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VOLUME 2: EXPERTS' MEETING

First meeting of African Ministers of Health jointly convened by the AUC and WHO

Luanda, Angola, 14–15 April, 2014

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Group photograph taken shortly after the opening ceremony

1. SUMMARY REPORT

INTRODUCTORY REMARKS AND OPENING ADDRESS

1. The First African Ministers of Health meeting jointly convened by the African Union Commission (AUC) and World Health Organization (WHO) was held in Luanda, Angola, from 16 to 17 April 2014. The meeting was preceded by an Experts' Meeting held from 14 to 15 April 2014. The Experts' Meeting was officially opened by the Minister of Health of the Republic of Angola, Honourable Dr José Vieira Dias Van-Dúnem. It was attended by delegates from 51 Member States and partner organizations.

2. In his introductory remarks on behalf of the Director-General of WHO, Dr Luis Gomes Sambo, WHO Regional Director for Africa thanked the Government and people of the Republic of Angola for hosting and sponsoring the meeting. He recalled that this landmark meeting was being organized within the framework of the Memorandum of Understanding signed between the African Union Commission and the World Health Organization in July 2012. He stated that the biennial meeting of African ministers of health was established to provide a forum for Member States to deliberate and agree on African health priorities and propose solutions and harmonized mechanisms for their implementation. He indicated that it was the responsibility of the experts to come up with workable solutions for addressing public health challenges to enable countries to make a difference in the health of the people and to attain the regional and global health goals and targets.

3. Dr Sambo reminded the meeting that Africa accounted for an estimated 12% of the population of the world but has the highest burden of communicable diseases and noncommunicable diseases, including outbreaks as is the case with viral haemorrhagic fever in West Africa. Africa also has the highest rates of under-five mortality and maternal mortality, with many countries not on track to achieve MDGs 4, 5 and 6. WHO and AUC are working to improve ways of supporting countries to reduce this burden. He added that although progress had been made, much more needed to be done while taking advantage of the new opportunities to contribute to the overall social and economic development of the continent.

4. In his remarks, the Director of Social Affairs of the African Union Commission, Ambassador Olawale Maiyegun, speaking on behalf of the Commissioner for Social Affairs of the African Union, Dr Mustapha Kaloko, acknowledged that the presence of the delegates was a demonstration of their interest in and commitment to health matters in the Region. He indicated that the meeting was historic. It was a follow-up to the high-level meeting of the WHO Director-General and the President of the AUC, held in March 2013, in Boston, on the sidelines of the International Conference on Tobacco. The Ambassador reiterated that the AUC considered disease as not only a health matter but also a human development issue. He called on Member States to address the key health challenges related to maternal and child health, sexual and reproductive health, communicable and noncommunicable diseases, epidemics and public health emergencies, and health systems strengthening on the continent.

5. In opening the meeting, the Minister of Health of the Republic of Angola, Honourable Dr José Vieira Dias Van-Dúnem, noted that the health challenges that the African continent faced, including the high burden of disease, high maternal and child mortality rates, circulation of falsified and counterfeit medicines and public health emergencies, require concerted action by all stakeholders. He called upon the experts to provide workable solutions to ensure that adequate quantities of quality medicines are available, including locally-produced medicines, and that effective response to the numerous public health emergencies are mounted, and Universal Health Coverage becomes attainable by Member States. He wished the experts fruitful discussions in order to facilitate the deliberations of the Ministers of Health. He then officially declared the meeting open.

APPOINTMENT OF THE CHAIRPERSON, VICE-CHAIRPERSON AND RAPPORTEURS

6. The Regional Director introduced the session by informing the participants that there was need for electing Office Bearers (Chairperson, Vice-Chairperson and Rapporteurs) to facilitate the conduct of the meeting. The Regional Director stated that since the Terms of Reference for the conduct of the meeting had not been adopted formally, the election process for this first meeting would only serve for this first meeting, and that subsequent meetings would follow the process outlined in the Terms of Reference document.

7. The representative from the Kingdom of Morocco asked for the floor on a point of order. The Regional Director explained that he was not the Chairperson of the meeting but was temporarily coordinating the meeting on behalf of the Secretariat to facilitate the election

of the Bureau. He then gave the floor to the representative of Morocco to raise his point of order. The Morocco representative questioned the participation of the Sahrawi Republic at the meeting organized by WHO as a specialized United Nations Agency.

8. The WHO Regional Director took the floor to clarify WHO's position, emphasizing that co-organizing the meeting with the African Union is not and cannot be taken to be a recognition by WHO of Sahrawi Arab Democratic Republic's statehood. The Regional Director took note of the statement by the Representative of Morocco. He highlighted the challenges inherent in organizing a joint conference between organizations that have different governance systems and membership. In this connection, he stressed that co-organizing the meeting with the African Union is not a recognition by WHO of the statehood of entities that are not members of WHO or the United Nations and that the General Assembly and Security Council of the United Nations do not consider as states. He further stated that this being the first of the AUC-WHO biennial meeting of African ministers of health, the outcomes of discussions on agenda item 3 on the Terms of Reference for the conduct of the meetings would guide the procedures for convening future meetings.

9. The Representative of the African Union Commission took the floor and expressed agreement with the WHO Regional Director's statement.

10. The Experts' Meeting appointed the following bureau:

Chairperson:	Dr Adelaide Carvalho, Director-General of Public Health, Angola
Vice-Chairperson:	Dr Edith Clarisse Kouassy, Deputy Director-General, Ministry of Health, Cote d'Ivoire
Rapporteurs:	Dr Jane Ruth Aceng, Director-General, Health Services, Ministry of Health Uganda (English)
	Dr Medard Toung Mve, Adviser of the Minister of Health Gabon (French)

Dr Eduardo Samo Gudo Jr,
Scientific Director of the National Health Institute,
Mozambique (Portuguese)

Dr Mohamed Abugalia,
Director of Health Protection Department,
National Centre for Disease Control,
Libya (Arabic)

TERMS OF REFERENCE FOR THE CONDUCT OF THE AUC-WHO BIENNIAL MEETING OF AFRICAN MINISTERS OF HEALTH (AUC/WHO/2014/DOC.8)

11. In reviewing the terms of reference of the AUC-WHO biennial meeting of African ministers of health, the experts proposed that the meeting would be open to all States that are members of both the African Union and the World Health Organization, while observers such as representatives of international organizations may be invited. The provisional agenda of each session would be drawn up in consultation with the African Union Commissioner for Social Affairs and the WHO Director-General and be guided by deliberations of the Heads of State and Government and proposals by Member States. The meetings should be held at least once every biennium and be preceded by a preparatory meeting — "Meeting of Experts" — which would review the agenda and working documents and prepare the final deliberations by the Ministers of Health, with final decisions — referred to as "Commitments" — reached generally by consensus.

12. The Experts' Meeting also recommended that Office Bearers — Chairperson, two Vice-Chairpersons and four Rapporteurs — would be elected from among representatives of Members States and would stay in office until their successors are elected at the subsequent meeting. The AU Commissioner for Social Affairs and the WHO Director-General would lead the Secretariat to the meeting; and the working languages of the meeting would be Arabic, English, French and Portuguese with statements being simultaneously interpreted. With regard to the host agreement, the experts recommended that the AU Commissioner for Social Affairs and the WHO Director-General should enter into an agreement with the host Member State which would work out the detailed budgetary and other implications for each party, including the application of the necessary privileges and immunities for the two Organizations as well as other participants. It was also recommended that any proposals for amendment to the terms of reference should be made within 24 hours after the meeting´s decision to adopt them.

UNIVERSAL HEALTH COVERAGE IN AFRICA: FROM CONCEPT TO ACTION
(AUC/WHO/2014/DOC.1)

13. In discussing the document on Universal Health Coverage (UHC), the experts observed that while Africa bears a heavy burden of communicable diseases and noncommunicable diseases, most countries were not on track to attain the health MDGs as the majority of the populations were not covered by the existing effective interventions. It was reiterated that UHC - defined as "ensuring that all people can use the needed promotive, preventive, curative, rehabilitative and palliative health services of adequate quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship" - was a means to improve the situation.

14. The experts discussed the challenges countries faced in moving towards UHC, including lack of sustained political commitment, inadequate coherence of health financing policies, and weak and fragmented health systems. They then underscored the need for countries to learn from the several experiences on the continent and elsewhere that could inform and accelerate the move towards UHC. They also underscored the need to pay special attention to issues related to prevention, equity in access, quality of service, development of human resources for health, financial risk protection, health system strengthening and sustainability.

15. The experts recommended that the Member States take the following concrete actions to accelerate progress towards UHC:

    (a) Affirm sustained high-level political commitment to UHC by developing a comprehensive "equity through UHC" vision and strategy and putting in place mechanisms for coordination and implementation of UHC;

    (b) Improve financial risk protection and expand population coverage by developing/improving comprehensive policies and strategies for health financing, promoting prepayment mechanisms to cover all populations, and implementing public equity funds;

    (c) Expand the provision of integrated people-centred service delivery for UHC by undertaking comprehensive and coordinated health systems strengthening and developing decentralized health services; and

    (d) Implement a monitoring and evaluation framework to measure progress towards UHC.

16. It was recommended that the AUC and WHO, in collaboration with relevant stakeholders, support African countries to develop their health financing mechanisms in order to move towards and sustain UHC.

17. The meeting endorsed Document AUC/WHO/2014/Doc.1 and recommended a draft Commitment on Universal Health Coverage to the Ministerial Meeting for consideration and adoption.

AFRICAN MEDICINES AGENCY: SETTING MILESTONSES TOWARDS ITS ESTABLISHMENT (AUC/WHO/2014/DOC.2)

18. The meeting recalled that to prevent the circulation and use of substandard/spurious/falsely-labelled/falsified/counterfeit (SSFFC) medical products, the Sixtieth Session of the WHO Regional Committee for Africa, in 2010, recommended the establishment of an African Medicines Agency (AMA) in order to strengthen the capacity of National Medicines Regulatory Authorities (NMRAs). In addition, the 19th Summit of African Heads of State and Government, in 2012, adopted the African Union Roadmap on shared responsibility and global solidarity for AIDS, tuberculosis and malaria response in Africa which, among other things, calls for laying the foundation for a single African medicines regulatory agency as stated in the Pharmaceutical Manufacturing Plan for Africa (PMPA).

19. The experts acknowledged that several initiatives for harmonizing the regulation and legislation of pharmaceutical products were ongoing at country and subregional levels and that would contribute to an enabling environment for improving local production of medical products and for timely establishment of the AMA. They agreed that the rationale for establishment of the AMA was to provide, as an organ of the AU, a platform for coordination and strengthening of ongoing initiatives to harmonize medicines regulation. AMA would also serve the purpose of pooling expertise and strengthening capacities and networking for optimal use of the limited resources available. AMA would therefore provide guidance and complement and enhance the efforts of the Regional Economic Communities (RECs) and national regulatory bodies towards harmonization of the regulation of medical products. By enhancing the regulatory environment, AMA would contribute to improving access to quality medical products.

20. The experts proposed that the vision of the AMA would be to ensure that all Africans had access to affordable medical products for priority diseases/conditions that meet internationally-recognized standards of quality, safety and efficacy. The AMA's mission at the continental

level would be to coordinate national and subregional medicines regulatory systems, carry out regulatory oversight of selected medical products including traditional medicine products and promote cooperation, harmonization and mutual recognition of regulatory decisions. AMA would serve as a reference centre to facilitate the work of national regulatory agencies and its core functions would include marketing authorization; inspection; market surveillance; safety monitoring; oversight of clinical trials; and quality control, without duplicating the activities covered by national regulatory authorities. It would have a small critical mass of competent staff to facilitate the work of experts and expert committees.

21. With regard to governance the Experts' Meeting proposed that the AMA be established by the African Union Summit of Heads of State and Government and be governed in accordance with the rules and procedures of the African Union. The resources of the AMA would be provided by the AU in accordance with its relevant practices and procedures and the primary source of funding would be the Member States of the AU. The Experts Meeting proposed a roadmap for the establishment of the AMA comprising the following: (a) adoption of a proposal for the establishment of the AMA by the AU Conference of ministers of health; (b) decision/endorsement by the AU Summit of Heads of State and Government; (c) designation of the host institution; (d) approval of the governing body of the AMA; and (e) appointment of staff and allocation of resources. It was expected that the AMA would be launched by 2018 and that efforts would be made to ensure that the agency capitalized on existing mechanisms, experiences and technology to work effectively towards the attainment of its objectives.

22. It was recommended that AUC and WHO establish a task force that would facilitate the implementation of the agreed milestones with due regard to regional representation and the skills required.

23. The meeting endorsed Document AUC/WHO/2014/Doc.2 and recommended a draft Commitment on the African Medicines Agency to the Ministerial Meeting for consideration and adoption.

NONCOMMUNICABLE DISEASES IN AFRICA: POLICIES AND STRATEGIES TO ADDRESS RISK FACTORS (AUC/WHO/2014/DOC.3)

24. The meeting observed that globalization of marketing and trade particularly in tobacco, alcohol and food, with attendant increase in tobacco consumption, harmful use of alcohol, unhealthy dietary habits in addition to physical inactivity have contributed to a rapid rise

in NCDs. Indeed, NCDs are responsible for 2.9 million deaths annually in Africa. Member States, recognizing the growing burden of NCDs and their risk factors, had made important commitments requiring multisectoral actions. These include priority actions addressing cost-effective and affordable intervention "best buys" aimed at reducing exposure to risk factors such as tobacco use, harmful use of alcohol, unhealthy diet and lack of physical activity. However, many governments in Africa have been unable to meet the ever-expanding needs for legislation, policies, and regulatory frameworks that protect populations and individuals from exposure to risk factors for NCDs.

25. The experts underscored the need to address the full scope of NCDs as highlighted in the Brazzaville Declaration on NCDs and the 2013–2020 WHO Global Action Plan for NCDs Prevention and Control. These documents address NCDs and their risk factors including noncommunicable conditions such as violence and injuries, mental health and sickle-cell disease. They also reiterated the importance of adopting a multisectoral "whole-of-government approach" advocating for and educating policy-makers, stakeholders and the general public on the need to enforce existing legislation, and for increased resources, both domestic and external, to address NCDs. The experts also called for the establishment of effective surveillance and monitoring systems for NCDs.

