	80	69
Mauritania	576	606	225	316	101	142	63	71
Mauritius	50	40	26	23	12	10	4	4
Mozambique	298	624	177	443	77	186	36	117
Namibia	674	658	306	767	132	316	75	96
Niger	315	314	124	174	55	78	35	36
Nigeria	278	615	124	311	55	137	32	81
Rwanda	201	562	159	397	62	162	62	128
Sao Tome & Principe	345	252	135	103	61	46	38	26
Senegal	378	504	192	270	86	121	42	58
Seychelles	113	56	43	33	20	15	9	5
Sierra Leone	491	977	214	517	96	230	55	119
South Africa	774	998	301	940	130	382	78	218
Swaziland	665	1,084	267	1,155	113	458	76	278
Togo	775	787	327	389	145	171	89	105
Uganda	296	561	163	355	69	154	56	84
UR Tanzania	270	459	178	312	77	135	36	66
Zambia	636	568	297	553	123	228	100	102
Zimbabwe	246	597	136	557	54	227	47	131
AFR	**333**	**547**	**162**	**363**	**70**	**155**	**42**	**83**

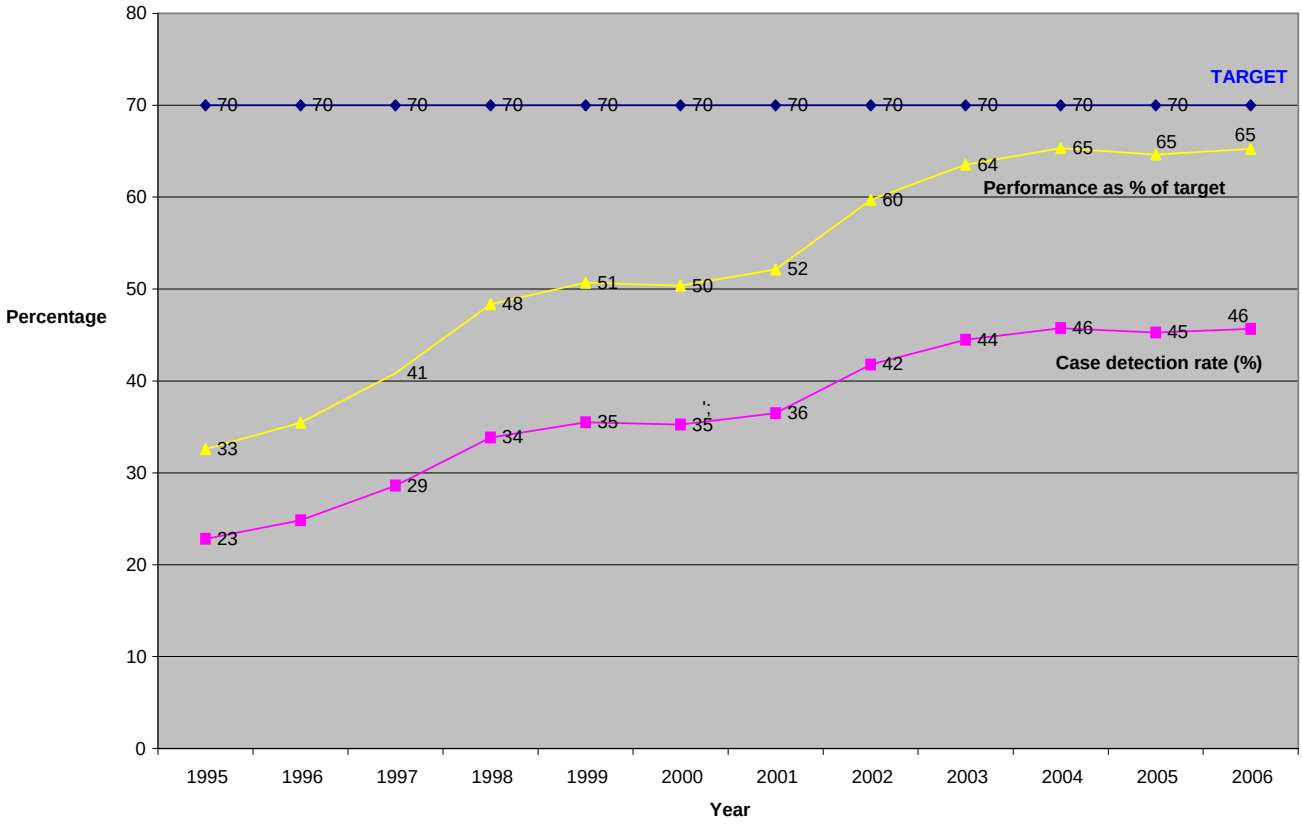
4.2.3: Status of case detection and treatment success rates

Based on the WHO TB Global Report 2008, as of end 2006, 10 countries[28] had met the World Health Assembly target of 70% case-detection rate, and 8 countries[29] had achieved the 85% treatment-success rate. Only 2 countries (Algeria and Benin) had met both targets (Table 4.2.3).

a): Case detection rates:

At 46%, new smear positive case detection rate for the African Region is still far below the 70% target set by the WHA, MDGs and the AU Heads of state and Government Call for Universal Access. While increasing overtime during the past five years (Figure 4.2.3 (a)), the region is only achieving 65% of the target.

