HEALTH:

ASSURING HEALTH SECURITY FOR ALL

ESSAY

VIEWPOINT

Finishing the job on HIV/AIDS

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What it will take to end the HIV/AIDS pandemic as a global health threat by 2030

In the wake of the COVID-19 pandemic, there is a renewed need for domestic and donor support to end the HIV/AIDS pandemic as a global health threat. This requires a strong emphasis on galvanizing political and programmatic leadership to sustain the response, centering programs around health equity, sustainably strengthening public health systems, and health security.

Introduction

In 2001, the Heads of State of Africa met in a special summit in Abuja devoted specifically to addressing the exceptional challenges of HIV/AIDS. The HIV/AIDS pandemic had been raging worldwide with an acute impact on most countries in Africa. The spread of the disease was impacting every dimension of society–in African countries most affected, AIDS had lowered life expectancy of adults on average by 20 years. This session, which came soon after the unprecedented U.N. Security Council Resolution in 2000 declaring HIV/AIDS a security threat, acknowledged the tremendous impact that the spread of HIV was having on the continent as not only a health crisis, but also an economic and security crisis, which would lead to massive instability in the continent if left unchecked.

The Abuja summit concluded with heads of state committing to take personal responsibility and provide political leadership at the highest level to commit all necessary resources and measures to attack the epidemic–from pledging 15 percent of budgets to the health sector, providing access to affordable treatment, scaling-up educational efforts, to reforming national policies. These commitments helped spark a regional movement to attack the HIV/AIDS pandemic on the continent by governments, donors, advocates, non-profits, private companies, and more.

Progress to date

Twenty years later, the annual number of new infections has dropped by 75 percent (from 3.4M to 870,000), and deaths have dropped 80 percent (from 2.3 million to 460,000) in Africa.[1] Several high-burden African countries have reached the UNAIDS 90-90-90 targets.[2] It is no coincidence that this period has resulted in the fastest economic growth in Africa's history and has seen tremendous gains in other development indicators such as poverty alleviation, educational attainment, gender equity, and maternal and child health. Analysis comparing U.S. President's Emergency Plan for

1 UNAIDS. 2021. "UNAIDS Data 2021." Reference. The Joint United Nations Programme on HIV/AIDS.

2 90% of all people living with HIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; 90% of all people receiving antiretroviral therapy will have viral suppression.

AIDS Relief (PEPFAR) recipient countries with similar non-PEPFAR supported low- and middle- income countries found that PEPFAR countries experienced 35 percent greater reductions in child mortality, 25 percent reductions in maternal mortality, and significant improvements in childhood immunizations. GDP per capita growth rates were 2.1 percentage points higher for PEPFAR countries compared to non-PEPFAR supported countries, and the share of girls and boys out of school declined by 9 and 8 percent respectively. The effects were strongest where PEPFAR engaged in more intensive planning and funding.[3]

Despite this progress, we are at a new inflection point in the HIV/AIDS pandemic in part because of the COVID-19 pandemic. The pandemic particularly impacted access to HIV prevention services, and the rate of decline of new infections has slowed. If the current pace continues, we will be off-track to reach the UNAIDS global target of 370,000 infections by 2025.

What is worse is that the most vulnerable populations continue to be at the highest risk. Approximately 52 percent of children living with HIV receive the lifesaving treatment they need, compared to 76 percent of adults.[4] Adolescent girls and young women continue to be more than twice as likely to be infected relative to their male counterparts. And Key Populations (KP)–men who have sex with men, transgender persons, people who inject drugs, sex workers, incarcerated people)–make up an increasingly large share of new infections.

PEPFAR's five-year strategy

To meet the moment in the trajectory of the HIV/AIDS response, we launched PEPFAR's new 5-year strategy on December 1, 2022. The strategy outlines several areas that PEPFAR will be pursuing to help achieve the global goal of ending HIV/AIDS as a global health threat. There are three key areas where African policymakers have a unique role to play in the response.

1. Elevating HIV/AIDS to the highest levels of political leadership to sustain the response

The 2001 Abuja summit was a powerful example of African political leadership. African heads of state outlined concrete goals and commitments and helped to galvanize the global community to aid in the response. In the decade that followed, thanks in large part to continued African leadership and partnerships, 27 countries increased the proportion of their expenditures on health. However, the situation has deteriorated; in 2016, 19 African countries were spending less on health as a percentage of their public spending than the early 2000s, and only three countries exceeded the 15 percent threshold.[5]

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3 Carbaugh, Alicia, Anna Rouw, and Jennifer Kates. 2022. "HIV Policy Alignment with International Standards in PEPFAR Countries." Kaiser Family Foundation.

4 WTO. 2022. "New global alliance launched to end AIDS in children by 2030." Joint News Release. World Trade Organization.