26. In order to accelerate implementation of actions to address NCDs and their risk factors, the experts recommended that Member States should:

    (a) set national NCD targets for 2025 based on national situations, taking into account the nine global targets for NCDs;

    (b) develop a national multisectoral plan to achieve national targets, taking into account the WHO Global NCD Action Plan 2013–2020 and regional action plans;

    (c) prioritize the implementation of very cost-effective and affordable interventions ("best buys") to reduce exposure to risk factors for NCDs and enable health systems to respond;

    (d) strengthen primary health care to significantly reduce cases of strokes, heart attacks and other complications of hypertension and diabetes;

    (e) strengthen national surveillance of NCDs and integrate surveillance into national health information systems to ensure the collection of data on the 25 globally agreed indicators;

(f) protect public health policies from interference by vested interests of industry through comprehensive legislation and enforcement of national laws and policies;

(g) ratify the WHO Framework Convention on Tobacco Control (FCTC) and the Protocol to Eliminate Illicit Trade in Tobacco Products;

(h) mobilize resources — both domestic and external — including the use of innovative financing mechanisms to support sustained implementation of multisectoral plans; and

(i) set milestones for a roadmap aimed at preventing and controlling NCDs in Africa.

27. The experts recommended that AUC and WHO, in collaboration with relevant stakeholders, support resource mobilization efforts and strengthen the capacity of countries to prevent and control NCDs and their risk factors. The experts also recommended the participation of ministers of health in the UN General Assembly comprehensive review meeting on NCDs and their risk factors to be held in New York in July 2014.

28. The meeting endorsed Document AUC/WHO/2014/Doc.3 and recommended a draft Commitment on controlling NCDs to the Ministerial Meeting for consideration and adoption.

ENDING PREVENTABLE MATERNAL AND CHILD DEATHS IN AFRICA (AUC/WHO/2014/DOC.4)

29. The Experts' Meeting expressed concern that despite the strong political will on the continent to improve health outcomes for women and children and the substantial resources generated by recent global and regional initiatives, the situation of women and children has not been improving rapidly enough in Africa. Many African countries are facing a daunting challenge in achieving Millennium Development Goal 4 (MDG4) on Reducing under-five mortality rate by two thirds between 1990 and 2015 and Millennium Development Goal 5 (MDG5) on Reducing maternal mortality by 75% and achieving universal access to reproductive health care. To date, only three countries in Africa are projected to achieve MDG5 while 19 countries are on track to achieve MDG4 by 2015.

30. The meeting agreed that the main challenges facing Member States included delays in accessing quality care, weak health systems, including acute shortage of human resources, insufficient financial resources, insufficient access to family planning services especially for adolescents, gaps in availability and timeliness of reliable data to guide decision-making and weak coordination of donors. The meeting recognized the need to emphasize community empowerment and improvement of socioeconomic conditions given that a large proportion of maternal, newborn and child deaths occur at home.

31. The experts expressed concern about the Human Resources for Health (HRH) challenges African countries are facing, including the inadequate production and deployment of skilled staff to rural and remote areas where most maternal and child deaths occur. They encouraged Member States to invest in HRH through effective training, deployment and retention strategies including better remuneration and motivation within the framework of the Roadmap for HRH development already adopted by ministers of health.

32. The meeting recommended that in order to end preventable maternal, newborn and child deaths, Member States should facilitate implementation of the following actions:

    (a) ensure access to an integrated package of essential interventions and services along the continuum of care, including improving the quality of maternal, newborn and child health (MNCH) services;

    (b) ensure long-term sustainable health financing options to have UHC and remove financial barriers to accessing MNCH services;

    (c) invest in the critical social, economic and environmental determinants of health;

    (d) establish and strengthen tracking and monitoring mechanisms including institutionalization of maternal and perinatal death reviews and surveillance as well as strengthening of civil registration of births and deaths; and

    (e) ensure better coordination, alignment and harmonization of existing Reproductive, Maternal, Newborn and Child Health (RMNCH) initiatives.

33. It was recommended that the AUC and WHO, in collaboration with the relevant stakeholders, should (a) support Member States in implementing interventions and monitoring progress towards the attainment of MDG4 and MDG5 by 2015 and beyond in order to end preventable

maternal, newborn and child deaths by 2035; (b) compile and disseminate best practices in ending preventable maternal, newborn and child deaths; (c) report regularly on progress every two years starting from 2014.

34. The meeting endorsed Document AUC/WHO/2014/Doc.4 and recommended a draft Commitment on ending preventable maternal and child deaths to the Ministerial Meeting for consideration and adoption.

ESTABLISHMENT OF AN AFRICAN CENTRE FOR DISEASE CONTROL AND PREVENTION (AUC/WHO/2014/DOC.5)

35. The Experts' Meeting recalled that at the African Union Special Summit on HIV, Tuberculosis and Malaria (ATM) in Abuja in July 2013, the Heads of State and Government took cognizance of the need to establish an African Centre for Disease Control and Prevention (ACDCP) to conduct life-saving research on priority health problems in Africa and to serve as a platform to share knowledge and build capacity in responding to public health emergencies and threats. The Special Summit then requested the AU Commission to work out the modalities for establishing an ACDCP. The request was reaffirmed in decision Assembly/AU/Dec.499 (XXII) of the 22nd Ordinary Session of the African Union (AU) Assembly in January 2014 that stressed the urgency of establishing the Centre. The decision further requested the AU Commission, working in collaboration with the Government of Ethiopia and other Member States, to submit a report to the Assembly by January 2015 including the legal, structural and financial implications of the establishment of the Centre. By that same decision, the AU Assembly recommended the establishment of the Centre.

36. The meeting discussed extensively the objectives for establishing the Centre, its modus operandi, including its headquarters and satellite agencies in the form of centres of excellence and specialized laboratories, among others. The experts observed that there was a need to re-define the objectives of the ACDCP, taking into consideration existing capacities; relationship with other organizations such as AUC and WHO and the priority areas that needed to be addressed in the continent. They also stated that the ACDCP should be a reference centre to complement the work of national institutions. The ACDCP would build partnership with other centres for disease control and prevention (US, EU, China, etc.) in agreed areas.

37. The Experts' Meeting recommended that a Task Force comprising the AUC, WHO and interested Member States be established to define the vision, mission, objectives and modalities for establishing the Centre, including its legal, structural and financial implications and its relationship with the African Public Health Emergency Fund.

38. It was recommended that the AUC and WHO, in collaboration with relevant stakeholders, support efforts towards the establishment of the ACDCP.

39. The meeting endorsed Document AUC/WHO/2014/Doc.5 and recommended a draft Commitment on the establishment of an African Centre for Disease Control and Prevention to the Ministerial meeting for consideration and adoption.

ACCOUNTABILITY MECHANISM TO ASSESS THE IMPLEMENTATION OF COMMITMENTS MADE BY AFRICAN MINISTERS OF HEALTH (AUC/WHO/2014/DOC.6)

40. The Experts' Meeting recalled that the AUC had now partnered with WHO in convening joint meetings of African ministers of health to address a number of health-related challenges in Africa. There is also an increasing number of ministerial meetings across the continent of Africa and beyond as most Regional Economic Communities, Regional Health Organizations, UN agencies and international civil society organizations convene ministerial meetings that culminate in commitments, decisions and declarations. The AUC-WHO partnership aims to ensure that all the decisions at such meetings are taken in an efficient manner, "buy-in" for implementation is obtained from all stakeholders, and the decisions are implemented in order to produce the desired outcomes.

41. The Experts' Meeting recommended that the goal of the accountability mechanism would be to increase the possibility of implementing decisions taken by ministers of health, identify challenges to implementation and provide solutions to the identified challenges. The specific objectives are:

    (a) to review the steps Member States and other stakeholders are taking to implement decisions;

    (b) to identify the causes underlying the non-implementation of commitments made by African ministers of health;

    (c) to improve the speed and effectiveness at which decisions are implemented;

(d) to support Member States and other stakeholders to implement commitments made by African ministers of health; and

(e) to ensure that the commitments made by African ministers of health are implemented.

42. In discussing the pillars of the accountability mechanism, the experts agreed that the focus of the mechanism will not only be on assessing the implementation of commitments but also on making the commitments implementable. The experts proposed that the five pillars of the mechanism would be as follows: (a) setting up an implementation and monitoring framework, including timelines for implementation of commitments; (b) creating awareness on the commitment and its corresponding implementation plan; (c) providing post-conference support for implementation; (d) conducting a formal assessment of implementation by an assessment committee comprising the AUC, WHO and experts and/or institutions from Member States; and (e) establishing a memory bank or a mechanism for recalling the rationale behind each commitment to facilitate institutional memory.

43. The accountability mechanism would seek to assess the effectiveness, efficiency, impact and sustainability of commitments made by African ministers of health. The experts reiterated that the accountability mechanism was not aimed at only identifying what was implemented or not implemented and whether the desired goal was achieved or not but also to consider what was learnt from the experience and how this could help to resolve challenges and share good practices.

44. It was also recommended that the AUC and WHO work with Member States to monitor the implementation of the commitments and report to subsequent joint meetings of ministers of health.

45. The meeting endorsed Document AUC/WHO/2014/Doc.6 and recommended a draft Commitment on an Accountability Mechanism to the Ministerial Meeting for consideration and adoption.

WRAP-UP AND ADOPTION OF THE REPORT OF THE EXPERTS' MEETING

46. The report of the Experts' Meeting was adopted with amendments.

2. WORKING DOCUMENTS

AUC/WHO/2014/DOC.8
17 APRIL 2014

AGENDA ITEM 3 **ORIGINAL: ENGLISH**

TERMS OF REFERENCE FOR THE CONDUCT OF THE AUC-WHO BIENNIAL MEETING OF AFRICAN MINISTERS OF HEALTH

1. General Objectives

The biennial meeting of African ministers of health (hereinafter referred to as the "Meeting"), jointly convened by the African Union Commission (hereinafter referred to as the AUC) and the World Health Organization (hereinafter referred to as WHO), shall provide a forum for Member States to deliberate and agree on African health priorities and devise strategies and harmonized mechanisms for their implementation and for ensuring accountability. The AUC and WHO shall be Conveners.

2. Attendance and participation

(a) The Meeting shall be open to all States that are members of both the African Union and the World Health Organization as represented by their Ministers of Health (hereinafter referred to as "Ministers"). Whenever necessary, a minister may delegate a representative to participate in the meeting on his/her behalf. The ministers and/or representatives shall be accompanied by advisers who shall also be known as "experts" for purposes of the Meeting.

(b) The African Union Commissioner for Social Affairs (hereinafter referred to as the "Commissioner") together with the WHO Director-General (hereinafter referred to as the "Director-General") may invite representatives of international organizations, particularly those with an interest in the items on the agenda, African regional economic communities, and health partners to participate in the meeting, as observers, without vote.

3. Agenda

(a) The provisional agenda of each session shall be drawn up in consultation with the Commissioner and the Director-General. It shall be dispatched together with the notice of convocation at least eight weeks before the commencement of the session.

(b) The provisional agenda of each session shall include:

(i) items proposed by a Member State three months before the next session;

(ii) items jointly agreed by the Conveners.

4. Sessions and format of the meeting

(a) The Meeting shall be held in April every biennium. At each session the Meeting shall determine the date and place of its next session.

(b) Notices convening the Meeting shall be co-signed and sent out to Member States by the Commissioner and the Director-General at least eight weeks before its commencement. The AUC shall also communicate the notices to Member States via a Note Verbale.

(c) The Meeting shall be preceded by a preparatory session (hereinafter referred to as a "Meeting of Experts") which shall review the agenda and the working documents, and prepare the final deliberations by the ministers of health. The Meeting of Experts shall provide a technical report whose findings and recommendations shall be considered by the Meeting of Ministers.

(d) Final decisions (referred to as Commitments) of the Meeting shall be reached by consensus. In instances where consensus is not reached decisions shall, as a last resort, be made by a majority vote of the Member States present and voting.

5. Office Bearers

(a) The Meeting, as well as the Meeting of Experts, shall elect Office Bearers (Chairperson, two Vice-Chairpersons and four Rapporteurs) from among the representatives of Member States. Their term of the office shall last until their successors are elected at the subsequent Meeting. In electing the Office Bearers, the Meeting shall consider subregional representation.

(b) If the Chairperson is absent from a session or a meeting or any part thereof, he/she shall designate one of the Vice-Chairpersons to preside over the session or meeting. If the Chairperson is unable to make this designation, the Meeting shall appoint one of the Vice-Chairpersons to preside over a session or Meeting.

6. Secretariat

(a) The Commissioner and the Director-General shall act as the Secretariat of the Meeting and of any subdivision thereof. They may delegate these functions.

(b) The Secretariat shall jointly prepare the working documents of the Meeting and may make oral or written statements concerning any question under consideration.

(c) The Secretariat shall, in close collaboration with the rapporteurs, prepare and disseminate the final report and Commitments of the Meeting in the working languages for adoption before the end of every session.

7. Languages

(a) Arabic, English, French and Portuguese shall be the working languages of the Meeting.

(b) Statements made in any of the four working languages shall be interpreted into the other three working languages.

(c) All Commitments of the Meeting shall be written in the working languages.

8. Host agreement and budgetary implications

(a) Any Member State may volunteer to host the Meeting. In the event that no Member State volunteers to host the meeting, the Conveners shall jointly decide on a venue.

(b) The Commissioner and the Director-General shall enter into an agreement with the host Member State which shall provide detailed budgetary and other hosting implications for each Party, including granting of the necessary privileges and immunities to the two Organizations as well as all participants.

9. Amendment to the terms of reference

Amendments of, or additions to, these terms of reference may be adopted by the Meeting after due consideration of the amendment proposals, provided that at least twenty-four hours have elapsed between the receipt of the amendment proposals and a decision by the Meeting.

AUC/WHO/2014/DOC.1
17 APRIL 2014

AGENDA ITEM 4

ORIGINAL: ENGLISH

UNIVERSAL HEALTH COVERAGE IN AFRICA: FROM CONCEPT TO ACTION

CONTENTS

BACKGROUND

1. Africa bears a heavy burden of communicable diseases and noncommunicable diseases. It harbours 69% of the world's HIV cases, 26% of TB cases and 80% of malaria cases. It also accounts for 47% of global under-five mortality and 56% of maternal mortality. Most countries in Africa are not on track to attain the health MDGs. While this situation prevails, effective interventions to improve health outcomes exist. A major reason for this situation is that most of the populations are not covered by these effective interventions.