Figure 4.2.3(a): Trend of case detection rate and percentage of target



b): Treatment Success Rates

At 76%, the treatment success rate (89% of target) for the 2005 new smear positive patient cohort falls short of the WHA, MDG, Stop TB Partnership and AU UA targets. Only eight countries from the African Region[30] have reached the target. This compares to two countries in 2001, three countries in 2002,

[28] Algeria, Angola, Benin, Botswana, Cameroon, Kenya, Lesotho, Madagascar, Namibia, and South Africa
[29] Algeria, Benin, Comoros, DR Congo, Eritrea, Gambia, Mauritius and Sierra Leone
[30] Algeria, Benin, Democratic Republic of Congo, Eritrea, Gambia, Mauritius and Sierra Leone

four countries in 2003, and eight countries in 2004. A further four countries[31] have attained treatment success rate of 80% and above but below 85%. However, treatment success rate has been increasing gradually since 1999 (Figure 4.2.3(b)).

Figure 4.2.3(b): Trend of treatment success rate and percentage of expected target. African Region 1994-2005

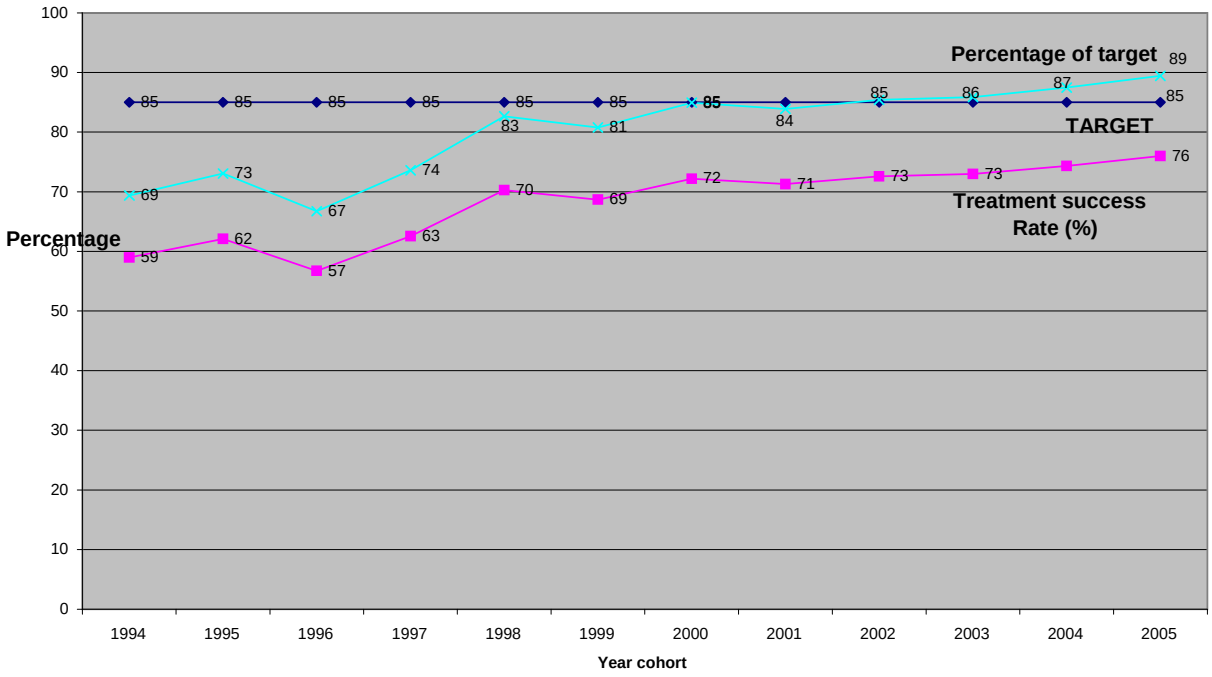


Table 4.2.3: Proportion of New smear positive TB cases Detected and Cured under DOTS

Country	Case Detection Rate (%) (70% target)			Treatment Success Rate (%) (85% target)		
	1995	**2000**	**2006**	1995	2000	2005
Algeria	-	126	102	-	87	87
Angola	-	-	76	-	68	72
Benin	83	86	86	73	-	87
Botswana	73	75	80	67	77	70
Burkina Faso	11	17	17	25	60	71
Burundi	19	-	24	45	80	78
Cameroon	-	31	91	-	77	74
Cape Verde	-	-	33	-	-	64
Central African Republic	-	-	69	37	57	65
Chad	36	-	-	47	-	-
Comoros	54	49	42	90	93	91
Congo	69	86	51	-	69	28
Cote d'Ivoire	50	32	37	68	-	75
DR Congo	41	48	61	80	78	85
Equatorial Guinea	85	-	-	89	-	-
Eritrea	-	42	35	-	76	88
Ethiopia	15	30	27	61	80	78
Gabon	-	-	58	-	-	46