5 WHO. 2016. "Public Financing for Health in Africa: From Abuja to the SDGs." World Health Organization.

In many countries, donors are currently performing many of the core functions around performance management and service delivery. Until countries take over programmatic accountability, the HIV/AIDS response will continue to be viewed as a donor-led activity.

New political leadership is needed to sustain progress. Over the next decade, HIV/AIDS programs should primarily become the responsibility of African countries as support from outside donors inevitably declines, even as PEPFAR continues its commitment to our partner countries. This should start with clear political commitments from Heads of States to lead and manage their own HIV response–by articulating and acting on their own vision and holding their ministries accountable for results. This will help to unlock greater programmatic leadership for the oversight and management of HIV prevention and care efforts, and the broader strengthening of health systems (workforce, labs, data and surveillance, supply chains, etc.) that underpin HIV/AIDS programs.

In many countries, donors are currently performing many of the core functions around performance management and service delivery. Until countries take over programmatic accountability, the HIV/AIDS response will continue to be viewed as a donor-led activity. Over time, more robust political and programmatic leadership should help to unlock financial leadership as well by encouraging ministries of finance, and development to recognize that investing in HIV/AIDS and health systems programs domestically will yield high returns.

PEPFAR will help to enable these three components of sustaining the response by working with countries in partnership with the African Union (AU) and other regional and global entities to jointly develop a sustainability roadmap, articulating a shared pathway for countries to take increasing responsibility for their own epidemics and hold all parties accountable for results.

2. Improving health equity for priority populations

The HIV/AIDS pandemic does not affect people uniformly. We know that persistent inequities for the most marginalized populations persist—countries should address these inequities head-on to close these gaps. This starts with adolescent girls and young women, who remain disproportionately impacted by the HIV/AIDS pandemic in Africa. Governments need to recommit to providing holistic, multi-layered support and enabling policy environments that for meet the needs of girls and women given the intersecting challenges they face that increases their risk for contracting HIV. This includes ensuring they can stay in school, access economic opportunities to earn livable incomes, receive comprehensive destigmatized sexual and reproductive health services like PrEP, and thrive in their daily lives free from violence.

Children remain less likely than their adult counterparts to receive treatment, despite the existence of highly effective pediatric treatments in the form of dolutegravir. This gap is unacceptable, and the seven countries that make up the roughly 80 percent of these missing children (Democratic Republic of Congo, Mozambique, Nigeria, South Africa, Tanzania, Uganda, and Zambia) should especially double down on the funding and management of preventing mother to child transmission (PMTCT) and care linkage programming.

Lastly, Key Populations (KPs)—continue to bear the highest per capita risk of contracting an HIV infection. Governments and donors need to bring KPs and community organizations in the lead to inform the design and expansion of equitable and nondiscriminatory prevention, testing, and treatment services. Governments also need to look critically at the restrictive laws and policies that criminalize or stigmatize

Between 70-90 percent of drugs consumed on the African continent are imported; (China and India have comparable populations and import 5 percent and 20 percent, respectively). For vaccines, only 1 percent of vaccines consumed are manufactured in Africa.

these populations and prevent them from accessing the services they need–and learn from peer countries in the region who have successfully pursued reforms.

3. Leveraging the PEPFAR platform to strengthen public health systems and health security

During the COVID-19 pandemic, the recent Ebola outbreak in Uganda, and other disease outbreaks, the public health infrastructure, relationships, and practices that PEPFAR has helped to establish and strengthen for HIV proved essential to responding to new and unexpected health threats. While maintaining focus on HIV as our core mission, moving forward, PEPFAR will continue to apply lessons learned from HIV and intentionally strengthen overall public health systems to respond to health security threats. Such investments will aim to protect HIV/AIDS gains and ensure increased sustainability for countries' HIV/AIDS response.

Regionalized and modernized supply chains for health commodities

The COVID-19 pandemic has clearly demonstrated the need for a robust regionally diversified, sustainable pharmaceutical manufacturing and supply chain ecosystems to protect against health security threats, including in Africa. A strong, diversified, and sustainable manufacturing base would also decrease procurement costs, prevent stockouts, introduce new products faster, and create substantial economic benefits. However, between 70-90 percent of drugs consumed on the African continent are imported; (China and India have comparable populations and import 5 percent and 20 percent, respectively). For vaccines, only 1 percent of vaccines consumed are manufactured in Africa.[6]

For Africa to address this challenge, it needs a holistic approach and an enabling environment for sustainable regional manufacturing that allow manufacturers to supply multi-country geographies, promote healthy competition, and enables sizeable, sustainable manufacturers to emerge. PEPFAR will lead by setting explicit, ambitious targets for African procurement of HIV commodities for the next decade and will adjust our procurement policies to help jumpstart demand– and drive other donors to follow.

To create this enabling environment, we will need to work with African policymakers and multilateral organizations to develop tariff and trade policies, environmental policies, and regulatory policies to support sustainable local manufacturing capacities. It will also be critical for African policymakers to certify and fund the African Medicines Agency (AMA) to lead in certification of products and implement the African Free Trade agreement to enable cross-border trade. Leaders of global and African development finance institutions should take this opportunity to provide financing and other support to pharmaceutical manufacturers standing up or expanding operations and enhancements to health supply chains across the region.