2. Accessibility and coverage of essential health services is currently low: only 43% of pregnant women have four antenatal care visits compared with the global average of 55%; only 49% of births are attended by skilled attendants compared with the global average of 70%. In order to improve the situation there is need for a significant improvement in the coverage of essential services to the population. Universal health coverage has been proposed as the means to achieve this goal.

3. Universal Health Coverage is defined as ensuring that all people can use the needed promotive, preventive, curative, rehabilitative and palliative health services of adequate quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

4. Moving towards Universal Health Coverage is a gradual process. It involves making progress on several fronts for all people: the range of services available (consisting of the medicines, medical products, health workers, infrastructure and information); the proportion of the costs of those services covered; and the proportion of the population covered.

5. This requires an efficient health system that provides the entire population with access to good quality services, health workers, medicines and technologies. It also requires a financing system that protects people from financial hardship and impoverishment due to health care costs.

6. The World Health Report 2010, entitled: *Health systems financing—the path to universal coverage*, urges WHO Member States to move towards Universal Health Coverage whereby all people have access to the needed health services of good quality without suffering financial hardship.

7. Universal Health Coverage has been advocated for and endorsed at the global and regional levels[1] and it has been acknowledged as essential to achieving and sustaining the health MDGs. It is increasingly considered as an integral part of the post-2015 sustainable development agenda.

8. Several low-and middle-income countries have made tremendous progress towards reaching Universal Health Coverage with lessons learnt, challenges identified and recommendations made. They have shown that Universal Health Coverage is an attainable goal and a legitimate aspiration of all countries.

9. Many opportunities for moving towards Universal Health Coverage exist in the African continent, such as the global drive in support of Universal Health Coverage. The international community and development partners have agreed that ensuring universal access to quality and affordable health services is a key to ending extreme poverty. Africa's economy grew by 4.8% in 2013 and is projected to grow by 5.3% in 2014. That provides an opportunity for increased government spending on health and for increased commitment of national governments, spurred by the results achieved by African countries already engaged in the pursuit of Universal Health Coverage. Other encouraging developments include the availability of several tools and proven strategies to move towards UHC, the increasing involvement of civil society and the demand of people for better health services.

10. Access to health services ensures that people are healthier while financial risk protection prevents people from being pushed into poverty. Therefore, Universal Health Coverage is a critical component of sustainable development and poverty reduction, and a key element of social inequity reduction.

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[1] The 15th Session of the Assembly of the African Union (AU) on 24 July 2010 in Kampala, Uganda; the AU Conference of Ministers of Economy and Finance on 28 March 2011 in Addis Ababa, Ethiopia; the interministerial conference of 4-5 July 2012 in Tunis, Tunisia; the ministerial level roundtable on UHC organized jointly by WHO and World Bank, 18-19 February 2013, WHO headquarters, Geneva, Switzerland; the Africa Health Forum 2013: Finance and Capacity for Results, hosted by The World Bank in collaboration with Harmonization for Health in Africa, April 18-19, 2013, Washington, DC; the Panel Discussion –Towards UHC in the African Region during the Sixty-third session of the WHO Regional Committee for Africa, 2–6 September 2013, Brazzaville, Congo; the MDG forum during the UN General Assembly on 24 and 25 September, 2013. The Rio+20 Declaration.

CURRENT SITUATION AND LESSONS LEARNED FROM UHC EXPERIENCES

11. There is no single stepwise blueprint or linear process for implementing Universal Health Coverage. Although the key ingredients for ensuring Universal Health Coverage are in place in most countries, the countries are performing at different levels and the approaches to progressing towards Universal Health Coverage are country-specific. Fortunately, no country is starting from scratch and the efforts towards Universal Health Coverage can build on existing health systems and social protection mechanisms. Several lessons have been learned globally and regionally. The lessons can inform and accelerate the move towards Universal Health Coverage. These lessons include ensuring equitable access by removing financial barriers especially direct payments (user fees); making prepayment compulsory; establishing large risk pools; and government financial coverage of health costs for people who cannot afford to contribute.

12. In line with the objectives of Universal Health Coverage some countries of the continent[2] are implementing strategies to improve access to and coverage of health services while many other countries have made commitments to take measures towards achieving Universal Health Coverage. By adhering to the principles of Universal Health Coverage, countries will be able to address their priority health problems especially by scaling up priority interventions aimed at reducing the huge double burden of disease through robust national health systems based on the Primary Health Care approach.

13. Ghana has been implementing health financing reforms since 2004 in order to increase population coverage with prepayment pooled mechanisms, reduce direct out-of-pocket payments (OOP) and increase the range of services provided in the benefit package. The Ghana National Health Insurance Scheme (NHS) is one of the most comprehensive schemes to be established in sub-Saharan Africa. Under the scheme, exemptions for the poor were included initially. Indeed, relatively poor districts and disadvantaged population groups have higher NHIS coverage. The key design principles are 'equity' in access to a defined benefit package irrespective of the capacity to pay and 'risk equalization' meaning the financial risk of illness is equally shared among all.

2. Botswana, Gabon, Ghana and Rwanda.

14. Making prepayment compulsory is very crucial to achieving Universal Health Coverage. For example, Rwanda has enacted a law regarding the creation, organization, operation and management of a national health insurance scheme. The law stipulates that: "Any person residing in Rwanda shall be bound to health insurance, any foreigner entering the country shall also be bound to health insurance within a time limit not exceeding fifteen days". The scheme now covers about 92% of the population and finances medical consumables, services, capital projects, logistics and equipment for service providers. In addition, a strategy to identify destitute people in order to determine national health insurance scheme contribution subsidies and exemptions has been devised, and the Government and development partners pay for groups that have been identified as part of poverty alleviation activities.

15. The current health financing system in Botswana is a tax-based system providing a large risk pool to ensure coverage of the population for a wide range of services. Out-of-pocket spending in Botswana, which is only 4% of total health expenditure, is the lowest in Africa. Government expenditure on health, estimated at around US$ 446 per capita, is also above the average of US$ 228 per capita in Africa and other upper middle-income countries elsewhere in the world.

16. In 2007 Gabon initiated health financing reforms in order to achieve Universal Health Coverage. A Fund was established with resources derived from special taxes paid by mobile telephone and money transfer companies. The Fund is also financed through social contributions by wage earners, independent workers, employers and the Government. The Government has adopted a gradual approach to membership starting with the poorest. The introduction of compulsory health insurance in Gabon starting with a mechanism to cover the poorest, based on special taxes, is an innovative and promising experience.

17. Morocco and Tunisia have expanded the population covered by pre-payment arrangements that provide access to needed health services by establishing medical assistance schemes funded by government revenues. Morocco's medical assistance scheme *(Regime d'Assistance Médicale or RAMED)* and Tunisia's free medical assistance *(Assistance Médicale Gratuite)* provides coverage for the poor and vulnerable populations that are not usually covered by social health insurance schemes. In Morocco, the RAMED and the social health insurance scheme *(Assurance Maladie Obligatoire de base)* have jointly expanded coverage to 62% of the Moroccan population. In Tunisia, the *Assistance Médicale Gratuite* and the social health insurance schemes (*Caisse Nationale d'Assurance Maladie)* have a combined population coverage of 92%.

18. Instead of establishing separate pre-payment arrangements for poor and vulnerable populations, Egypt and Sudan have expanded population coverage by utilizing government revenues to subsidize the poor and vulnerable population under their respective social health insurance schemes. In Sudan, the Ministry of Finance and Zakat charities have subsidized the National Health Insurance Fund coverage of around 400 000 poor families. In Egypt, the Health Insurance Organization's coverage of school children is funded from government revenues.

19. Several countries are grappling with the uneven distribution of existing health facilities, with urban areas being better endowed than rural areas. Improving equity in access requires equitable distribution of adequately equipped health facilities between rural and urban areas and availability of a competent health workforce. This calls for renewed emphasis on the Primary Health Care approach of bringing services closer to communities, with well-articulated and reliable referral systems, and possible creation of new cadres of human resources. Increasing the population covered has been achieved by improving geographical access through expansion of the health infrastructure and use of community-based workers (Ghana, Ethiopia, Tanzania…). Other strategies include waiving user fees for vulnerable groups such as women, children, the elderly and the poor, and providing free services for a defined package of essential services.

20. A review[3] has shown that interventions towards Universal Health Coverage improve access to health care. It has also shown that Universal Health Coverage often has a positive impact on financial protection and, in some cases, on health status. The review further shows that the effect of Universal Health Coverage schemes on access, financial protection, and health status varies according to contexts, Universal Health Coverage scheme design, and Universal Health Coverage scheme implementation processes.

3. Ursula Giedeon, Eduardo Andrés Alfonso, Yadira Diaz: The Impact of Universal Coverage Schemes in the developing world. A Review of Existing Evidence. The World Bank, Washington DC, January 2013.

21. Worth noting is that the removal of user fees can create unexpected negative effects. For example, in Uganda, 10 years[4] after introducing free care in public facilities, 29% of households still experience catastrophic health expenditures and out-of-pocket expenditure has increased from 38% in 2001 to 50% by 2010 while the percentage of patients choosing private sector providers has increased significantly, except among the absolutely poor.

CHALLENGES

22. Many challenges exist in the quest for Universal Health Coverage. Notable among them are: (a) lack of sustained political commitment, clear vision and a well-charted roadmap for universal health coverage; (b) lack of coherent health financing policies, resulting in limited financial resources and absence of financial risk protection arrangements for large segments of population groups; (c) inequitable and inefficient allocation of funds to the appropriate service delivery level for effective interventions to address priority health problems; (d) weak and fragmented health systems, resulting in inequitable provision and low quality of health services including use of traditional medicine; (e) weak partnership between the private sector and the public sector; (f) weak information systems to assess performance and monitor progress towards UHC; (g) inadequate health coverage during major emergencies and humanitarian crises.

CONCRETE ACTIONS TO ACCELERATE PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE

Member States should:

23. **Affirm sustained high level political commitment to Universal Health Coverage by:**

    (a) Developing a comprehensive "equity through Universal Health Coverage" vision and strategy with evidence-based policies and actions that emphasize intersectoral action, financing strategies ensuring financial risk protection, and reorientation of service delivery.

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[1] WHO, State of health financing in the African Region. WHO, Regional Office for Africa, Brazzaville, Congo, January 2013.

(b) Putting in place mechanisms for coordination and implementation of Universal Health Coverage e.g. establishing a national multisectoral Steering Committee to pilot the project and undertaking advocacy for a sustained national commitment.

24. **Improve financial risk protection and expand population coverage by:**

(a) Developing/improving comprehensive policies and strategies for health financing to realize aggregate increase in funds for health and to enhance the quality of services and efficient utilization of funds to reduce out-of-pocket payments, at least for vulnerable populations and priority services.

(b) Promoting prepayment mechanisms to cover all the population and introducing prepayment and pooling arrangements that share financial risks across the whole population. This includes mobilization of increased resources for health through government revenue, tax funding and/or mandatory (i.e. social or national) health insurance premiums and/or subsidies.

(c) Implementing public equity funds to cover the health costs of people who are not able to contribute.

25. **Expand the provision of integrated people-centered service delivery for Universal Health Coverage by:**

(a) Undertaking comprehensive and coordinated health system strengthening through investing in human resources and upgrading infrastructure and equipment, production, procurement and supply of quality and safe medical products and health technologies.

(b) Developing decentralized health services in order to expand and update service delivery platforms to reach poor, vulnerable and marginalized populations especially in rural areas with quality, integrated, people-centered health services, based on national and local priorities responsive to local needs and contexts and based on Primary Health Care including regulated traditional medical practice.

26. **Implement a monitoring and evaluation framework to monitor progress towards Universal Health Coverage by** monitoring and evaluating progress towards Universal Health Coverage as a whole and across the three coverage dimensions, through, among others, the production of data to monitor evidence of inequalities, and evaluation of the impact of policies and programmes on health equity and progressive attainment of UHC.

WHO and Partners should:

27. Provide technical assistance to countries for developing/revising normative documents towards Universal Health Coverage such as policies and strategies; laws and other legislative instruments on Universal Health Coverage; and a framework to monitor Universal Health Coverage.

28. Crucially: (a) build the capacity of countries to undertake necessary diagnostic and analytical work; (b) develop a framework that allows monitoring of UHC along its three dimensions; (c) facilitate national policy dialogue between ministries of health, ministries of finance, ministries of planning and other related ministries to develop evidence-based financing options; (d) facilitate sharing of experience among countries; (e) assist countries to generate and mobilize the resources needed to progress towards Universal Health Coverage.

CONCLUSION

29. Universal Health Coverage represents a transformational shift from separate management of multiple pieces (hospitals, private clinics, and community health centres) to a single well-coordinated system able to guarantee equitable access to a diversity of beneficiaries, including the poorest and the vulnerable, while protecting them from facing financial hardship.

30. Universal Health Coverage is feasible in the context of countries in Africa and is urgently needed to expedite the improvement of the health status of people in an equitable manner. There are challenges being faced and countries have already started to address them. As Universal Health Coverage requires the full involvement of multiple players, sensitization and consensus building will always be necessary to achieve that end. There is a strong momentum for Universal Health Coverage and countries should seize the opportunity to take concrete steps to move towards the achievement of Universal Health Coverage.

AUC/WHO/2014/DOC.2
17 APRIL 2014

AGENDA ITEM 5

ORIGINAL: ENGLISH

AFRICAN MEDICINES AGENCY: SETTING MILESTONES TOWARDS ITS ESTABLISHMENT

CONTENTS

BACKGROUND

1. Effective medicines regulation promotes and protects public health. Regulation aims to ensure the quality, safety and efficacy of medical products[1] through the enforcement of legislation, norms and standards. National Medicines Regulatory Authorities (NMRAs) with adequate capacity including a clear legal mandate, quality management systems, human and financial resources, infrastructure and enforcement systems can efficiently play this role of medicines regulation. However, the regulatory systems in many countries are weak, delaying access to quality medical products and resulting in the proliferation of substandard/spurious/falsely-labelled/falsified/counterfeit (SSFFC) medical products.