[31] Kenya, Rwanda, United Republic of Tanzania and Zambia

Gambia	74	-	64	76	-	87
Ghana	15	37	38	54	50	73
Guinea	44	54	55	78	68	72
Guinea-Bissau	-	45	64	-	-	69
Kenya	57	51	70	75	80	82
Lesotho	59	72	79	47	-	73
Liberia	-	26	55	79	80	76
Madagascar	52	-	73	55	70	74
Malawi	42	44	42	71	73	73
Mali	16	17	26	59	-	75
Mauritania	-	-	34	-	-	55
Mauritius	89	90	67	-	93	86
Mozambique	57	45	47	39	75	79
Namibia	21	77	83	-	56	75
Niger	-	40	49	-	65	74
Nigeria	11	12	20	49	79	75
Rwanda	35	33	27	-	61	83
Sao Tome & Principe	-	-	-	-	-	-
Senegal	62	53	-	44	52	-
Seychelles	-	83	-	89	82	-
Sierra Leone	28	33	35	69	77	86
South Africa	-	58	71	-	66	71
Swaziland	-	-	49	-	-	42
Togo	13	11	19	60	-	71
Uganda	-	48	44	-	63	73
UR Tanzania	57	49	46	73	78	82
Zambia	-	-	53	-	-	84
Zimbabwe	-	45	42	-	69	68
AFR	**23**	**35**	**46**	62	72	76

4.2.4: Prevalence of Drug Resistant TB

Drug resistant TB constitutes a silent component of the TB epidemic in the region. Until an outbreak of XDR-TB was reported in early 2006, little attention was being paid to identification and treatment of drug resistant TB, even though evidence shows that it exists everywhere it has been surveyed for.

Regular case notification initiated in 2007 yielded 8,474 MDR-TB cases from 28 countries. Four countries, namely, Botswana (2 cases), Lesotho (1 case), Mozambique (1 case) and South Africa (536) also reported 541 XDR-TB cases. By the end of 2007, there were still 10 Member States without facilities for TB culture and drug susceptibility Testing, constituting 78.3% coverage with culture and drug susceptibility testing coverage by country. Table 4.2.4 shows MDR-TB cases notified by country during 2007, and countries' status of treatment programmes for MDR/XDR-TB as of January 2008.

Table 4.2.4: Notified MDR-TB cases January-December 2007, and status of treatment programmes

Country	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Total	Status of treatment programme
Algeria														Present, Govt supported
Angola						2							2	None, ad hoc
Benin	0	0	3	0	0	1	1	0	1	0	0	0	6	Present, Govt supported
Botswana			9	0	1	12	11	7	9	2	20	28	99	Present, Govt supported
Burkina Faso														Present, GLC supported
Burundi	4	4	2	2	3	2	2	1	4	1	4	2	31	None, ad hoc
Cameroon	2	7	2	2	1	2	3	0	3	1	0	5	28	None, ad hoc
Cape Verde														No C & S lab
CAR						5							5	None, ad hoc
Chad														No C & S lab
Comoros														No C & S lab
Congo Brazzaville														No C & S lab
Cote d'Ivoire	0	2	1	4	1	6	0	0	0	6	1	0	21	None, ad hoc
DRC	10	8	14	17	20	15	22	11	16	11	4	7	155	Present, GLC supported
Ethiopia	14	10	12	14	14	9	19	12	14	10	9	8	145	None, ad hoc
Eritrea														No C & S lab
Equatorial Guinea														None, ad hoc
Gabon														No C & S lab
Gambia														None, ad hoc

Ghana														None, ad hoc
Guinea Conakry														Present, GLC supported
Guinea Bissau														No C & S lab
Kenya	**5**	**7**	**7**	**9**	**7**	**9**	**9**	**8**	**3**	**9**	**4**		**77**	Being set up, GLC supported
Lesotho							**2**	**17**	**1**	**17**	**5**	**4**	**46**	Being set up, GLC
Liberia														No C & S lab
Madagascar	**0**	**0**	**0**	**0**	**2**	**1**	**0**	**0**	**0**	**0**	**3**	**0**	**6**	None. Ad hoc
Malawi						**1**							**1**	None, ad hoc
Mali	**2**	**2**	**1**	**0**	**1**	**1**	**1**	**4**	**1**	**0**	**0**	**0**	**13**	Starting, KNCV & Gvt
Mauritania					**3**			**3**					**6**	None
Mauritius														None, Ad hoc
Mozambique	**10**	**12**	**9**	**9**	**7**	**27**	**13**	**15**	**6**	**36**	**16**	**3**	**163**	Present, GLC supported
Namibia													**150**	Present, Govt supported
Niger	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**2**	None, ad hoc
Nigeria	**1**	**0**	**2**	**0**	**5**	**1**	**1**	**2**	**1**	**0**	**1**	**2**	**16**	None. Ad hoc
Rwanda	**6**	**9**	**12**	**6**	**12**	**13**	**8**	**5**	**13**	**9**	**4**	**8**	**105**	Present, GLC supported
Sao Tome						**1**							**1**	No C & S lab
Senegal						**9**							**9**	None, ad hoc
Seychelles														None, ad hoc
Sierra Leone														None, ad hoc, NO DST
South Africa	**611**	**546**	**671**	**529**	**769**	**748**	**466**	**594**	**722**	**739**	**460**	**514**	**7369**	Present, Gvt supported
Swaziland												**67**	**67**	Present, Gvt supported
Togo													**0**	None, ad hoc
Tanzania						**8**							**8**	Being set up, GLC pre-approval stage
Uganda												**67**	**67**	Present, GLC supported
Zambia	**3**	**0**	**4**	**10**	**1**	**0**	**0**	**1**	**0**	**0**	**2**	**5**	**26**	Present, Gvt supported
Zimbabwe														None, ad hoc
AFR	**668**	**607**	**750**	**602**	**847**	**873**	**558**	**680**	**795**	**841**	**533**	**720**	**8624**	