But manufacturing is not enough to get the products to the people who need them quickly and efficiently. We continue to see high rates of stockouts across PEPFAR-supported countries, and our supply chains are simply not people-centered.

6 Nweneka, Chidi Victor and Tolu Disu. 2022. "The future of vaccine manufacturing in Africa." Foresight Africa 2022, Public Health Chapter. The Brookings Africa Growth Initiative.

African policymakers need to promote a long-term vision for a modern and sustainable supply chain, which includes movement away from the emergency nature of Central Medical Stores and integration of private sector providers across the value chain; strengthening government capacity in supply chain leadership, oversight, comprehensive planning and risk management; and diversifying channels of last-mile delivery of products beyond the public clinics. Policymakers need to also recognize that supply chains go beyond ministries of health and engage the ministries of finance, development, and trade to remove bottlenecks that create artificial supply shortages at the port or the border. PEPFAR will coordinate with African partners and other donors to help to strengthen country capacity to lead in the development and implementation of this long-term approach to supply chain modernization.

Robust Health Workforce

Despite the lessons from Ebola, COVID-19 and other outbreaks, the health workforce remains one of the most under-invested areas of the public health system. Africa needs 6,000 field and 25,000 frontline epidemiologists but has only trained 2,000 and 5,000 respectively. In 2017, the AU launched a two million community healthcare worker initiative, but to date only a few hundred thousand professionalized workers have been deployed, and many remain un-salaried, and poorly trained, equipped, and supervised. Nurses continue to be under-equipped and poorly prepared for new outbreaks, leading to high rates of mortality among their cohort.

Country leaders need to bring together ministries of health, education, and finance to develop an integrated plan to train, finance, and support the next cohort of nurses, community health workers, epidemiologists, and health data scientists. PEPFAR and other disease-specific donors need to align their future health workforce investments to better support those integrated country plans and, workforce leadership programs going forward.

Empowered National Public Health Institutes

National Public Health Institutes (NPHIs) serve as the backbone of an effective public health response; during COVID-19, countries with strong NPHIs were more effective in coordinating the outbreak response. More than 30 African countries have already created NPHIs, and for those countries it is incumbent on political leaders to financially support their core capabilities (surveillance, lab networks, emergency operations centers, research). PEPFAR will work to strengthen NPHIs by partnering with the Africa CDC to enlist NPHIs to lead on core HIV-control functions such as conducting household surveys to measure the epidemiological change in the disease and leveraging their EOCs to tackle pockets of new infections.

Conclusion

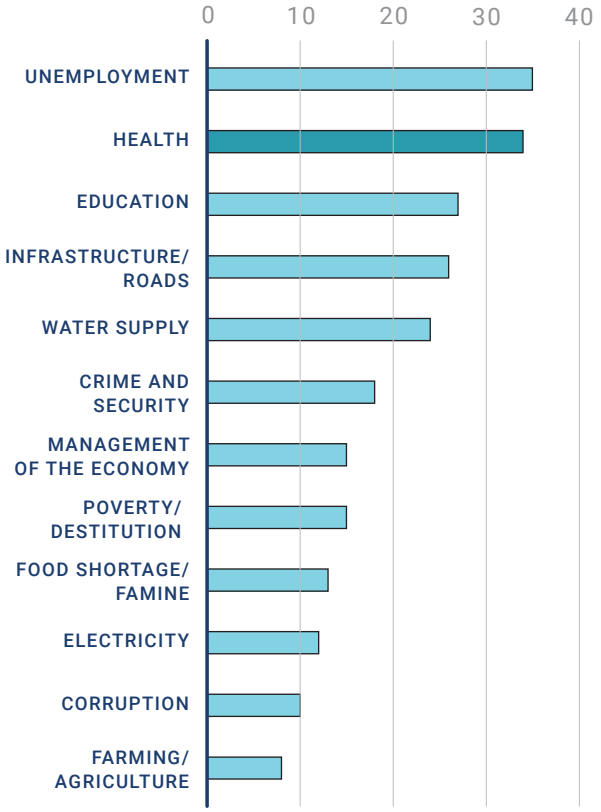
PEPFAR has a critical role to play in the future of the HIV/AIDS response. But without leadership from policymakers, all our collective efforts will be unsustainable. African leaders need to recognize that strong public health systems are a fundamental element of strong national security and economic growth, and prioritize it accordingly in domestic budgets, laws, and policies. Country leaders also should endorse, fund, and strengthen regional institutions such as the Africa CDC and AMA who are taking a lead in coordinating the health response. Disease-specific donors including PEPFAR need to come together to harmonize and prioritize public health systems and security investments, and support country leadership in developing and implementing integrated national plans. We have come so far, and together we can end HIV/AIDS as a public health threat on the continent and globally.