2. To prevent the circulation and use of SSFFC medical products, the Sixtieth Session of the WHO Regional Committee for Africa, held in Malabo, in 2010, stressed the need to strengthen the capacities of NMRAs and, to that end, recommended the establishment of an African Medicines Agency (AMA).

3. The promotion of sustainable access to quality and affordable medicines and integration of local production into the overall health systems strengthening package have been among the key priorities of African leaders. Under the theme "Strengthening of Health Systems for Equity and Development in Africa", the AU Conference of African Ministers of Health (CAMH3) in April 2007 responded to the AU Assembly decision 55 taken during the Abuja Summit in January 2005 which mandated the AU Commission to develop a Pharmaceutical Manufacturing Plan for Africa (PMPA) within the framework of the New Partnership for Africa's Development (NEPAD) Planning and Coordinating Agency (AU 2007).

4. The PMPA aims at strengthening the ability of local pharmaceutical manufacturers to produce high quality, affordable essential medicines that will contribute to improved health outcomes and the realization of direct and indirect economic growth. Furthermore, the AU Heads of State and Government at their 19th Ordinary Assembly in July 2012 committed to consolidating efforts for local production and strengthening regulatory oversight in Pillar II of the AU Roadmap on shared responsibility and global solidarity on AIDS, TB and Malaria (ATM) which also underscores the need to accelerate access to affordable and quality-assured medicines and health-related commodities.

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1. Medical products include medicines, vaccines, diagnostics, and medical devices.

5. The roadmap calls for laying the foundation for a single African medicines regulatory agency as stated in the PMPA while strengthening regional medicines regulatory harmonization initiatives. The roadmap also recognizes the coordination mechanism established by the African Union Commission (AUC), the NEPAD together with the various Regional Economic Communities (RECs) as platforms that should work together towards achieving convergence of medicines regulation and legislation.

6. Furthermore, the Sixty-third session of the WHO Regional Committee for Africa, held in September 2013, adopted a technical document[2] that emphasizes the need for sustainable funding mechanisms to reinforce NMRAs without conflict of interest and for effective implementation of regulatory functions. Member States recommended a stepwise approach in establishing the AMA, involving the RECs and the AUC.

7. Subsequently, the 8th African Vaccine Regulatory Forum (AVAREF), held in Uganda, in October 2013, and the 3rd African Medicines Regulators Conference (AMRC), held in South Africa, in December 2013, discussed and supported the idea of establishing a single AMA. To that end, the meeting participants called on existing networks and regional platforms to share information and experiences on joint inspections and reviews, harmonization of efforts to develop a model law, guidelines, technical documents and procedures to serve as a basis for establishment of the AMA.

8. Globally, there is only one example of a regional centralized regulatory system, i.e. the European Medicines Agency (EMA).[3] The European Union (EU) harmonization, which began in 1965, started with the establishment of Community-wide mechanisms and a clear definition of the mandate of the Community and the mandate of Member States. The whole idea originated from the need to have a common market and was based on the very advanced national systems and supportive legal instruments already in place in Member States. After 30 years of efforts the centralized medicines agency, called EMA, finally became operational in 1994/1995. All Member States had to accept the body of European Union rights and obligations binding the Member States together within the European Union, commonly known as the *community acquis*, and to implement the regulatory framework for accession to EMA.

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2. "Strengthening the capacity for regulation of medical products in the African Region".
3. www.ema.europa.eu.

9. The EMA is now responsible for scientific evaluation of hundreds of applications for marketing authorization for human and veterinary medicines that fall within the scope of the centralized mechanism. The EMA provides scientific advice for the centralized mechanism, while the European Commission (EC) makes decisions regarding marketing authorization. A representative of each EU Member State participates in the work of the scientific committee that provides scientific advice to the EMA.

10. However, thousands of other medicines that do not fall within this scope are marketed in the European Union either in individual Member States, in accordance with their national authorization procedures, or in multiple Member States through decentralised or mutual-recognition procedures. EMA depends entirely on the services of experts who are full-time employees of the NMRAs in their respective countries and are fully paid by Member States. Functions such as inspection, quality monitoring and safety monitoring are carried out by the NMRAs in the Member States. For their part, NMRAs in Africa assess and register medical products and some Member States have bilateral mutual agreements in this regard.

MEDICINES REGULATORY SYSTEMS IN AFRICA: A SITUATION ANALYSIS

11. Between 2002 and 2010, WHO provided support to 26 countries in the African Region to assess their regulatory systems and to draw up and implement institutional development plans.[4] In 2010 and 2011, NEPAD undertook a situation analysis of the status of harmonization of medicines registration in the East African Community (EAC),[5] Economic Community of West African States (ECOWAS)[6] and Southern African Development Community (SADC) respectively. Other assessments and reviews have also been undertaken in the recent past at subregional[7] and regional[8] levels.

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4. WHO/EMP/QSM/2010.4, Assessment of medicines regulatory systems in sub-Saharan African countries: an overview of findings from 26 assessment reports, Geneva, World Health Organization, 2010.
5. AU/NEPAD, Situational analysis study on medicines registration harmonization in Africa. Final report for the East African Community (EAC), 2010.
6. AU/NEPAD, Situational analysis study on medicines registration harmonization in Africa. Final report for the Economic Community of West African States (ECOWAS), 2011.
7. *UEMOA, Etude de faisabilité sur le changement de statut des autorités de réglementation pharmaceutique des Etats membres de l'UEMOA, CHRCP,* 2011.
8. http://www.who.int/medicines/areas/coordination/coordination_assessment/en/; accessed; 21 February 2014.

12. Various study findings by, among others, WHO (2004 and 2010), NEPAD (2010 and 2011), US Food and Drug Administration (2010) and Management Sciences for Health (2010) show that most African countries are not yet in a position to meet internationally accepted requirements for regulation of medical products. The main findings are that currently only 4% of Member States have moderately developed national regulatory capacity compared with countries of the developed world, while 33% of AU countries have regulatory capacity to carry out most functions to varying degrees and 24% have basic regulatory capacity (i.e. carry out minimum functions).

13. An estimated 39% of AU Member States have limited regulatory capacity to implement all the regulatory functions. The analysis further reveals that most NMRAs have inappropriate organizational structures to implement medical products regulatory functions. In some countries, the entities responsible for coordinating and overseeing the implementation of medical products regulation are units under departments of the ministry of health. Although these entities are expected to be autonomous, full-fledged departments with statutory authority (boards or commissions) to ensure their independence, transparency and accountability in decision-making, the reality is different in most cases.

14. The analysis of studies shows that RECs, namely EAC, SADC, ECOWAS, West African Economic and Monetary Union (UEMOA) and Central African Economic and Monetary Union (CEMAC) are at various stages of economic integration and have policies, laws, regulatory tools and standards for harmonization of medical products regulation. Some of the RECs are also working towards joint dossier reviews and inspection of pharmaceutical manufacturing plants, which is a key factor for building regulatory capacity among participating countries in regional harmonization schemes.

15. For instance, through the African Medicines Regulatory Harmonization (AMRH) initiative, the EAC has developed regionally-agreed technical guidelines for regulation of medicines and is in the process of developing a pharmaceutical policy and bill for the EAC Food and Drug Safety Commission. Other RECs such as SADC and ECOWAS have also made major milestones in the establishment of their medicines regulation harmonization projects. African countries in the WHO Eastern Mediterranean Region do not cooperate in medicines regulation in the RECs. However, there is convergence of efforts in the Gulf Cooperation Council (GCC) on medicine registration as GCC acts as a pooled procurement entity for its members. Taken together, such efforts form an important foundation for the establishment of the AMA.

ISSUES AND CHALLENGES

16. Despite the capacity building efforts of WHO and partners to strengthen national and sub-regional regulatory systems and promote harmonization, evidence shows that the capacity of countries to regulate medical products is still inadequate in Africa. However, some of the countries have better regulatory systems than others. This disparity in regulatory capacity provides further justification for establishing a continental regulatory system. Moreover, implementation of agreed procedures and processes, coordination of regulatory practices across subregions, priority-setting for products against target diseases, promotion of manufacturing and optimal use of the limited resources available to the NMRAs remain significant challenges. These can be effectively addressed through a regional regulatory system, i.e. the AMA.

RATIONALE FOR ESTABLISHMENT OF THE AMA

17. The AMA is intended to be an organ of the AU, legally mandated by Member States. It will provide a platform for coordination and strengthening of ongoing initiatives to harmonize medicines regulation. It will also serve the purpose of pooling expertise and capacities and strengthening networking for optimal use of the limited resources available. AMA will therefore provide guidance and complement and enhance the efforts of the RECs towards harmonization of medical products regulation. By enhancing the regulatory environment, AMA will contribute to enhancing access to medical products.

OPPORTUNITIES

18. The Global Fund to fight AIDS, TB and Malaria (GFATM), Global Alliance for Vaccines and Immunization (GAVI), UN Commission for Life-saving Commodities for maternal, reproductive and child health and the Neglected Tropical Diseases partnership as well as networks of regulators (e.g. AVAREF and AMRC) all represent opportunities to enhance regulatory convergence at the continental level. These initiatives, which aim at enhancing the availability of medical products, require adequate regulatory oversight.

19. African countries recognize the need for a coordination mechanism for the regulation of medical products, and AMA will fulfil that need. The time frame for establishment of AMA should take account of the current opportunities and partnerships to support global health initiatives and will require less investment if established sooner rather than later.

PROPOSAL FOR ESTABLISHMENT OF THE AMA

Vision and mission

20. **Vision:** The vision for establishment of the AMA is to contribute to improving access to affordable medical products for priority diseases/conditions that meet internationally-recognized standards of quality, safety and efficacy.

21. **Mission:** The mission of the AMA at the continental level is to coordinate national and subregional medicines regulatory systems, carry out regulatory oversight of selected medical products and promote cooperation, harmonization and mutual recognition of regulatory decisions.

Guiding principles

22. The guiding principles of the AMA will be as follows:

    (a) **Good governance and stewardship:** AMA will observe practices of good governance in creating an enabling environment for sustained regulatory systems, partnership and coordination of activities in an integrated manner.

    (b) **Competency:** AMA will fulfil its functions by deploying and maintaining the best competencies available.

    (c) **Ownership:** Member States will have primary ownership of AMA to ensure that its financial, human, infrastructural and other resources are adequate for performing its functions.

(d) **Transparency and accountability in decision-making:** The AMA will make its decisions independently, based on current scientific evidence, professional ethics and integrity. The detailed evidence of its decision-making process and the justification for its decisions will be fully respected. The AMA will be accountable to Member States of the African Union.

(e) **Confidentiality:** The AMA will adhere to the principles of confidentiality in all its operations.

(f) **Commitment to sound quality management:** In all its functions the AMA will adhere to international standards of quality management and create the conditions for continuous improvement of its regulatory practices and those of NMRAs of Member States of the African Union.

(g) **Partnerships and collaboration:** The AMA will build and strengthen partnerships and promote collaboration and information sharing with all relevant stakeholders.

(h) **Support for innovation:** The AMA will support innovations that will enhance access to new medical products in order to address the public health priorities of Africa.

Functions of the AMA

23. The AMA will have a coordination and stewardship function for the regulatory activities of the Member States. Among the core regulatory functions, the AMA will perform the following:

(a) **Marketing authorization:** The AMA will be responsible for evaluation and decision-making with regard to selected medical products for treatment of priority diseases/ conditions as determined by the African Union.

(b) **Inspection:** The AMA will undertake coordination and share information on a regular basis in regard to all products that it has authorized for marketing.

(c) **Market surveillance:** The AMA will coordinate the collection and sharing of information on all medical products including SSFFC medical products.

(d) **Safety monitoring:** The AMA will be responsible for making regulatory decisions concerning products selected for treatment of priority diseases/conditions as determined by Member States, based on available safety information. In addition, the AMA will collect and store information on the quality and safety of medical products and share them with all its Member States and even globally. It will also establish collaboration with global and regional centres in the area of safety monitoring.

(e) **Oversight of clinical trials:** The AMA will coordinate joint reviews of applications for clinical trials conducted in several countries (multicentre trials).

(f) **Quality control:** The AMA will coordinate and network quality control laboratory services for national and subregional regulatory authorities.

(g) **Capacity strengthening:** The AMA will support strengthening of the capacity of national and subregional regulatory systems.

Expert committees

24. The AMA will have a small critical mass of competent staff to facilitate the work of experts and expert committees. To ensure that NMRAs retain their human resources, the AMA will rely on the contributions of NMRA experts for the evaluation of applications for marketing authorization. Through their participation in the work of these expert committees and regulatory evaluation, the NMRAs will enrich their capacities to perform their mandated functions more effectively.

Governance of the AMA

25. The AMA will be established by the African Union Summit of Heads of State and Government. It will be governed in accordance with the rules and procedures of the African Union. The resources of the AMA will be provided by the AU in accordance with its relevant practices and procedures.

ACTIONS REQUIRED: MILESTONES AND CORRESPONDING TIMELINES

26. The milestones with corresponding timelines in the establishment of the AMA are summarily presented in the table below.

Milestone	Timeline
Adoption of proposal for the establishment of the AMA by the AU Conference of African Ministers of Health	2014
Establishment of a Task Team/Project Unit for operationalization of the objectives of the AMA by Ministers of Health	2014
Decision/endorsement in principle by the AU Summit of Heads of State and Government	2015
Designation of host institution/country	2016
Approval of the governing body of the AMA	2017
Appointment of staff and allocation of resources	2017
Launch of the AMA	2018

FINANCIAL IMPLICATIONS

27. The primary source of funding of the AMA will be the Member States of the AU. In addition, Member States of the AU will provide contribution in kind by dedicating part of the time of their NMRAs staff to the work of the AMA. Funding may also be sought from financial institutions and development partners. As an independent regulatory authority, its funding should not put it in any situation likely to undermine its decision-making processes. A business plan and corresponding budget will be developed by the Task Team to cover staff cost, equipment/infrastructure, and operational costs. The proposed funding mechanism should ensure long-term sustainability and independence of decisions made by AMA.