4.2.5: Status of implementation of TB/HIV Interventions

The key Abuja special Summit targets for TB/HIV interventions are to test 100% of TB patients for HIV and commencing 100% of eligible co-infected TB patients on ART. During 2006, only 22% of notified cases (287,945 TB cases) were tested for HIV, 150,739 (52.3%) of which tested positive. This compares to 11.2% and 52.0% respectively for 2005. By country,

Of those who tested positive, 37.1% were started on Anti-Retroviral Therapy (ART), increasing from 27.3% in 2005 but still far short of the 100% target. At this rate, the region is unlikely to reach the 100% target by 2010 set by the special summit.

However, 11 countries[32] recorded ART coverage of 30% and above, ranging from 30.8% in Rwanda to 56.9% in Malawi. Zambia with the highest coverage in 2005, recorded a 44.3% decline in coverage during 2006. Furthermore, 89.1% were started on Co-trimoxazole preventive therapy (CPT), a 23.4% increase compared to a figure of 72.2% for 2005. Based on this trend, it is likely that 100% coverage with this intervention could be achieved by 2010. At this rate, Universal access to CPT is likely to be achieved by 2010. Table 4.2.5 shows coverage for the three interventions by country for 2005 and 2006.

Table 4.2.5: Status of implementation of key TB-HIV interventions. African Region 2005 and 2006

	Total cases notified		Proportion (%) of notified cases tested for HIV		Proportion of tested cases positive for HIV		Proportion (%) HIV positive put on CPT		Proportion (%) HIV positive put on ART	
Country	2005	2006	2005	2006	2005	2006	2005	2006	2005	2006
Algeria	21336	21263								
Angola	38317	54699								
Benin	3,457	3734	23	88.9	13.8	14.9	0	68.2	0	43.1
Botswana	10,228	8,519	22.4	53.8	79.8	71.1	0	0	0	0
Burkina Faso	3,659	4,248	33.2	33.2	46.1	50.8	67.8	65.7	32.4	26.9
Burundi	6627	6176	0	0						
Cameroon	22,073	24879	0	34.7		38.9		0		0
Cape Verde	305	276	97.7	97.8	4.7	3	0	100	100	0
Central African Republic	3411	6375	0	0						
Chad	6505		0							
Comoros	112	116	100	100	1.8	1.7	100	0	100	0
Congo	9959	8600	0	0						
Côte d'Ivoire	20,026	21,145	20.4	27.5	38	36.7	38	55.6	13.9	46.7
DR Congo	99,558	98,139	1.9	1.3	20.5	14.3	73.6	90.4	0.8	54.3
Equatorial Guinea										
Eritrea	3612	3136	0	0						
Ethiopia	125,135	123,009	2.6	2.6	41.1	39.8	88.3	85.6	29.4	27.3
Gabon	2611	3206	7.1	20.1	100	100	100	100	0	0
Gambia	2120	1881	0	29.2		25.8		0		16.2
Ghana	12,124	12511	7	17.1	40.3	33.3	100	68.2	36.8	13.9
Guinea	7090	9076	0	0						
Guinea-Bissau	1816	2161	11	7	55	56.3	100	100	30	50.6
Kenya	108,401	115,234	14.4	60.1	57.2	52	44	141.2	17.3	42.9
Lesotho	10,802	13368	1.4	18.8	81.4	88.6	78.7	56.2	0	8.6
Liberia	3456	4514	3.3	15.2	12.3	14.7	0	0	0	0

[32] Benin, Cote D'Ivoire, DRC, Guinea Bissua, Kenya, Malawi, Mauritius, Mozambique, Rwanda, South Africa and Zambia