FIG.25 AFRICANS INDICATE THAT HEALTH IS AMONG THE MOST PRESSING POLICY ISSUES

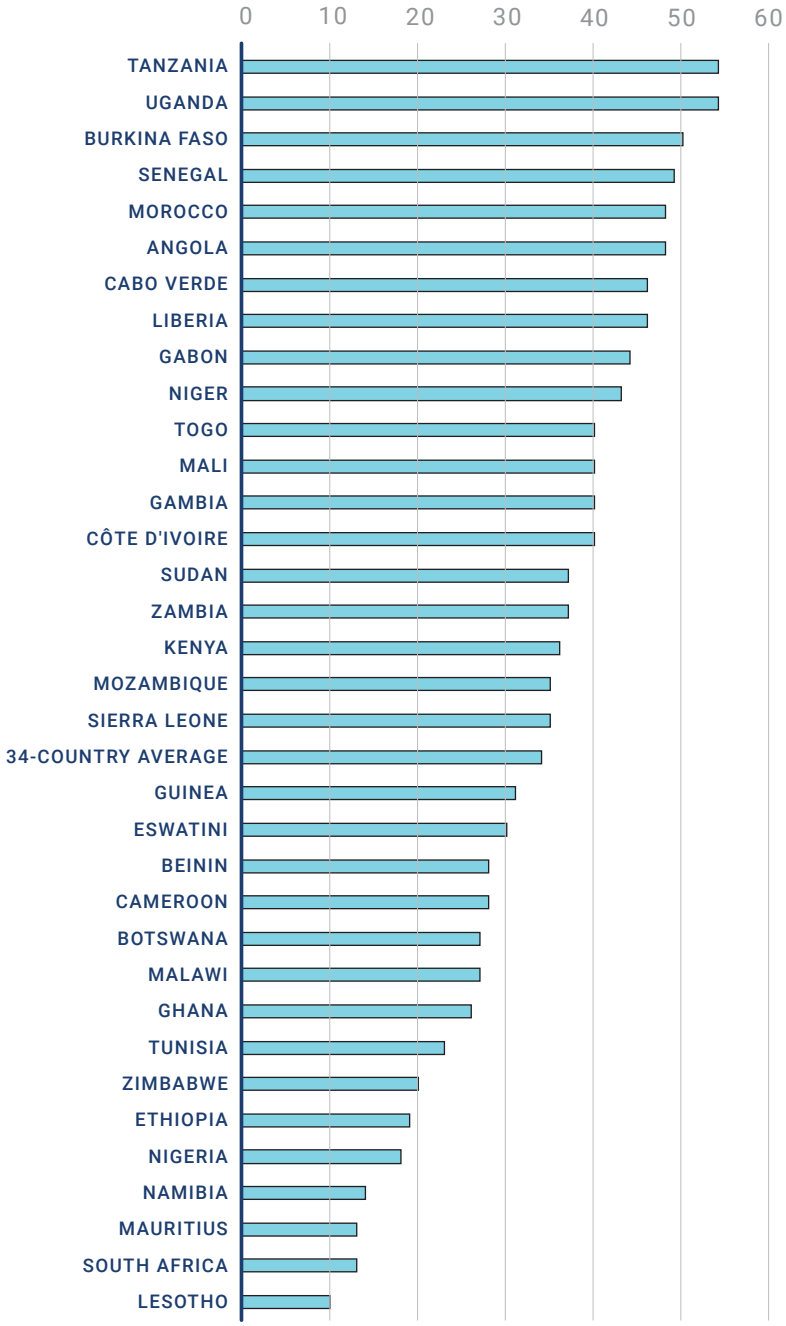
In a recent survey from Afrobarometer, Africans indicated that health was the second most critical problem facing their country today, just after unemployment.

Respondents in some countries, such as Tanzania, Uganda, and others, name health as the single most important problem facing their country.

SHARE OF RESPONDENTS NAMING THE ISSUE AS THE MOST IMPORTANT PROBLEM (%)



SHARE OF RESPONDENTS INDICATING HEALTH AS THE MOST IMPORTANT PROBLEM (%)



Note: Respondents were asked: In your opinion, what are the most important problems facing this country that government should address? (Respondents were allowed up to three answers, so percentages add to more than 100%. Figure shows % who cite each response as one of their three responses).
Source: Salau and Logan. 2022. Rising concern, falling performance: Health-sector challenges evident before and after onset of COVID-19 pandemic. Afrobarometer Policy Paper No. 80.