ROLES AND RESPONSIBILITIES

Member States

28. Member States of the African Union will have the following roles and responsibilities:

    (a) Delegate to the AMA some of the regulatory functions for selected medical products in accordance with the agreement establishing the AMA.

    (b) Allocate adequate resources for the operationalization of the AMA.

    (c) Mobilize additional resources for the AMA.

    (d) Designate a host country/institution and appoint the staff of the AMA.

    (e) Commit themselves (through a Memorandum of Understanding) to the decisions of the AMA.

Regional Economic Communities (RECs)

29. The roles and responsibilities of the RECs will be as follows:

    (a) Ensure the incorporation of regional regulatory policies, standards and practice as part of health protocol in existing trade treaties.

    (b) Ensure the coordination of Member States and their participation in the regional regulatory harmonization schemes.

African Union Commission

30. The roles and responsibilities of the AUC will be as follows:

    (a) Ensure the operationalization and domestication of the AU Model Law on medicines regulation and harmonization.

    (b) Ensure the availability of technical, legal, managerial and administrative procedures for the establishment of the AMA.

World Health Organization

31. WHO in collaboration with relevant stakeholders will provide technical support to the AMA and to subregional and national medicines regulatory authorities.

African Union Commission (AUC) and World Health Organization (WHO)

32. The AUC and WHO in collaboration with relevant stakeholders will establish the Task Team to operationalize the agreed milestones for the establishment of the AMA with due regard to regional representation and skills required to meet the stipulated mandate and criteria for the selection of a host country of the AMA.

WAY FORWARD

33. The first African Ministers of Health meeting jointly convened by the AUC and WHO has reviewed and adopted this proposal and provided policy guidance for the establishment of the AMA.

AUC/WHO/2014/DOC.3
17 APRIL 2014

AGENDA ITEM 6

ORIGINAL: ENGLISH

NONCOMMUNICABLE DISEASES IN AFRICA: POLICIES AND STRATEGIES TO ADDRESS RISK FACTORS

CONTENTS

EXECUTIVE SUMMARY

1. The global burden and threat of noncommunicable diseases (NCDs), mainly cardiovascular diseases, cancer, diabetes and chronic respiratory diseases, pose one of the major challenges to development in the twenty-first century. These diseases undermine social and economic development and hinder the achievement of the Millennium Development Goals in Africa. It is estimated that up to two thirds of premature deaths from NCDs are linked to exposure to four common risk factors, namely tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity. Exposure to the risk factors are prevalent in Africa but are preventable through a multisectoral approach requiring governments to assume a primary role and responsibility that goes beyond the health sector alone. Furthermore, up to half of all NCD-related deaths are linked to weak health systems.

2. Member States of the African Union (AU) have recognized the growing burden of NCDs and their risk factors and have made important commitments to take multisectoral action at national, regional and global levels. These include commitments that Heads of State and Government made in the Political Declaration of the High-Level Meeting of the UN General Assembly on Prevention and Control of Noncommunicable Diseases (September 2011), and subsequent resolutions adopted by the World Health Assembly and WHO Regional Committees, as well as the commitments made at the 6th session of the AU Conference of African Ministers of Health in April 2013.

3. However, despite these commitments and actions, more needs to be done to scale up action to address NCDs and their risk factors in Africa. Implementation of a set of cost-effective interventions and affordable multisectoral interventions by all Member States can reduce exposure to risk factors and lead to a reduction of premature deaths from NCDs.

CONTEXT

Burden of noncommunicable diseases

1. Noncommunicable diseases (NCDs) are responsible for 2.9 million deaths annually in countries in the WHO African Region.[1] Of these deaths, 1.3 million (45%) are premature, occurring between the ages of 30 and 70 years.[2] For the African countries of the WHO Eastern Mediterranean Region, premature deaths account for 24% to 51% of all deaths due to NCDs.[3] The probability of dying from any of the major NCDs between the ages of 30 and 70 years ranges from 14% in Tunisia to 36% in Malawi.[4]

2. According to the Brazzaville Declaration on NCDs prevention and control in the WHO African Region, NCDs include cardiovascular diseases, diabetes, cancers, chronic respiratory diseases, haemoglobinopathies (in particular sickle cell disease), mental disorders, violence and injuries. The persistent burden of communicable diseases associated with the ever increasing burden of NCDs and the associated disabilities and premature deaths has put Africa under a double burden of diseases. Health systems are weak in addressing NCDs and should be strengthened by giving adequate attention to inter alia: health financing; training; retention of the health workforce; procurement and distribution of medicines, vaccines, medical supplies and equipment; improving infrastructure; and delivering evidence-based and cost-effective services for NCDs.

3. Premature deaths from NCDs reduce productivity, curtail economic growth and trap populations in the lowest income quintiles in chronic poverty. The exorbitant costs of treating NCDs and their complications are driving approximately 100 million people in Africa into poverty annually and undermine socioeconomic development.[5] Up to two thirds of premature deaths are linked to exposure to four shared common modifiable risk factors namely tobacco use, harmful use of alcohol, unhealthy diet, and physical inactivity. These risk factors are preventable through action that requires governments to assume the primary role and responsibility of reducing exposure.

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1. WHO Global Burden of Disease (2011).
2. WHO Global Burden of Disease (2011).
3. WHO Global Status Report on NCDs (2010).
4. WHO Global Burden of Disease (2008).
5. A report of the African Union in April 2013.

Determinants and risk factors for NCDs

4. Globalization of marketing and trade particularly in tobacco, alcohol and food, rapid urbanization and population ageing have led to a rapid rise in NCDs and an interplay between communicable diseases, maternal and perinatal conditions, nutritional deficiencies and NCDs in Africa. Many governments in Africa have been unable to meet the ever-expanding needs for legislation, policies, and regulatory frameworks that protect populations and individuals from exposure to risk factors for NCDs.

5. The prevalence of exposure to risk factors for NCDs is high in Africa. The average prevalence of current smoking among persons aged 15 years and above in Africa is 15%.[6] There is increasing consumption of unhealthy foods rich in calories, sugars, fats and salt but poor in nutrients. The prevalence of overweight is also increasing among Africans, estimated at 25% for persons aged 20 years and above. Harmful use of alcohol is also common. Although 7 out of 10 people in Africa abstain from alcohol use, the average volume of pure alcohol consumed per drinker per unit of time is high. For instance, in some countries of the WHO African Region, consumption is estimated at about 35 liters of pure alcohol per drinker per year.

6. In contrast, in countries of the WHO Eastern Mediterranean Region, per capita consumption is generally far lower than the global average. However, the pattern of consumption is generally 2 on a scale of 1–5 implying that there is heavy episodic drinking. In Africa physical inactivity is prevalent with higher rates among women and children compared with men. The prevalence of insufficient physical activity in African populations is estimated at 26% in people aged 15 years and above. The major contributory factors for physical inactivity include lack of leisure and recreation facilities, increased use of motorized transportation, and less physically-demanding employment.

7. Singly or in combination, these behavioural risk factors contribute to four key metabolic/physiological changes: raised blood pressure, hyperglycemia, hyperlipidemia, and overweight/obesity. These, in turn, increase the risks of diabetes, hypertension and a number of common cancers. National health systems should be oriented towards promoting

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6. Facts on tobacco use in the African Region, World Health Organization, Regional Office for Africa, Brazzaville, 2012.

and supporting healthy lifestyles among individuals, families and communities within the primary health care context in order to effectively respond to the complex social, cultural and behavioural issues associated with NCDs; as well as secondary and tertiary prevention of NCDs.

8. The 6th Session of the AU Conference of African Ministers of Health (Addis Ababa, 25-26 April 2013) that convened under the theme *"The Impact of NCDs and Neglected Tropical Diseases on Development in Africa"*, expressed concern that Africa has been experiencing adverse socio-economic consequences of NCDs, that situation is slowing progress towards the attainment of the Millennium Development Goals. The ministers called upon the African Union Commission, together with regional health organizations, WHO, and other partners, to develop a roadmap for tackling NCDs in Africa.

9. Member States in Africa have also made global commitments to address NCDs. In September 2011, Heads of State and Government adopted a Political Declaration at the High-level Meeting of the UN General Assembly on the Prevention and Control of NCDs.[7] The Declaration urges governments to adopt innovative approaches to NCD policy development to ensure that NCDs receive an appropriate multisectoral response. Accordingly, the Declaration set forth recommendations to promote, establish or strengthen, by 2013, multisectoral national policies and plans for the prevention and control of NCDs.

10. In order to implement the commitments of the Political Declaration, the 66th World Health Assembly in May 2013 adopted nine voluntary targets to reduce NCDs and endorsed the WHO Global NCD Action Plan 2013–2020 that provides a roadmap and a menu of policy options for Member States. United Nations agencies and non-state actors have committed themselves to take coordinated and coherent action, at all levels, to support these global commitments. Member States also committed to consider setting national targets based on the global targets. The WHO Regional Committees for Africa and the Eastern Mediterranean have further supported these commitments, for example, through developing regional frameworks for action to implement the UN Political Declaration.[8] The WHO Executive Board at its 134th session in January 2014 recommended four priority actions for consideration by the Sixty-seventh World Health Assembly. These are: (i) strengthening governance for NCDs; (ii) reducing exposure to risk factors for NCDs; (iii) enabling health systems to respond; and (iv) measuring results.

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7. Resolution A/RES/66/2 available at http://www.un.org/en/ga/search/view_doc.asp?symbol=%20A/RES/66/2
8. EM/RC59/R.2.

11. These priority actions address cost-effective and affordable intervention "best buys" that aim to reduce exposure to risk factors in Member States. Examples of such interventions include addressing: **tobacco use** (increasing taxes, running mass media campaigns, legislating for completely smoke-free environments, issuing effective health warnings, and banning all forms of tobacco advertising, promotion and sponsorship), **harmful use of alcoho**l (reducing availability, using pricing policies, restricting or banning advertising and promotion) and **unhealthy diet** (reducing salt intake, increasing the intake of fruits and vegetables in diets, replacing trans-fats with unsaturated fat, and implementing public awareness programmes on diet and physical activity).

12. To fully implement these ''best buys'' there is need for a multisectoral, whole-of-government approach aimed at reducing the exposure of populations and individuals to common risk factors for NCDs. The WHO 2013 Country Profile of Capacity and Response to NCDs found that, while more countries have policies to tackle NCDs (compared with 2010), only a few of the policies are multisectoral and engage sectors outside health. In addition, existing plans are often not funded or implemented. Similarly, the African countries of the WHO Eastern Mediterranean Region have NCD units in ministries of health (or equivalent), but lack the capacity needed to implement national prevention programmes.

IMPLEMENTATION OF KEY POLICIES, STRATEGIES AND INTERVENTIONS TO ADDRESS NONCOMMUNICABLE DISEASES

13. WHO has produced policies, strategies and tools to address NCDs and their risk factors. Examples of these include: The *Global Action Plan for the Prevention and Control of Non communicable diseases (2013-2020); The Moscow Declaration on NCDs (2011); the WHO Framework Convention on Tobacco Control (2003); and the Global strategy on diet, physical activity and health (2004). Others are the African Regional Strategy to Reduce Harmful Use of Alcohol (2010), the Brazzaville Declaration on NCDs (2011), Health Promotion: Strategy for the African Region (2012) and the East Mediterranean Regional Framework for Action to Implement the UN Political Declaration.*[9] In addition, there have been other corresponding initiatives to reduce exposure to risk factors for NCDs. They include taxation, capacity building and enactment of laws on product marketing and labelling.

9. EM/RC59/R.2.

14. **Tobacco use:** The WHO Framework Convention on Tobacco Control (WHO FCTC) provides a clear way forward for tobacco control in Africa, but countries are at different stages of its implementation. In Africa, 45 countries are Parties to the WHO FCTC, 34 countries have set national objectives for tobacco control, while 41 countries have established national tobacco control agencies. Only five[10] countries levy taxes at over 70% of retail price. Thirty-two countries have measures to protect people from exposure to second-hand tobacco smoke in public places, but only six of these have comprehensive smoke-free legislation. Thirty-eight countries have legislation to ban tobacco advertising, promotion and sponsorship, 11 of which have imposed a total ban. Twenty-nine countries have run national surveys in the past five years to monitor the tobacco epidemic among both adults and youths.

15. **Harmful use of alcohol:** In 2010, the WHO Regional Committee for Africa adopted the *Regional Strategy to Reduce Harmful Use of Alcohol.*[11] *The Global Survey on Alcohol and Health (GSAH)* conducted in 49 countries of the African Union shows that, to date, 10 countries have comprehensive alcohol policies at various stages of implementation. Only 10 countries have established a coordination mechanism aimed at bringing together other sectors or stakeholders to address harmful use of alcohol. Regarding drink-driving policies, only 18 countries apply the maximum limit of 0.5 g/l for blood alcohol concentration (BAC) while the remaining countries either have no set BAC limits or the levels are above 0.5g/l. Although taxation has increased in 15 countries, stronger measures are required to regulate traditional outlets, underage drinking and advertising which often target young people, women and the poor.

16. **Unhealthy diets and physical inactivity:** The *WHO Global Strategy on Diet, Physical Activity and Health*[12] (DPAS) focuses on the promotion of healthy diets and regular physical activity for the prevention of noncommunicable diseases. Implementation should be multisectoral and use a range of regulatory instruments, focusing on population-wide prevention policies; health promotion in settings like schools, workplaces, recreational facilities and communities; and improving health literacy, diet and physical activity across population groups and settings including schools, workplaces and residential areas. Early nutrition interventions for Member States, as contained in the WHO Comprehensive Implementation Plan for Maternal, Infant and Young Child Nutrition 2012–2025,[13] are required to prevent the rapid rise in the burden of NCDs.