Madagascar	19475	22,517	9	0	0.9		0		0	
Malawi	27,610	27,011	44.3	63.9	69	69.9	91.7	93.2	49.2	56.9
Mali	4877	5224	0	9.2		14.6		0		0
Mauritania	2218	2766	0.5	0	0					
Mauritius	127	115	90.6	87	1.7	5	100	80	50	80
Mozambique	33,718	35632	0	24.2		70.4		17.4		45.9
Namibia	15894	15,771	16	0	57.5		0		0	
Niger	8224	8755	0	0			42.8		34.2	
Nigeria	66,848	74,225	10.3	10.1	18	20.7	0	0	0	0
Rwanda	7,680	8,283	65.1	76.1	45.5	40.7	15.3	43.9	12.8	30.8
Sao Tome & Principe	142	153	100	100	3.5	2	0	0	0	0
Senegal	10120		0							
Seychelles	14		0				100		100	
Sierra Leone	6,930	8208	0	15		8.5		100		0
South Africa	302,467	341,165	22.5	32.3	51.9	52.8	100	97.9	33	40.1
Swaziland	8,864	9195	0	20.1		79.9		87.9		19.4
Togo	2636	2924	0	0						
Uganda	41,809	41,579	25.2	26	71.3	58.9	25.1	23.2	10.1	7.9
UR Tanzania	64,200	62,100	2.5	11.5	52.1	50.5	61.1	56.9	22.4	25.9
Zambia	53,267	51,179	2	22.6	56.7	62.2	0	30.6	68.1	37.9
Zimbabwe	54891	47774	0	0						
AFR	1,254,751	1 310 841	11.2	22	52	52.3	72.2	89.1	27.3	37.1

Based on these figures, the proportion of TB cases tested for HIV had doubled between 2005 and 2006 but falls far below the Universal Access target of 100%.

By country, only Comoros and Sao Tome and Principe had achieved the target in both years. Cape Verde and Mauritius consistently tested over 80% of notified cases and should easily reach the set target by 2010. Benin, Botswana, Ethiopia, Kenya, Malawi and Rwanda are also making sufficient progress from year to year to reach the target by 2010.

4.3: Access to essential anti-TB medicines

Uninterrupted supply of first line anti-TB medicines is a basic requirement for effective DOTS based TB Control Programmes. With the set up of the Global Drug Facility (GDF) for access to free quality anti-TB first line drugs to all DOTS based programmes with a GNP of less than 3,000 USD, the availability of first line anti-TB drugs has improved tremendously. By the end of December 2007, all 36 eligible countries from the region that applied to the GDF secured 3 year first line anti-TB drug grants, including pediatric formulations for some countries.

Notwithstanding, latest available information[33] indicates that only 69% of 42 countries that submitted reports had uninterrupted supply of first line anti-TB drugs at both the central and peripheral levels during 2006, while 92.8% had uninterrupted supply at peripheral level. Since implementation is mostly at peripheral level, approximately 7.2% of countries ran out of drugs at some point, thereby limiting access to these. This is a significant short fall with regard to Universal Access to essential TB treatment.

[33] WHO Global TB Report 2008

For the treatment of drug resistant TB, of the 26 countries that reported at least a case of MDR or XDR-TB during 2007, only 17 countries (65.4%) have an organized treatment programme. Even then, except for those supported through the GLC, not all patients have access to second line anti-TB drugs. As of January 2008, only 9 countries[34] had applied and been approved to access concessionary priced second line drugs from the Green Light Committee (GLC) of the Stop TB Partnership. This facility is available to all DOTS based TB Control programmes and should be utilized more widely than is currently the case considering the wide spread existence especially of MDR-TB cases.

4.4: Resource Mobilization

4.4.1 National financing of TB services

During 2006, 39 of the 46 Member States (84.7%) % provided information on Financing TB Control[35]. These countries represent 93% of estimated TB incidence in the Region for that year. TB specific disaggregated data mobilized at national level is however not readily available as most programmes are implemented within primary health care services.

WHO has since developed a planning and budgeting tool that is designed to help countries align their strategic plans and budgets with all the elements of the new Stop TB Strategy. During 2007, 35 countries in the African Region were introduced to the tool and used it to elaborate programme budgets. This is expected to improve the process of budget estimation and expenditure accountability in the coming years.

4.4.2 External financing of TB services

During the past five years, external funding for TB control activities has increased significantly. The Global Fund to Fight AIDS, TB and Malaria (GFATM) has been the single most important source. During rounds 1-7 from 2002-2007, approximately 953 million USD (37% of total available grants global) was approved for TB Control activities in the African Region. This is the largest proportion, followed only by the West Pacific Region at 430 Million USD (Figure 4.7.1)[36]. Notwithstanding, this has not been marched with spending (Table 4.7.1) and translating into increased case detection and treatment success rates.

[34] Burkina Faso, DRC, Guinea Conakry, Kenya, Lesotho, Mozambique, Rwanda, Tanzania (pre-approval stage) and Uganda
[35] WHO Global TB Control Report 2008
[36] Adopted from WHO Global TB Control Report 2008

Figure 4.7.1: Global Fund funding for TB Control by WHO Region in Million US $. Rounds 1-7