Leveraging lessons from COVID-19 to build stronger health systems

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Sir Winston Churchill averred, in the aftermath of World War II, that one should never let a "good" crisis go to waste. The COVID-19 pandemic offered several lessons for Africa's health systems that should form the basis for a stronger, more inclusive recovery. **One such lesson is that African governments ought to prioritize investments in the health sector as a means, not only to improve population health, but also to safeguard the economy**. African health systems are chronically underfunded; it is estimated that on average African countries' government expenditure on health, as a share of gross domestic product (GDP), is 2 percent—far less than the 5 percent recommended threshold for low- and middle-income countries to register meaningful improvements in population health outcomes.[1] COVID-19 has made it abundantly clear that the social and economic fortunes of a country are conjoined with population health. For example, the World Bank estimated that COVID-19 was responsible for a 3.3 percent economic contraction of Africa's GDP in 2020, pushing 40 million individuals into poverty.[2] Under-investment in the health sector meant that African health systems were ill-prepared for the pandemic, and thus, suffered great economic loss.

One way to unlock additional financing and resources for the health sector is to exploit efficiency gains by reducing wastage. Two strategies are worth considering. African countries could achieve better outcomes from existing resources by introducing and institutionalizing the use of economic evidence to guide and inform healthcare resource allocation decisions in ways that promote value-for-money. One such approach is health technology assessment (HTA). HTA is a multidisciplinary process that uses explicit methods to determine the value of health interventions and services in ways that promote efficiency and other health system goals. Good examples of countries that have implemented HTA to improve the efficiency of their health system include Thailand's universal coverage scheme, and the UK's National Health Service (NHS). Likewise, there is also a need for African governments to tackle corruption head-on by implementing effective anti-corruption strategies. Some estimates put the loss of healthcare resources owing to weak governance and accountability environments that in turn facilitate health sector corruption to as much as 10 percent annually.[3]

The second lesson is that African countries ought to foster self-reliance by investing in the manufacture of essential health commodities. The vaccine nationalism and apartheid witnessed during the COVID-19 pandemic, coupled with international supply chain disruptions, exposed the vulnerability of African health systems to over-reliance on imports. Some estimates indicate that Africa imports

1 AHAIC Commission. 2021. "The State of Universal Health Coverage in Africa." The Africa Health Agenda International Conference Commission.

2 World Bank. 2020. "World Bank Confirms Economic Downturn in Sub-Saharan Africa, Outlines Key Polices Needed for Recovery." World Bank Group.

3 Gee, Jim and Mark Button. 2015. "The financial cost of healthcare fraud 2015: What data from around the world shows." PKF Littlejohn LLP.

It is imperative however, that these efforts are coordinated and aimed at addressing continental shortages, rather than narrow individual country needs. Vaccine and pharmaceutical manufacturing in Africa will only be sustainable if the market can support commercial viability.

more than 80 percent of its pharmaceutical and medical consumables, and 99 percent of its human vaccines.[4] It is encouraging that several African countries have since initiated plans to establish local vaccine manufacturing. African governments must also understand that the sustainable development of vaccines and pharmaceutical manufacturing is underpinned by a vibrant research and development (R&D) ecosystem. While African countries have committed to spending 1 percent of their GDP on R&D, the continent's funding of R&D stood at only 0.42 percent, compared to the global average of 1.7 percent.[5]

The third lesson is that African governments must re-prioritize universal health coverage (UHC). COVID-19 revealed that countries with advanced UHC systems are far better at responding to a pandemic or health shock.[6] A system where individuals face financial barriers to access healthcare, compromises vital public health strategies during a disease outbreak (i.e., detect, isolate, and treat) such that infected individuals go undetected and cannot access isolation or treatment services, and thus continue to spread disease. While many African countries have made political commitments to UHC, this commitment has hardly translated to investment and implementation. Out-of-pocket spending, as a share of total health spending, in Africa is also among the highest in the world at 38 percent—with countries like Nigeria having levels as high as 77 percent.[7] During the pandemic, this manifested in the form of individuals not accessing testing, isolation, and treatment because they could not afford to pay for these services, and in some cases, individuals are being forcefully detained in health facilities for not being able to pay the costs of isolation or care.

In addition to increasing health sector funding, several shifts will be required to course correct the continent's UHC aspiration. The first shift is the need for African countries to re-orient their UHC plans and ground them on tax-funded approaches as opposed to contributory health insurance. Many African countries are planning or already implementing public health insurance systems that rely on individual/household premium contributions as a means to achieve UHC. There is overwhelming evidence that it is problematic to achieve scale and equity in coverage, with health insurance systems that rely on individual/household premium contributions—especially in Africa where large shares (up to 80 percent) of the population are in the informal sector with unpredictable and irregular incomes. A recent analysis found that only four out of 36 African countries (Rwanda, Ghana, Gabon, and Burundi) have achieved health insurance coverage levels greater than 20 percent, and that coverage for all four countries, was characterised by substantial funding from tax revenues.[8]

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4 AHAIC Commission. 2021. "The State of Universal Health Coverage in Africa." The Africa Health Agenda International Conference Commission.

5 Adepoju, Paul. 2022. "Africa's future depends on government-funded R&D." Nature Africa. An Audience With, 25 September 2022.