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10. Egypt, Madagascar, Mauritius, Sudan and Tunisia.
11. WHO, Regional Strategy to reduce Harmful use of Alcohol in the Region (Doc AFR/RC60/4): Brazzaville, World Health Organization, Regional Office for Africa, 2010.
12. Available at http://www.who.int/dietphysicalactivity/goals/en/
13. Available at http://www.who.int/nutrition/topics/wha_nutrition/en/

CHALLENGES

17. Despite the progress made, challenges remain in realizing the commitments made to address NCDs and their risk factors in Africa. These include:

    (a) limited development and/or systematic enforcement of national laws (evidence-based legislation and regulations, fiscal policies) to reduce exposure to risk factors for NCDs;

    (b) fragile health systems, including lack of reorientation of health systems and primary care; inadequate access to affordable essential medicines for NCDs; weak mechanisms for sustainable health financing; inadequate human resources capacity at national and local levels; weaknesses in screening, early detection, cure, care and rehabilitation programmes;

    (c) limited surveillance and health information systems to monitor the trends of NCDs and their risk factors and assess progress in implementing agreed policies, strategies and interventions;

    (d) interference by industry players, particularly those associated with tobacco, alcohol, non-alcoholic beverages and unhealthy foods, through intensified marketing and involvement in national policy development, which weakens regulatory laws in favour of self-regulation;

    (e) political instability, conflicts, natural disasters, and chronic emergencies.

ACTIONS REQUIRED

18. In order to accelerate implementation of actions identified at both global and regional levels to address NCDs and their risk factors, countries of Africa should:

    (a) increase the priority accorded to NCDs in development work at regional and national levels; integrate the prevention and control of such diseases into policies across all government departments and provide high-level leadership, through the participation of the public sector in partnership with civil society organizations, the private sector and communities, in NCDs prevention and control; and intensify advocacy.

(b) Set national NCD targets for 2025 based on national situations, taking into account the nine global targets for NCDs.

(c) Develop a national multisectoral plan to achieve national targets, taking into account the WHO Global NCD Action Plan 2013–2020 and regional action plans.

(d) As part of the implementation of a national multisectoral action policy and plan, prioritize the implementation of very cost-effective and affordable interventions ("best buys") to reduce exposure to risk factors for NCDs and enable health systems to respond.

(e) Strengthen primary health care to prevent NCDs morbidity and mortality due to related complications such as strokes, heart attacks, amputations and blindness through the multiple risk factor approach that is a very cost-effective "best buy".

(f) Strengthen national surveillance of NCDs, covering monitoring of (i) risk factors and determinants; (ii) outcomes (mortality and morbidity); and (iii) health systems response; and integrate surveillance into national health information systems to ensure the collection of data on the 25 globally agreed indicators.

(g) Protect public health policies from interference by vested interests of industry through comprehensive legislation and enforcement of national laws and policies.

(h) Ratify the WHO FCTC and the Protocol to Eliminate Illicit Trade in Tobacco Products.

(i) Mobilize resources and allocate them in adequate, predictable and sustainable manner for prevention and control of NCDs and for universal health coverage, through an increase in domestic budgetary allocations, voluntary innovative financing mechanisms and other means, including multilateral financing, bilateral sources, and private and/or nongovernmental sector(s).

(j) Use all the above-mentioned action points to set milestones for a roadmap aimed at preventing and controlling NCDs in Africa.

19. AUC, WHO and partners should also ensure that NCDs and their risk factors are integrated in emergency and disaster preparedness and response in countries of Africa.

20. Members States in Africa should take advantage of the United Nations General Assembly comprehensive review and assessment meeting scheduled to take place on 10 and 11 July 2014 in New York to take stock of the progress made in implementing the commitments in the Political Declaration, identify gaps and reaffirm their political commitment to respond to the challenge of NCDs.

AUC/WHO/2014/DOC.4
17 APRIL 2014

AGENDA ITEM 7

ORIGINAL: ENGLISH

ENDING PREVENTABLE MATERNAL AND CHILD DEATHS IN AFRICA

CONTENTS

BACKGROUND

1. Women and children's health is given particular recognition as a development and human rights issue in Africa.[1,2,3] Investing in the health of women and children lays a strong foundation for sustainable social, economic and environmental development, and for peace and security. It has been estimated that increasing health expenditure by just US$ 5 per person per year, between 2013 and 2035, in 74 high-burden countries (46 of which are in Africa) could yield up to nine-fold dividends in economic and social terms.[4]

2. For over 10 years, there has been a strong political will on the continent to improve health outcomes for women and children. Evidence of this includes the Continental Policy Framework on Sexual and Reproductive Health Rights (SRHR) and the Maputo Plan of Action for SRHR implementation as well as the strong commitments expressed by African States in regard to the Campaign for Accelerated Reduction of Maternal Mortality (CARMMA) and the UN Global Strategy on Women's and Children's health and its related *Every Woman, Every Child campaign.*

3. In 2010, the African Union, for the first time ever, focused the deliberations of its Assembly of Heads of State and Government on the theme of *"Maternal, Infant and Child Health and Development in Africa".*[5] In 2013 the African Union and the Government of South Africa hosted an international conference on maternal, newborn child health. The conference came up with a plan of action for ending preventable maternal, newborn and child deaths.

4. The recent global and regional initiatives aiming to improve women and children's health have generated substantial resources. Over US$ 40 billion have been committed to improving health outcomes for women and girls since the launch of the UN Global Strategy in 2010. Of that amount, over US$ 25 billion have been already disbursed.[6] In addition, the increase in domestic resources in some countries has led to reinvestments in social policies[7] including in the health sector.

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1. African Union. African Charter on the Rights and Welfare of the Child, 1990.
2. African Union. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2003.
3. Addressing the Challenge of Women's Health in Africa. Report of the Commission on Women's Health. WHO Regional Office for Africa, Brazzaville 2012.
4. The Partnership for Maternal, Newborn and Child Health, 2011. A Global Review of the Key Interventions Related to Reproductive, Maternal, Newborn and Child Health (Rmnch). Geneva, Switzerland: PMNCH.
5. African Union Summit on Maternal, Infant and Child Health and Development, 19-27 July 2010 Kampala, Uganda.
6. The PMNCH 2013 Report: Analysing Progress on Commitments to the Global Strategy for Women's and Children's Health. Geneva, 2013.
7. Africa Progress Panel. Africa Progress Report 2013: Equity in Extractives, Geneva, 2013.

5. Despite these tremendous efforts, the situation of women and children has not been improving. Many African countries are facing a daunting challenge in achieving Millennium Development Goal 4 (MDG4) on reducing under-five mortality rate by two thirds between 1990 and 2015 and Millennium Development Goal 5 (MDG5) on reducing maternal mortality by 75% and achieving universal access to reproductive health care.

6. Maternal deaths have been reduced globally including on the African continent. It declined by 41% between 1990 and 2010 in sub-Saharan Africa and by 66% in North Africa[8] over the same period. At the same time most countries in the Region are a long way from reaching the MDG target related to family planning. Despite the increased political attention to family planning in recent years, most countries are far from reaching the set goal of 0% unmet need for family planning.

7. On the African continent only three countries (Equatorial Guinea, Egypt and Eritrea) are projected to achieve MDG5 by 2015. In addition, sub-Saharan Africa has the largest proportion (10%) of maternal deaths attributed to HIV. In fact, in 2010, of the 19 000 maternal deaths due to HIV/AIDS worldwide, 17 000 (91%) were in sub-Saharan Africa. In addition, for a woman who dies while giving birth, an estimated 20 women suffer from injuries including obstetric fistula.

8. Overall mortality rates for adolescent girls aged 15–19 years in low-and middle-income countries are over four times higher than for girls in high-income countries and over ten times higher when the comparison is made between girls in Africa and girls in high-income countries.[9] Nearly 50% of unsafe abortions among girls aged 15 to 19 years occur in Africa and over 40% of new HIV infections in Africa occur among young people.

9. Africa accounts for the highest number of deaths among children under five years of age. Estimates in 2012 indicate that of the 6.5 million global under-five deaths, 4 million occurred in Africa.[10] Despite the rapid pace of reduction of under-five mortality, progress in improving child survival is still too slow. Most of the child deaths are due to preventable and treatable conditions such as pneumonia, diarrhoea, malaria and newborn conditions.

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8. Trends in maternal mortality: 1990–2010. WHO, UNICEF, UNFPA and The World Bank estimates. World Health Organization, Geneva, 2012.
9. Patton GC, et al. 2009. "Global patterns of mortality in young people: a systematic analysis of population health data." Lancet 374: 881–892.
10. UNICEF, Levels and Trends in Child Mortality — Report 2013: Estimates developed by the UN Interagency Group for Child Mortality Estimation.

10. In 2012, about a third of under-five deaths in Africa occurred during the neonatal period at a rate of 30 deaths per 1000 live births, with sub-Saharan Africa alone accounting for 38% of global neonatal deaths. Most of these deaths are due to complications of prematurity and low-birth weight, birth asphyxia and infections. Improving newborn health will require targeted investments that are different from those required to improve the health of children under five years of age and those that are strongly linked to maternal health interventions.

11. While recognizing the progress made in improving the health of the populations, much remains to be done to improve the health of women, children and youths who are central to the sustainable development of African countries. Currently there are many opportunities that create an enabling environment for progress.

12. In line with the African Union Heads of State Summit Declaration on Maternal, Newborn and Child Health (MNCH) and the African Union MNCH Action Plan, this paper highlights three main issues and strategic considerations that could be pivotal in significantly improving the trends towards achieving the set targets. This paper also proposes actions for consideration by ministers of health of African countries.

ISSUES AND CHALLENGES

13. **Delay in accessing care:** In most African countries maternal, newborn and child deaths occur at home, while existing MNCH services are underutilized at moments critical for maternal and child health. Opportunities for strengthening care in households may be missed because families are not informed or empowered to take actions that promote health while at the same time the socioeconomic conditions in which they live hamper their ability to make appropriate choices. The delays caused by long distance before reaching health facilities, the care-seeking behaviour and choices of households, and financial constraints all contribute to poor MNCH outcomes.

14. **Weak health systems:** Establishing and sustaining a functional health system that can provide universal coverage of quality care is a challenge for many countries in Africa. Inadequate physical health infrastructure including transport for referral, lack of medicines and medical equipment constitute a barrier to equitable access to quality services.

15. **Acute shortage of skilled, motivated and appropriately deployed human resources:** Challenges linked to the training of human resources, their deployment to rural and remote areas where most of the maternal, newborn and child deaths occur, and their retention (linked to poor remuneration, management and career development among others) constitutes a major barrier to the provision of quality RMNCH services.

16. **Insufficient financial resources:** Current investment in health is not sufficient to meet health-related MDGs. In addition a 2010 WHO report highlights issues concerning efficient use of available resources. The high-level Taskforce for Innovative International Financing for Health Systems estimated that by 2009 a low-income country would need to spend on average US$ 44 per capita to strengthen its health system and provide an essential package of health services. This US$ 44 estimate was projected to rise to US$ 60 by 2015. According to a WHO national health account report 2012, Government Health Expenditure (GHE) in most African countries ranges from US$ 7 to US$ 618 per capita with 18 countries[11] spending less than US$ 20 per person per year, 14 countries[12] spending between US$ 20 and US$ 60 while only 14 countries[13] have GHEs above US$ 100.

17. **Gaps in availability of reliable data and timeliness to guide decision making in countries:** Insufficient, untimely availability and inadequate use of good quality data for many of the indicators coupled with limited funding to upgrade the civil registration and health information systems to generate these data constitute a major obstacle for monitoring and evaluation. In addition, the measurement of progress on MDGs is generally based on national averages that mask a number of subnational or regional disparities and inequalities.

18. In addition to the above, coordination of donors is weak, leading to fragmentation and competition in the implementation of identified strategies.

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11. Benin, Burundi, Central African Republic, Chad, Democratic Republic of Congo, Eritrea, Ethiopia, Gambia, Guinea, Kenya, Liberia, Mali, Malawi, Madagascar, Niger, Sierra Leone, Uganda and Tanzania.
12. Burkina Faso, Cameroon, Comoros, Cote D'Ivoire, Gambia, Mauritania, Mozambique, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sudan, Togo and Zambia.
13. Algeria, Angola, Botswana, Cape Verde, Equatorial Guinea, Gabon, Lesotho, Libya, Mauritius, Namibia, Seychelles, South Africa, Swaziland and Tunisia.

ACTIONS PROPOSED

19. In order to end preventable maternal and child deaths i.e. reduce maternal mortality to less than 50 per 100 000 live births, less than 20 child deaths per 1000 live births, and less than 10 newborn deaths per 1000 live births by 2035, known cost-effective interventions need to be scaled up and new strategies that are innovative and dynamic should be explored with the aim to improve equity between and within countries. Countries should explore the potential of new information and communication technologies to improve access to reproductive, maternal and child health care and to facilitate reporting and analysis of data to inform public health actions.

20. In this regard, countries should facilitate implementation of the following proposed actions:

    (a) Ensure access to an integrated package of essential and high impact interventions and services along the continuum of care, including for vulnerable and mobile populations, nomads, women and children in emergencies. This package ranges from access to voluntary family planning, prevention and management of complications of pregnancy, promotion of safe childbirth, access to emergency obstetric and newborn care services, and provision of essential vaccines (including new vaccines such as Rotavirus, pneumococcal and HPV) and treatment for HIV and AIDS, malaria, tuberculosis, diarrhoea, pneumonia and other neglected diseases. Targeted interventions should be implemented on a reasonable scale addressing both demand and supply aspects.

    (b) Scale up and improve investments in human resources for health using as guiding documents the Roadmap for Scaling up Human Resources for Health for Improved Health Service Delivery in the African Region 2012–2025 and the commitments of the Third Global Conference on Human Resources for Health, held in Recife, Brazil, in 2013.

    (c) Institutionalize long-term sustainable health financing options to have universal health coverage and remove financial barriers to accessing MNCH services. Countries should assess the progress they have made in the implementation of the "Abuja Call" targets on health financing and take the necessary action.

    (d) Support the development of a multisectoral coordination mechanism to oversee investments in the critical social, economic and environmental determinants of health. In recognition of the inherent impact of these distal determinants of maternal and

child health, countries should invest in girls' education, gender equality (including the prevention of child marriage), food and nutrition security, water and sanitation, and urban and rural infrastructure.

(e) Establish and strengthen tracking and monitoring systems (such as institutionalization of RMNCH performance management scorecards), disease surveillance (including institutionalization of maternal and perinatal death surveillance, review and response) and strengthening of civil registration of births and deaths in order to provide better information for action and monitor improvements in RMNCH.

(f) Work with civil society organizations to strengthen the capacity of communities and, particularly male involvement, in the identification of RMNCH problems, the planning, financing and implementation of solutions and the creation of accountability mechanisms.