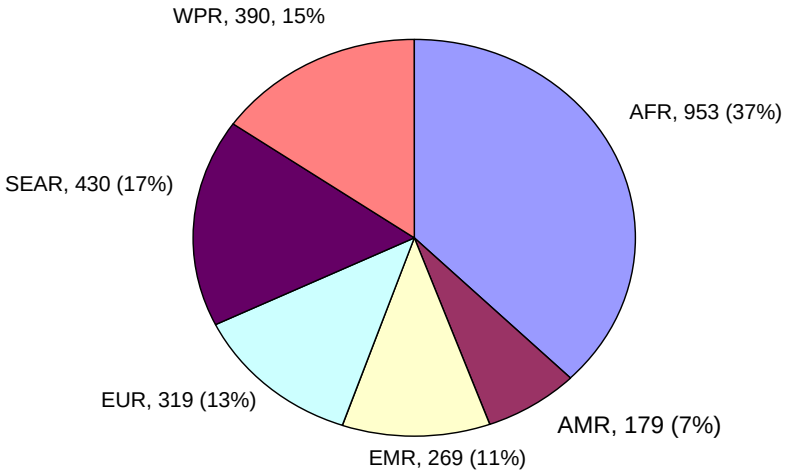


Table 4.7.1. (attached) shows TB and TB/HIV grants from the GFATM for countries in the WHO African Region for 2002-2007

5: Conclusions:

5.1: Leadership at National, Regional and Continental Levels

The 2006 Abuja Call for Universal Access to ATM services by 2010 by a United Africa is the most recent indication of stated ultimate political leadership for TB Control in the Region. It effectively ratifies continental commitment to the World Health Assembly, MDG and Stop TB Partnership targets for TB Control.

It also complements the 2001 Abuja Declaration on HIV/AIDS, Tuberculosis and other related Infectious diseases, the 2005 Declaration of TB as an Emergency in the Region by Ministers of Health of the WHO African Region and subsequent declaration of national emergencies by at least 18 countries, and is itself complemented by subsequent commitments on TB/HIV and related strategies by the declarations of the Ministers of Health of the African Region and various regional economic communities in 2007 and 2008.

The stated commitment not withstanding, national financing of health and TB Control programmes is still insufficient to support requisite scale up towards universal access. To date, the target of “allocating 15% of national budgets to the improvement of the health sector” as stated in the 2001 declaration has only been achieved by a limited number of countries. Furthermore, a later call to allocate 34USD per capita for health is yet to be realised by the majority of countries.

5.2: TB Prevention, Treatment, Care and Support

5.2.1: Estimated Prevalence, incidence and death rates

TB Prevalence and incidence measure the status of the TB epidemic with regard to existing cases and new cases occurring in a defined population at a point in time or during a defined time period. Both are directly linked to programme activity and population coverage with diagnostic and notification services. They are also directly linked to programme performance with regard to ability to successfully cure those with infectious forms of TB. Their trend provides a measure of the burden of tuberculosis on a population. Survey based accurate measures of both prevalence and incidence is the best way to determine this burden. However, these can be time consuming, costly and technically challenging such that they are beyond the routine use of most national programmes, even though they are encouraged where feasible. In the absence of such studies, proxy measures are being used by WHO to estimate prevalence, incidence and death rates.

Estimated TB prevalence, Incidence and death rates have all continued to increase. Absolute notified cases and TB notification rates have also continued to increase at regional level. As a case in point, notification rates as a proxy for TB prevalence have risen from 82 per 100,000 population in 1990 (the Stop TB Partnership set reference year for measuring progress towards the MDG targets) to 160 in 2006. At this rate, the TB control MDG targets for TB incidence and prevalence are unlikely to be achieved at regional level.

However, according to the WHO Global TB Report for 2008, by the end of 2006, six countries[37] had already halted and started to reverse overall and smear positive TB incidence as specified in the core MDG targets (without reference to the 1990 rates as specified by the Stop TB P[partnership operationalisation of the MDG targets). A further 6 countries[38] had already halted and started to reverse estimated TB prevalence, while four countries, namely, Angola, Comoros, Sao Tome & Principe and Seychelles had already halted and started to reverse death rates (Table 4.2.2).

5.2.2: Status of case detection and treatment success rates

Case detection rate:
Case detection is a function of availability of laboratory services to diagnose TB as well as the quality of the services offered. Poorly developed laboratory infrastructure, poor equipment, poor personnel skills, poor technique and poor interpretation skills all contribute to low case detection rates. In the era of HIV/AIDS, an increasing proportion of patients with sputum smear negative TB and extra-pulmonary TB has been observed due to the effect of the co-infection. However, where available, culture and other more specific diagnostic methods exist that correct for this atypical presentation.

[37] Comoros, Ghana, Mali, Mauritius, Sao Tome & Principe and Seychelles
[38] Angola, Benin, Cape Verde, Eritrea, Guinea Bissau and Niger

At 46%, new smear positive case detection rate for the African Region is still significantly below the 70% target set by the WHA, MDGs and the AU Heads of state and Government Call for Universal Access. While increasing overtime during the past five years, the region is only achieving 65% of the target.

However, based on the WHO TB Global Report 2008, as of end 2006, 10 countries[39] had met the World Health Assembly target of 70% case-detection rate, and 8 countries[40] had achieved the 85% treatment-success rate. Only 2 countries (Algeria and Benin) had met both targets (Table 4.2.3).