6 Haghighi, Hajar, Amirhossein Takian, and Mohsen Aarabi. 2020. "The role of universal health coverage in overcoming the covid-19 pandemic." BMJ Opinion.

7 AHAIC Commission. 2021. "The State of Universal Health Coverage in Africa." The Africa Health Agenda International Conference Commission.

8 Barasa, Edwine, et al. 2021. "Examining the level and inequality in health insurance coverage in 36 sub-Saharan African countries." BMJ Global Health 6, no. 4.

A second shift is the need for African countries to re-orient their health systems to prioritize primary healthcare (PHC)—a platform for providing basic health interventions and essential public health services. This would be a departure from the current arrangement where African health systems are hospital-centric, prioritizing higher-level care.

Contributory health insurance systems were also found to be highly inequitable on the continent. A third shift is the prioritization and financing of common goods for health (CGH). CGH are core, population-based functions that are essential to the health and wellbeing of entire societies, as opposed to individual-based services. Examples of CGH include disease surveillance systems, research and development, regulatory systems, and public health policies. CGH not only support the health and wellbeing of populations generally, but also bolster health security.

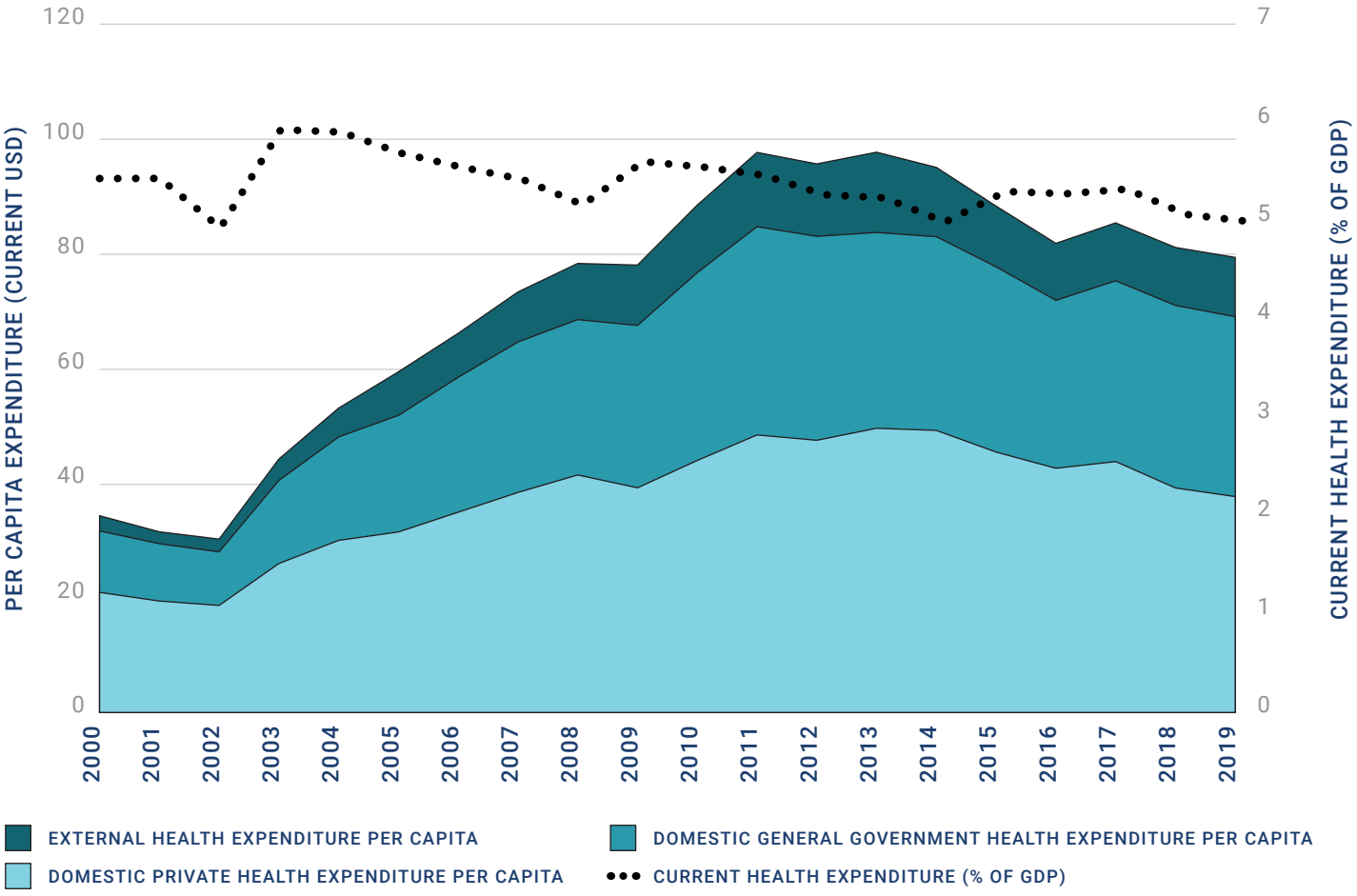
Lastly, several regional opportunities abound for African governments to leverage and strengthen their health systems. I will highlight two here. First, African leaders should take advantage of regional integration to strengthen healthcare markets and systems. The Africa Continental Free Trade Area (AfCFTA), is the world's largest free trade area in terms of population (1.3 billion) and number of countries (54), and has the potential to spur the growth of Africa's health markets by opening up markets for labour (health workers) and health commodities, and by attracting investments into the continent's health sector. In addition, it has the potential to support the continent's initiative to develop vaccines and pharmaceutical manufacturing.