(g) Ensure better coordination, alignment and harmonization of existing RMNCH initiatives. Countries should build on existing mechanisms or establish a coordination mechanism to oversee implementation and alignment with the plans of the various RMNCH regional and global initiatives.

AUC/WHO/2014/DOC.5
17 APRIL 2014

AGENDA ITEM 8

ORIGINAL: ENGLISH

ESTABLISHMENT OF AN AFRICAN CENTRE FOR DISEASE CONTROL AND PREVENTION

CONTENTS

* See paragraph 8

BACKGROUND

1. Globally, around 54.5 million people die each year. One in eight of these deaths occurs in children under five years of age. Most of these preventable deaths in children occur in low- and middle-income countries. About 74% of child deaths occur in Africa and South-East Asia and 45% of Disability-Adjusted Life Years (DALYs) in low-and middle-income countries are caused by noncommunicable diseases.[1] Africa bears a large proportion of the global burden of disease and current efforts to address this challenge need to be scaled up.

2. Africa also bears about half of the global burden of Neglected Tropical Diseases (NTDs). NTDs such as guinea-worm disease, buruli ulcer and human African trypanosomiasis affect only or mainly the African continent. Inaction on these diseases is having serious developmental and economic consequences because of the attendant decline in school performance, retardation of growth, absenteeism from school and work, and loss of productivity. It has further been noted that Neglected Tropical Diseases are affecting children, peasants and the poor, causing varying degrees of disability and perpetuating the cycle of poverty.[2]

3. Communicable diseases remain the commonest health condition and their prevalence and burden have a huge socioeconomic impact including loss of quality of life for many people in Africa. Communicable diseases such as malaria, tuberculosis, AIDS and meningitis still kill millions of people each year while cholera has become endemic in most African. Some of the new developments in communicable diseases in Africa include the resurgence of wild poliovirus in countries where polio had disappeared, while mortality due to measles and tetanus[3] is on the increase.

4. Africa has not been spared from natural and man-made disasters and, every day, hundreds of millions of people face threats to health and livelihoods because local and national systems that support their health and lives are either overwhelmed or too weak to withstand crises and extreme events. This calls for Africa to focus more on disaster preparedness and response. Floods, droughts and wars usually result in extreme humanitarian challenges including spread

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1. World Health Organization (2013). Mortality and global health estimates. Available from: http://www.who.int/gho/mortality_burden_disease/en/ [Accessed: 18 February 2014].
2. World Health Organization (2013). Neglected Tropical Diseases. Available from: http://www.afro.who.int/en/mozambique/country-programmes/disease-prevention-and-control/neglected-tropical-diseases.html[Accessed: 18 February 2014].
3. World Health Organization (2013). Integrated Disease Surveillance (IDS). Available from: http://www.afro.who.int/index.php?option=com_content&view=article&id=698&Itemid=883 [Accessed: 18 February 2014].

of diseases and escalation of malnutrition. Repeated floods, droughts, conflicts and disease outbreaks overstretch the already fragile health systems and other infrastructure and pose major challenges to emergency response. Furthermore, armed conflicts in Africa are recurrent and, in most instances, complex in nature.[4] One of the drawbacks in controlling diseases in humanitarian emergencies is inadequacy of situation analyses, standard guidelines and technical support. That calls for the provision of expertise to fill the gap, based on lessons learned from the work being done by WHO and other partners in countries where health is fragile. Africa should be able to achieve its primary objective in disaster preparedness and response and reduce avoidable loss of life and the burden of disease and disability.[5] In most cases, even when disease outbreaks are diagnosed in emergency situations, countries do not know how to respond to them. Hence, the establishment of a standard set of international health regulations is crucial.

5. Apart from the high prevalence of diseases in Africa, the continent also has limited ability to detect these diseases. Medical laboratories in Africa are underdeveloped and unable to meet the demands of rapidly growing health delivery services in the 21st century.[6] It has also been reported that Africa's poor diagnostic capacity is likely to persist for decades if no deliberate efforts are made. In that event, the existing diseases that pose a pandemic threat may not be identified in a timely manner to support containment efforts.[7] If this situation is to be averted, Africa needs to strengthen its health systems including its laboratory capacities. African laboratory services are usually characterized by inadequate staffing, equipment and supplies and these hinder early detection of epidemics such as Ebola, Marburg and both multidrug-resistant and extensively drug-resistant tuberculosis.[8] Africa needs to strengthen its public health laboratory systems by improving effective disease surveillance and preventing major emerging, re-emerging and endemic communicable diseases and noncommunicable diseases.

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4. World Health Organization (2013). Disaster Preparedness and Response (DPR). Available from: http://www.afro.who.int/index.php?option=com_content&view=article&id=981&Itemid=916 [Accessed: 18 February 2014].

5. World Health Organization (2013). Humanitarian Health Action. Available from: http://www.who.int/hac/about/faqs/en/index.html [Accessed: 18 February 2014].

6. African Society for Laboratory Medicine (2013). ASLM2020: Strategies and Vision to Strengthen Public Health Laboratory Medicine in Africa. Available from: http://www.google.com.et/url?sa=t&rct=j&q=&esrc=s&source=web&cd=7&ved=0CF0QFjAG&url=http%3A%2F%2Fwww.aslm.org%2F%3Fwpdmdl%3D1&ei=8-MCU-mRFJKrhAeQooHwBw&usg=AFQjCNE9K7vNmLlurM33LrXA5tcsZVVurw&bvm=bv.61535280,d.ZG4[Accessed: 18 February 2014].

7. SciDev. Net (2009). Expert Highlight Lack of Swine Flu Diagnosis. Available from: http://www.scidev.net/global/health/news/experts-highlight-lack-of-swine-flu-diagnostics.html [Accessed: 18 February 2014].

8. World Health Organization (2013).Fifty-eighth session of the WHO Regional Committee. Available from: http://www.afro.who.int/en/fifty-eighth-session.html [Accessed: 18 February 2014].

6. Contrary to previous perceptions, mortality risks for noncommunicable disease are highest in middle-and low-income countries especially in sub-Saharan Africa. Noncommunicable diseases (NCDs) like heart attacks and strokes, cancers, diabetes and chronic respiratory diseases account for over 63% of deaths in the world today. Every year, according to WHO, NCDs kill 9 million people aged below 60 years.

7. Taking into account all these challenges faced by the continent of Africa, there is need to put in place a structure to support African countries to effectively respond to emergencies, obtain technical support to address complex health challenges and build the needed capacity. An African Centre for Disease Control and Prevention (ACDCP) would be an ideal body to support African countries in reducing their disease burden, especially by addressing communicable diseases, emergency situations and capacity building.

8. The Ministers of Health reviewed the entire sections of the technical document AUC/WHO/2014/Doc.5 on the "establishment of an African Centre for Disease Control and Prevention".

   However, the meeting noted that some sections in the technical document were missing while others required further elaboration.

   The ministers of health therefore suggested, during the plenary, the incorporation of the following elements in the document:

   (a) clear justification for the establishment of the centre while taking cognizance of the existence of other regional centres of excellence;

   (b) definition of the mission and detailed terms of reference of the centre;

   (c) guidance on the criteria required for hosting the centre;

   (d) processes for determining the financial contributions from the Member States;

   (e) comprehensive roadmap for the implementation and sustainability of the centre.

   In order to finalize the technical document based on the recommendation of the ministerial meeting, it was agreed that a multi-task force be established, comprising the AUC, WHO, Government of the Republic of Ethiopia and interested Member States.

JUSTIFICATION FOR ESTABLISHING THE CENTRE
MISSION
OBJECTIVES FOR ESTABLISHING THE CENTRE

9. The main objectives for establishing the Centre are:

   (a) to effectively prevent, detect and respond to diseases;

   (b) to strengthen public health capability in disease detection, surveillance and response;

   (c) to establish information sharing network among relevant stakeholders and coordinate disease surveillance and detection as well as response to public health threats affecting Africa;

   (d) to contribute to country public health capacity building;

   (e) to act as Africa's disease database with a rich source of research capacity and through storage of relevant reports and pathogen samples;

   (f) to support the prevention and control of noncommunicable diseases;

   (g) to promote and undertake research related to noncommunicable diseases, communicable diseases, neglected tropical diseases, circulating pathogens and health protection;

   (h) to enhance cross-border and intersectoral collaboration in public health issues by raising awareness of the impact of public health threats on the health development of Member States and communities.

10. Furthermore, the Centre will align its work to existing guidelines such as the International Health Regulations framework.

MANDATE

11. At the African Union Special Summit on HIV, TB and malaria (ATM) in Abuja in July 2013, the Heads of States and Government took cognizance of the need for an African Centre for Disease Control and Prevention (African CDC) to conduct life-saving research on priority health problems in Africa and to serve as a platform to share knowledge and build capacity in responding to public health emergencies and threats. The Assembly then requested the AU

Commission to work out the modalities of establishing an African Centre for Disease Control and Prevention. The request was reaffirmed in decision **Assembly/AU/Dec.499 (XXII)** of the 22nd Ordinary Session of the African Union (AU) Assembly held in Addis Ababa, Ethiopia, in January 2014 that stressed the urgency to establish the centre. The decision further requested the AU Commission, working in collaboration with the Government of Ethiopia and other interested Member States, to submit a report to the Assembly by January 2015 including the legal, structural and financial implications of the establishment of the Centre. By that same decision, the AU Assembly recommended the establishment of the Centre.

TERMS OF REFERENCE FOR THE ACDCP
CRITERIA FOR HOSTING THE ACDCP
PROPOSED MODUS OPERANDI

12. The African Centre for Disease Control and Prevention (ACDCP) is expected to leverage the capacities that already exist on the continent. Consequently, it is important to undertake an inventory and mapping of:

    (a) All existing national CDC-type of institutions in Africa including those that are in the making.

    (b) Regional institutions that can be a component part of the network of the ACDCP e.g. African Society for Laboratory Medicine, African Field Epidemiology Network, and African Medicine Harmonization and Regulatory Authority (when established).

    (c) Research institutions that will be part of the ACDCP network e.g. UVRI, KEMRI, ANDI, etc.

    (d) What can be done at national level and what can be done at regional and continental levels, i.e. the value addition of the ACDCP.

13. In line with above, the following modus operandi is proposed with regard to the establishment of the African Centre for Disease Control and Prevention.

Structure

14. The ACDCP is expected to have its headquarters in one African country with satellite agencies in the form of centres of excellence, specialized laboratories and resources spread in selected countries or regions. The headquarters will be responsible for administration,

human resources management, resource mobilization and needs analysis and therefore its staff composition will be dominated by managers. Countries are expected to call upon the ACDCP for specific technical support and, in turn, the headquarters will call upon the appropriate specialized centre and regional or international organizations to address the countries' needs. The related financial and other resource needs will be met through the facilitation of the headquarters.

15. In order to reap the benefits of specialization, each satellite agency will focus on a particular area of service delivery (e.g. emergency response, emerging and re-emerging diseases, etc.) and will be called upon by the headquarters to respond to particular country requests. The staff in the satellite centres will be dominated by scientists (public health experts, epidemiologists, biologists, etc.) who will be experts in the Centre's area of speciality. However, the satellite centres may have a lean administrative structure.

16. The ACDCP will provide support to Member States on surveillance and response to ensure timely detection of communicable and noncommunicable disease threats, their assessment as well as enabling MS to mitigate them. This will aim to coordinate and complement the response activities of WHO and the Global Alert and Response Network (GOARN).

17. The specific types of response include access to diagnostic testing by transporting samples to pre-designated specialized laboratories and centres of excellence in a network for Africa and abroad, stockpiles of materials as well as the deployment of experts and scientists.

18. High-level advocacy with Member States and donors for resource mobilization will be needed to ensure that the mechanisms put in place actually work. ACDCP will establish an information sharing network with WHO and international partners.

19. The ACDCP will also act as a resource centre for reports on good practices, African pathogen species/strains, case reports and specialized laboratories for storage of samples following internally set standards such as IHR while collaborating with already established internal organizations.

Linkages

20. The ACDCP will not commence with the establishment of a brick and mortar structure but will leverage on what already exists. Existing regional centres that demonstrate the required capacity can be adopted by the ACDCP through mutual agreements. Learning institutions

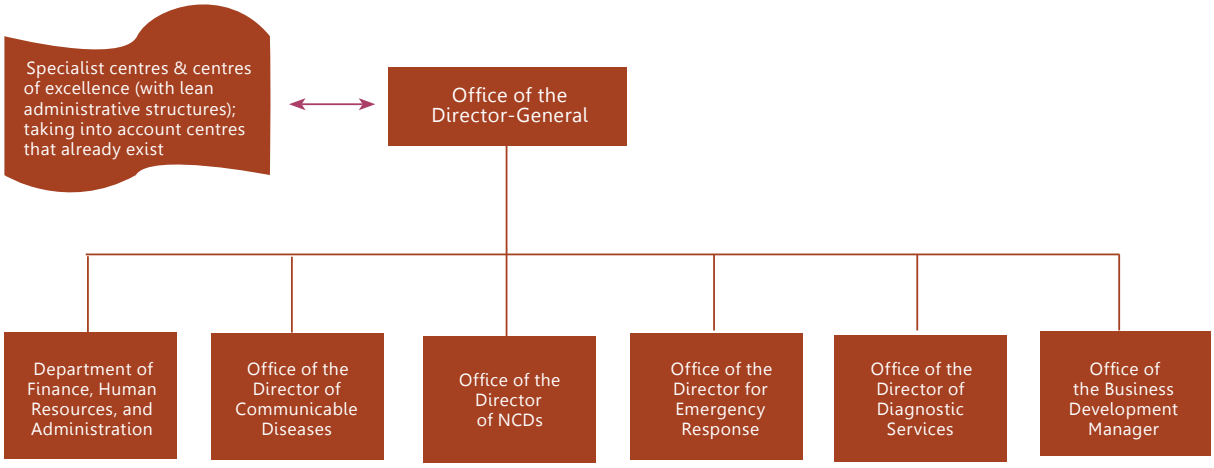
and professional institutions such as the African Society for Laboratory Medicine can play a role in capacity building, quality assurance and quality control. The ACDCP will cooperate with organizations such as the African Union Commission and the World Health Organization for policy direction.