Treatment Success Rates

The level of cured patients and the treatment success rate measure the effectiveness of a programme to reduce sources of infection in a community. This measure is directly affected by the proportion of patients that fail on treatment (Treatment Failures), default from treatment (Treatment Defaulters) are transferred out to other registration units (Transfer out) or die from any cause while on TB treatment***.***

At 76%, the treatment success rate for the 2005 new smear positive patient cohort represents only 89% of WHA, MDG, Stop TB Partnership and African Union Universal Access targets.

Only eight countries from the Region[41] have reached the treatment success target. This compares to two countries in 2001, three countries in 2002, four countries in 2003, and eight countries in 2004. A further four countries[42] have attained treatment success rate of 80% and above but below 85%.

However, treatment success rates have been increasing progressively since 1999.

5.2.3: Drug Resistant TB

Drug resistant TB is essentially a man made problem arising from causes related to the practice of health care workers or the patient. In the former, inadequate dosage, improper drug combinations, or incorrect duration of treatment are the main causes. In the latter, patient intolerance to some drugs, failures to adhere to treatment or defaulting are the commonest causes.

Available data shoes that drug resistant TB has emerged as a silent element of the TB epidemic in the region. Regular case notification initiated in 2007 yielded 8,624 MDR-TB cases from 28 countries and 541 XDR-TB cases from four countries.

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[39] Algeria, Angola, Benin, Botswana, Cameroon, Kenya, Lesotho, Madagascar, Namibia, and South Africa

[40] Algeria, Benin, Comoros, DR Congo, Eritrea, Gambia, Mauritius and Sierra Leone

[41] Algeria, Benin, Democratic Republic of Congo, Eritrea, Gambia, Mauritius and Sierra Leone

[42] Kenya, Rwanda, United Republic of Tanzania and Zambia

By the end of 2007, there were still 10 Member States without facilities to identify drug resistant TB cases, translating into 78.3% coverage with culture and drug susceptibility testing coverage by country.

Of the 26 countries that reported at least a case of MDR or XDR-TB during 2007, only 17 countries (65.4%) have an organized treatment programme. As of January 2008, only 9 countries[43] had applied and been approved to access concessionary priced second line drugs from the Green Light Committee (GLC) of the Stop TB Partnership. This facility is available to all DOTS based TB Control programmes.

5.2.4: Status of implementation of TB/HIV Interventions

While the increase in notified TB cases in the region is widespread, it is most noticeable where HIV prevalence is high. HIV promotes the progression of TB infection to disease while TB is responsible for over 40% of AIDS related deaths in the region and is an AIDS defining condition. Several randomised trials have demonstrated the effectiveness of joint tuberculosis and HIV/AIDS interventions in reducing morbidity and mortality among dually infected persons[44] and such interventions are now recommended as standard minimum package of care for dually infected persons.

During 2006, only 22% of notified cases were tested for HIV, compared to the 100% set by the Abuja Summit. However, this represents a 1005 increase in coverage compares to 11.2% for 2005.

Of those who tested positive, 37.1% were started on Anti-Retroviral Therapy (ART), increasing from 27.3% in 2005. Again this is far less than the 100% target. At this rate, the region is unlikely to reach the 100% target by 2010.

However, 11 countries[45] recorded ART coverage of 30% and above, ranging from 30.8% in Rwanda to 56.9% in Malawi. Furthermore, 89.1% were started on Co-trimoxazole preventive therapy (CPT), a 23.4% increase compared to 72.2% in 2005. At this rate, Universal access to CPT is likely to be achieved by 2010.

5.3: Access to essential anti-TB medicines

TB is a bacteriological disease and its treatment if fundamentally anti-bacterial. Uninterrupted access to effective and high quality anti-TB medicines is key to an effective TB control programme and must be ensured.

Overall, availability of first line anti-TB drugs has improved tremendously. By the end of December 2007, all 36 eligible countries from the region that applied to the GDF secured 3 year first line anti-TB drug grants, including pediatric formulations for some countries.

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[43] Burkina Faso, DRC, Guinea Conakry, Kenya, Lesotho, Mozambique, Rwanda, Tanzania (pre-approval stage) and Uganda

[44] WHO Interim policy on collaborative TB/HIV activities, Geneva, World Health Organisation, 2004

[45] Benin, Cote D'Ivoire, DRC, Guinea Bissau, Kenya, Malawi, Mauritius, Mozambique, Rwanda, South Africa and Zambia

Notwithstanding, latest available information[46] indicates that only 69% of 42 countries that submitted reports had uninterrupted supply of first line anti-TB drugs at both the central and peripheral levels during 2006. This is a significant short fall with regard to Universal Access to essential TB treatment.

For the treatment of drug resistant TB, only 65.4% of countries that reported some drug resistant TB cases had organized treatment programmes. Furthermore, as of January 2008, only 9 countries[47] had applied and been approved to access concessionary priced second line drugs from the Green Light Committee (GLC) of the Stop TB Partnership. This facility is available to all DOTS based TB Control programmes and should be utilized more widely than is currently the case.