Another regional opportunity that African health systems should take advantage of is, the continent's strong regional organizations that include the African Union (AU), the Africa Centres for Disease Control and Prevention (Africa CDC), and the African Development Bank (AFDB). These organizations not only have immense convening power, technical capacity, and capacity for advocacy, but they have also put in place initiatives whose implementation will leapfrog Africa's health system. For instance, the AU and Africa CDC have outlined a blueprint to strengthen health security in Africa labelled the "New Public Health Order." The AU has articulated a plan to spur pharmaceutical manufacturing—Pharmaceutical Manufacturing Plan for Africa (PMPA), while the Africa CDC has also laid out a framework for the development of local vaccine manufacturing (the partnership for Africa Vaccine manufacturing). Further, the AFDB has established the African Pharmaceutical Technology Foundation, that plans to spend $3 billion over the next decade to support the continent's pharmaceutical and vaccine manufacturing plans. However, these efforts will only be successful if African governments support and facilitate the leadership role of these regional agencies.

As we look forward to 2023 and beyond, here is hoping that African governments learn from the COVID-19 pandemic and invest in nurturing the resilience of the continent's health system to safeguard the health and the socio-economic wellbeing of the continent.

FIG.26 **HEALTH CARE SPENDING IN AFRICA DECLINED IN THE LAST DECADE**

Africa's health expenditure per capita has decreased since 2011. This contraction is not due to any one source in particular; domestic public, domestic private, and external sources of health expenditure have all declined in the last decade.



Source: World Bank. 2022. World Development Indicators. World Bank Group.

Confronting global inequalities to end HIV/AIDS

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Africa is not on track to end AIDS by 2030. The global crises of the COVID-19 pandemic and the war in Ukraine exacerbated intersecting inequalities—within Africa, as well as between Africa and the Global North. But there is good news: By tackling inequalities we can end AIDS. Here are four practical measures leaders can take.

Tackle inequalities faced by women and girls. In sub-Saharan Africa, adolescent girls and young women are three times more likely to be infected with HIV than boys and men of the same age.[1] The driving factor is inequality. Enabling girls to stay in school until they complete secondary education reduces their vulnerability to HIV infection by up to 50 percent.[2] When we include comprehensive sexuality education and other measures for girls' empowerment their risk is reduced even further. That is why 12 African countries have come together in the Education Plus Initiative, supported by the U.N. to make this happen. Beyond this, we must combine services for sexual and reproductive health, together with services for—preventing and responding to—sexual and gender-based violence, as well as HIV.

G-20 countries receive 136 million dollars in debt repayments from poor countries in the South. Meanwhile, in these countries, debt repayments are four times more than they spend on health, and twice what they spend on education.

Tackle inequalities faced by marginalized communities. UNAIDS' latest analysis shows no significant decline in new infections among gay men and other men who have sex with men in sub-Saharan Africa.[3] The evidence is clear: When you decriminalize, people will come forward for services, and when you criminalize, you push people away. In South Africa, where same-sex relationships are legal, gay men are 60 percent more likely to be living with HIV, but in Uganda where gay men are criminalized, they are 240 percent more likely.[4] There is a growing momentum for decriminalizing same-sex relationships—as South Africa, Lesotho, Cape Verde, Mozambique, Angola, and Botswana have. It is time for all of Africa to consign harmful and colonial punitive laws to history.

Tackle inequalities in resourcing, which the global crises have exacerbated. Every day, G-20 countries receive 136 million dollars in debt repayments from poor countries in the South.[5] Meanwhile, in these countries, debt repayments are four times more than they spend on health, and twice what they spend on education.[6] In the midst of a potential debt crisis, austerity measures, and higher inequality, some rich countries have cut back aid for global health and are considering even deeper cuts. Now is not the time to step away, it is the time to step up.