21. ACDCP will seek partnership with other CDC centres (US, EU, China and others) to benefit from technical assistance in implementing event-based surveillance, reporting systems and other needed training for the staff.

22. Collaboration could also be built around the internet scanning system that WHO and the Global Health Security Action Group (GHSAG) are jointly developing.

PROPOSED STRUCTURE/ORGANOGRAM OF THE CENTRE

23. In order to be effective and less resource-consuming, the ACDCP needs to have a structure that is as lean as possible. A proposed structure of its organogram is presented as follows:



24. A detailed organogram will be developed after conducting a needs assessment after which the organogram is expected to enumerate the staff in each office at the headquarters and in the satellite centres. While reporting to the Director-General, the other Directors and satellite centres can have their own support staff.

FINANCIAL IMPLICATIONS

25. The full financial implications will be determined after a situation analysis. It will include start-up costs (e.g. infrastructure and equipment), staff salaries, operational costs and mission costs. Resources are expected to be mobilized from regular contributions of African countries and counterpart funding from partners.

ROADMAP

26. The ACDCP could be operational by the end of the first quarter of 2015 if everything goes according to plan. To that end, a roadmap is proposed below:

ROADMAP TO ESTABLISHMENT OF THE ACDCP

TASK	DESCRIPTION	TIME-LINE
Stakeholders meeting	Inaugural meeting to discuss the operationalization of ACDCP.	June 2014
Stakeholders meeting	Meeting of relevant experts to discuss the legal requirements and implications.	June 2014
Situation analysis	Recruitment of a consultant to map the existing regional facilities (centres of excellence, capacity building organizations, etc.) providing support to African countries. This could include a feasibility study in terms of current national and subnational networks available, and cost-benefit analysis of the Centre.	July-August 2014
	Recruitment of a consultant to undertake a desk review of disease patterns and map hot-spots with a quantification of the work to be done to address the disease burden. This could also include mapping of capacities, taking into account the work already done by other stakeholders such as WHO/AFRO in supporting countries for capacity assessment.	
Stakeholders meeting: planning	Based on the outcome of the situation analysis, a site for the headquarters will be identified, a human resource plan developed, priority activities identified, and centres identified.	September 2014
Financial valuation	Following elaboration of the structure and activities, a financial evaluation may be carried out to assess the costs of running the ACDCP.	October 2014
Expanded stakeholders meeting	The meeting is aimed at mobilizing resources. Participants will include representatives of countries, AUC, UN agencies, development partners and other potential financial contributors.	November 2014
Stakeholders technical meeting	The meeting will develop the ACDCP's standard operating guidelines, staff ToRs and guidelines for supporting African countries. The meeting will also develop procurement plans, human resource recruitment plans, etc.	November 2014
Operationalization	Staff will be recruited, equipment procured, office space secured and demand created.	March 2015
Business development	Exploring new area of work, creating demand and mobilizing resources.	On -going

ANNEX 1
AU Assembly Decision on ACDCP

Assembly/AU/Dec.499(XXII)

DECISION IN THE ESTABLISHMENT OF AN AFRICAN CENTRE FOR DISEASE CONTROL AND PREVENTION (ACDCP) DOC.Assembly/AU/16 (XXII)Add.4

The Assembly,

1. **RECALLS** the Abuja Declaration of 16 July 2013;

2. **TAKES NOTE** of the proposal of Ethiopia to host the Centre in Addis Ababa;

3. **REQUESTS** the Commission to work out the modalities, in collaboration with the Government of the Federal republic of Ethiopia and other interested Member States including the legal, structural and financial implications relating to the centre and to submit a report in January

ANNEX 2

The Declaration of the 2013 Special Summit of African Union on HIV/AIDS, Tuberculosis and Malaria *(Reads in part)*:

*"ABUJA ACTIONS TOWARD THE ELIMINATION OF HIV AND AIDS, TUBERCULOSIS AND MALARIA IN AFRICA BY **2030**"*

We, the Heads of State and Government of the African Union, meeting at a Special Summit of the African Union in Abuja, Nigeria, on 15 and 16 July 2013 focusing on the Theme: "Ownership, Accountability and Sustainability of HIV/AIDS, Tuberculosis (TB) and Malaria Response in Africa: Past, Present and the Future" to review the progress made and the challenges faced in implementing the Abuja Declaration and Plan of Action on Roll Back Malaria (RBM) of 2000; the Abuja Declaration and Plan of Action on HIV and AIDS, Tuberculosis and Other Infectious Diseases (ORID) of 2001; and the Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa by 2010;

.....

To this end, we **undertake** to: .....

11. **FURTHER REQUEST** the Commission to work out the modalities of establishing an African Centre for Disease Control and Prevention;

AUC/WHO/2014/DOC.6
17 APRIL 2014

AGENDA ITEM 9

ORIGINAL: ENGLISH

ACCOUNTABILITY MECHANISM TO ASSESS THE IMPLEMENTATION OF COMMITMENTS MADE BY AFRICAN MINISTERS OF HEALTH

CONTENTS

INTRODUCTION

1. The African Union Commission (AUC) is the key organ that plays a central role in the day-to-day management of the African Union. Among others things, it coordinates and harmonizes the programmes and policies of the African Union with those of the Regional Economic Communities (RECs) and partners and ensures that the African Union's decisions are implemented.

2. The World Health Organization (WHO), in line with its core functions, provides normative guidance and policy advice, shares information on the health situation, contributes to institutional capacity building and provides technical support including those required by countries to enable them to meet their commitments within the framework of the resolutions and decisions of the World Health Assembly and Regional Committee.

3. The AUC has now partnered with WHO in convening joint meetings of African ministers of health to address a number of health-related challenges in Africa. This partnership is governed by an agreement between both the AUC and WHO and is consistent with the visions, priorities and overarching strategies of both Organizations with particular emphasis on speeding up health development on the continent.

4. There is an increasing number of ministerial meetings across the continent of Africa and beyond as most Regional Economic Communities, Regional Health Organizations, UN agencies and international civil society organizations all convene ministerial meetings that culminate in commitments. Failure to implement such commitments could result in loss of confidence and even fatigue among the intended beneficiaries.

5. The AUC-WHO partnership aims to ensure that all the decisions made at such meetings are implemented in order to produce the desired outcomes. Apart from making the best possible decisions in an efficient manner, the partnership will seek to obtain "buy-in" for implementation from all stakeholders. Buy-in is essential because, without it, many decisions may never be implemented.

OBJECTIVES

6. The goal of the accountability mechanism is to increase the possibility of implementing decisions taken by ministers of health, identify challenges to implementation and provide solutions to the identified challenges. The specific objectives are as follows:

   (a) to review the steps Member States and other stakeholders are taking to implement decisions;

   (b) to identify the causes underlying the non-implementation of commitments made by African ministers of health;

   (c) to ensure that the commitments made by African ministers of health are implemented;

   (d) to support Member States and other stakeholders to implement commitments made by African ministers of health;

   (e) to popularize and promote the speed and effectiveness at which decisions are implemented.

7. If the above-mentioned objectives are attained, the commitments of the ministers of health are likely to be fully implemented and shortcomings will be minimized.

PILLARS OF THE ACCOUNTABILITY MECHANISM

8. The focus of the mechanism will not only be on assessing the implementation of commitments but also on making commitments implementable. The accountability mechanism is composed of the five pillars listed below:

   (a) Setting timelines for implementation of commitments: every commitment made by ministers of health should be accompanied by a timeline for implementation. The ministers should stratify or segment the rate of implementation among Member States, depending on their capacities and their resources. Some Member States often argue that they are not in a race so there should be no timeline for implementation of commitments. However, this argument could adversely affect the assessment of implementation. Therefore, setting timelines is an imperative.

(b) Creating awareness: the implementers of a commitment may often not be the people who made it or participated in making it. Deliberate efforts should therefore be made to create formal links between the commitment made by ministers during a conference and its corresponding implementation plan. This could be achieved by developing a viable communication strategy and through increasing interaction between the two groups in the implementation plan. There is need for the participation of those who are likely to be affected by and/or involved in the implementation of the commitment.

(c) Post-conference support: some Member States may face the challenge of low capacity to implement commitments. Therefore, the AUC-WHO partnership should develop a country support mechanism that Member States may draw upon to provide on-the-spot or hands-on support for implementation of commitments and constantly remind countries of the need to implement commitments made.

(d) Formal assessment of implementation: formal assessment of implementation should be done by an assessment committee composed of AUC and WHO. The outcome of assessments should be used to improve future implementation through addressing bottlenecks and recognizing good practices.

(e) Institutional memory: usually the final commitment document is written in the form of a list of decisions made at a meeting without indicating the rationale for that decision. The joint AUC-WHO conferences should therefore have a memory bank or a mechanism for recalling the rationale behind each commitment. Recalling the rationale behind a commitment is crucial to guide those implementers who did not participate in making the commitment but need to make amendment(s) if implementation poses a challenge.

CONCLUSION

9. The accountability mechanism is not aimed at merely identifying what was implemented and what was not implemented. Whether the desired goal was achieved or not, it is important to consider what was learnt from the experience and this can help to resolve challenges and share good practices.

REFERENCES

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2. African Union (2001). The AU Commission. Available from: http://www.au.int/en/about/nutshell [accessed: 4 February 2014].

3. African Union (2008). Partnerships. The AU Commission. Available from: http://www.au.int/en/about/nutshell [accessed: 4 February 2014].

ANNEX

FOCUS OF THE ACCOUNTABILITY MECHANISM

The accountability mechanism should set forth the relevance, appropriateness, effectiveness, efficiency, impact and sustainability of commitments made by African ministers of health. The specific areas of focus under each section shall be as follows:

(a) Effectiveness

- (i) How effective was the implementation in addressing the targeted challenge?
- (ii) To what extent were the expected outcomes of the commitment attained?
- (iii) Did the implementation of the commitment benefit the target population?
- (iv) What were the major factors affecting the successes or failures of implementation?

(b) Impact

- (i) To what extent did the implementation of the commitment impact on the target population?
- (ii) What has been the impact of implementing the commitment?
- (iii) What real difference has the commitment made in the target population?

(c) Sustainability

- (i) To what extent can the commitment's impact continue without the AUC-WHO joint conference of ministers of health?
- (ii) To what extent were the stakeholders involved in the implementation?

(d) Efficiency

- (i) Was the commitment implemented in the most efficient way compared with other alternative ways?
- (ii) Was the commitment implemented as planned, in a timely manner, using the most appropriate resources?

3. AGENDA

AUC/WHO/2014/EXP/AGENDA
14 April 2014

EXPERTS' MEETING

Luanda, Republic of Angola, 14-15 April 2014

ORIGINAL: ENGLISH

1. Opening of the meeting :

   - *Introductory remarks – Dr Luis Sambo (RD/WHO)*
   - *Introductory remarks – Ambassador Olawale Maiyegun (Director of Social Affairs/AUC)*
   - *Opening Address – Dr J. Vieira Dias Van-Dùnem (Minister of Health, Republic of Angola)*

2. Appointment of the Chairperson, Vice-Chairperson and Rapporteurs

3. Terms of Reference for the conduct of the AUC-WHO Biennial meeting of African Ministers of Health (AUC/WHO/2014/Doc.8)

4. Universal Health Coverage in Africa: from concept to action (AUC/WHO/2014/Doc.1)

5. African Medicines Agency: setting milestones towards its establishment (AUC/WHO/2014/Doc.2)

6. Noncommunicable diseases in Africa: policies and strategies to address risk factors (AUC/WHO/2014/Doc.3)

7. Ending preventable maternal and child deaths in Africa (AUC/WHO/2014/Doc.4)

8. Establishment of an African Centre for Disease Control and Prevention (AUC/WHO/2014/Doc.5)

9. Accountability mechanism to assess the implementation of commitments made by African ministers of health (AUC/WHO/2014/Doc.6)

10. Wrap up and adoption of the meeting report and key recommendations (AUC/WHO/2014/Doc.7)

11. Closure of the meeting

4. PROGRAMME OF WORK

AUC/WHO/2014/EXP/POW
14 April 2014

EXPERTS' MEETING

Luanda, Republic of Angola, 14-15 April 2014

ORIGINAL: ENGLISH

DAY 1: Monday, 14 April 2014

08:30–09:00	**Agenda item 1**	Opening of the meeting - *Introductory remarks – Dr Luis Sambo (RD/WHO)* - *Introductory remarks – Ambassador Olawale Maiyegun (Director of Social Affairs/AUC)* - *Opening Address – Dr J. Vieira Dias Van-Dùnem (Minister of Health, Republic of Angola)*
09:00–09:30	**Agenda item 2**	Appointment of the Chairperson, Vice-Chairperson and Rapporteurs
09:30–10:30	**Agenda item 3**	Terms of Reference for the conduct of the AUC-WHO Biennial meeting of African Ministers of Health (AUC/WHO/2014/Doc.8)
10:30–11:00	***Tea break***	
11:00–12:30	**Agenda item 4**	Universal Health Coverage in Africa: from concept to action (AUC/WHO/2014/Doc.1)
12:30–14:00	***Lunch break***	
14:00–15:30	**Agenda item 5**	African Medicines Agency: setting milestones towards its establishment (AUC/WHO/2014/Doc.2)
15:30–16:00	***Tea break***	
16:00–17:30	**Agenda item 6**	Noncommunicable diseases in Africa: policies and strategies to address risk factors

DAY 2: Tuesday, 15 April 2014

09:00–10:30	**Agenda item 7**	Ending preventable maternal and child deaths in Africa (AUC/WHO/2014/Doc.4)
10:30–11:00	***Tea break***	
11:00–12:30	**Agenda item 8**	Establishment of an African Centre for Disease Control and Prevention (AUC/WHO/2014/Doc.5)
12:30–14:00	***Lunch break***	
14:00 – 15:30	**Agenda item 9**	Accountability mechanism to assess the implementation of commitments made by African ministers of health (AUC/WHO/2014/Doc.6)
15:30 – 17:00	***Tea break***	
17:00–17:30	**Agenda item 10**	Wrap up and adoption of the report of the Experts' meeting (AUC/WHO/2014/Doc.7)
17:30	**Closure of Experts' meeting**	