5.4: Resource mobilization

Adequate financial, human and logistic resources are a pre-requisite for implementation of TB control activities, as for other health services. Scale up towards universal access will entail even more funding and human resources. While donor funding provides significant additional resources, the best way to ensure sustainability is through allocation of national resources.

There is insufficient information to determine national funding for TB Control as most activities are implemented within primary health care services without clear ear marking for TB control.

During the past five years, external funding for TB control activities has increased significantly. The Global Fund to Fight AIDS, TB and Malaria (GFATM) has been the single most important source. During rounds 1-7 from 2002-2007, approximately 953 million USD (representing 37% of total available grants globally) was approved for TB Control activities in the African Region. Notwithstanding, this has not been marched with timely spending and has not translated into increased case detection and treatment success rates all round.

Despite the progress in tuberculosis control, the Region has failed in achieving the global targets for tuberculosis control. While DOTS has expanded, covering 94% of the regional population and treatment success is high (82%), the case detection rate is only 44%. To improve case detection, the regional plan to Stop TB was developed as part of the global plan 2006–2015. The budgetary need for the period of 2006 to 2015 indicated in the Plan is US$ 3.1 billion in the Region. Support to countries was enhanced and partnership development promoted.

[46] WHO Global TB Report 2008
[47] Burkina Faso, DRC, Guinea Conakry, Kenya, Lesotho, Mozambique, Rwanda, Tanzania (pre-approval stage) and Uganda

6: Conclusions and Key Recommendations

6.1: Conclusions

Tuberculosis control in Africa has progressed during the last decade but the continent still lags behind on major TB Control targets. Financial resources, traditionally a bottleneck for NTPs till the 2000's, is no longer a major factor as GFATM grants, GDF grants (for standard TB treatment), GLC support (for drug resistant TB), bilateral donors support and several Partnership mechanisms provide technical and financial assistance to cover most needs. In order to achieve Universal Access by 2010 and the MDG targets by 2015, much remains to be done, especially to:

- **Increase treatment success rate for smear positive TB cases:** through implementation of initiatives to reduce preventable unfavourable treatment outcomes such as patient default, transfer out and HIV/AIDS related TB deaths
- **Increase case detection rates:** through development and strengthening of laboratory infrastructure, public private partnerships in the delivery of TB services and expanded institutional and community DOTS services.
- **Detect, treat and prevent Drug resistant TB:** through surveillance, development of culture and DST capability for first line anti-TB drugs, and programmatic management of drug resistant TB cases as part of routine NTP activities

- **Scale up TB/HIV collaborative activities:** especially HIV testing among TB patients, Co-trimoxazole and other preventive therapy, and ART for eligible dually infected persons

- **Address Health Systems Components** that affect TB Control (laboratory networks, personnel, surveillance, supply systems and monitoring and evaluation.

6.2: Key Recommendations

6.2.1 All countries to periodically review their TB Control performance with regard to the WHA, MDG and Abuja targets and develop strategies to accelerate their attainment; working in close collaboration with national and regional stakeholders and the International Community.

6.2.2 Member states to decentralize and strengthen TB laboratory services in the public and private sectors to improve case detection and ensure quality assured laboratory services in pursuit of Universal Access to such services.

6.2.3 National TB Control Programmes to prioritize implementation of strategies to expand DOTS diagnosis and treatment services with a view to rapidly move towards the WHA, MDG, Abuja and Regional Committee targets for treatment success and case detection. This includes strengthening the capacity of the Health Systems to suspect and diagnose Tuberculosis, and to reduce treatment failures, treatment defaulters and transfer outs.

6.2.4 All countries with generalized HIV epidemic (5% or higher) in the general population to programme and implement in full the Regional Strategy for controlling TB-HIV with particular emphasis on universal access to HIV testing for TB patients, ART for eligible HIV positive patients and other interventions to reduce the burden of TB on People Living with HIV & AIDS, and reduce the burden of HIV &AIDS on dually infected TB patients.

6.2.5 Member states to allocate sufficient resources to ensure uninterrupted supply of first line anti-TB drugs at central and peripheral levels, including adequate buffer stocks at the various levels.

6.2.6 For drug resistant TB cases, national programmes to determine the burden of MDR-TB and initiate treatment programmes for all confirmed cases. National programmes should also mobilize sufficient quality assured second line drugs including concessionary priced drugs through the Stop TB Partnership Green Light Committee

6.2.7 Member states to respect the pledge to allocate at least 15% of the national budget to health development and allocate a sufficient amount of that for delivery for TB control interventions. Further, Member States to timely expend approved GFATM grants and submit proposals for more funding to meet funding gaps for scale up of activities towards universal access.

6.2.8 The UN and Other International Organizations and Donor Agencies are called upon to continue to mobilize required resources, as well as research for new TB drugs and provide technical support to Member States.

6.2.9 The African Union and Regional Economic Communities and Health Organizations to advocate to national governments in the 10 countries without local capability for TB culture and drug susceptibility testing for first line anti-TB drugs, to establish this capacity in order to facilitate diagnosis and treatment of MDR-TB cases. In this connection, they should also promote regional cooperation.