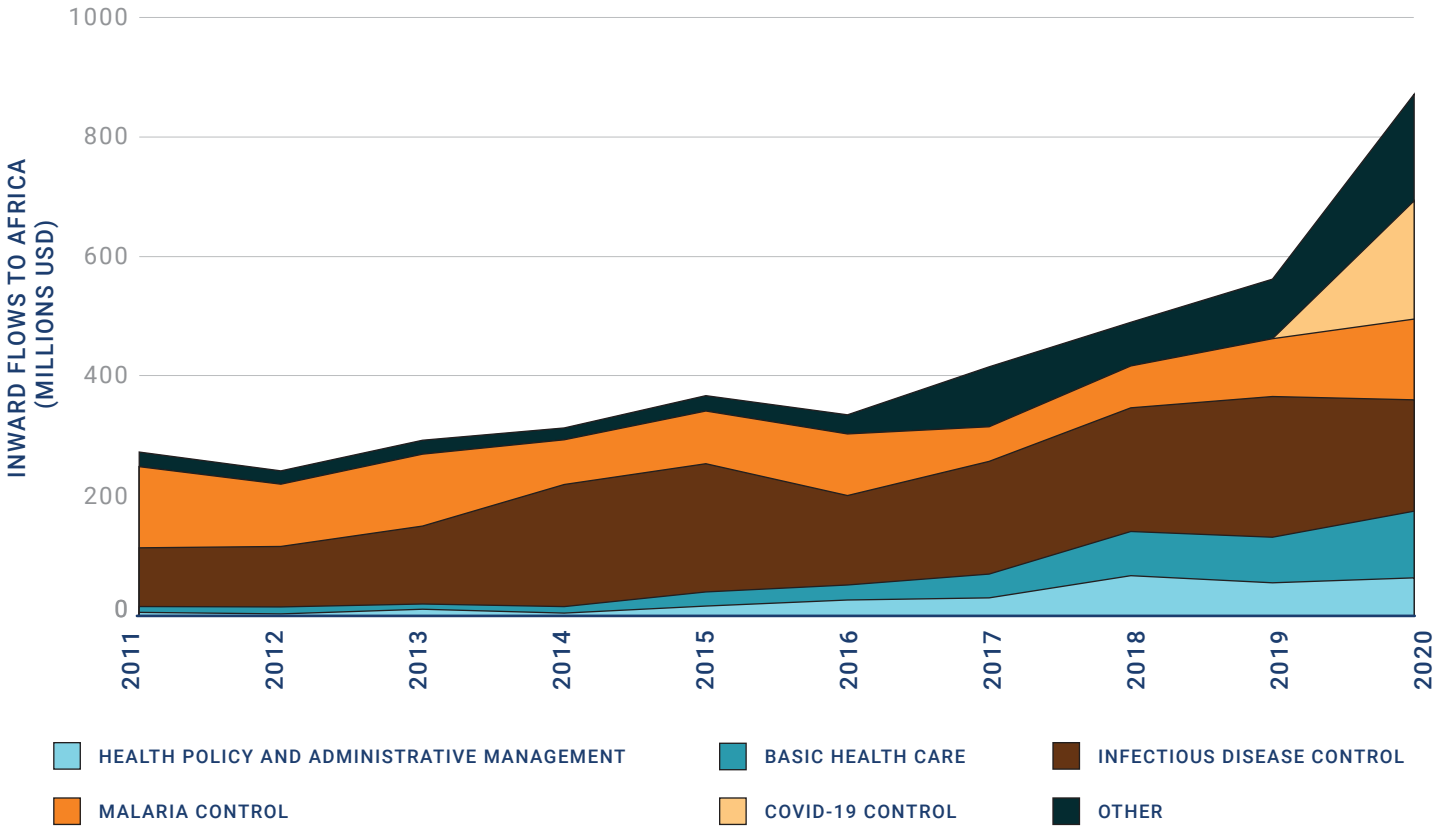
1 UNAIDS. 2022. "World Aids Day Report: Dangerous Inequalities." The Joint United Nations Programme on HIV and AIDS.
2 UNAIDS. 2021. "Keeping girls in school reduces new HIV infections." The Joint United Nations Programme on HIV and AIDS.
3 UNAIDS. 2022. "World Aids Day Report: Dangerous Inequalities." The Joint United Nations Programme on HIV and AIDS.
4 UNAIDS. 2022. "World AIDS Day 2022 – Message from Winni Byanyima, Executive Director of UNAIDS." Press Statement. The Joint United Nations Programme on HIV and AIDS.
5 Oxfam. 2022. "G20 must tackle the "cost of profit" crisis causing chaos worldwide, says Oxfam." Oxfam.
6 Ibid.

Tackle inequalities in access to medicines. We need to get the new, long-acting antiretroviral medicines that will make it easier to treat and prevent HIV in African countries; and at the same time as they are made available in the Global North. We also need to ensure such medicines are manufactured by multiple producers affordably, especially in Africa, where the disease is concentrated. This requires funding, the reform of failing rules on intellectual property, as well as support for distributed production, so access to life-saving science and medicine are no longer dependent on the passport people hold.

Through bold action to tackle inequalities, we can end AIDS.

FIG.27 **PRIVATE DEVELOPMENT FINANCING FOR AFRICA'S HEALTHCARE SECTOR**

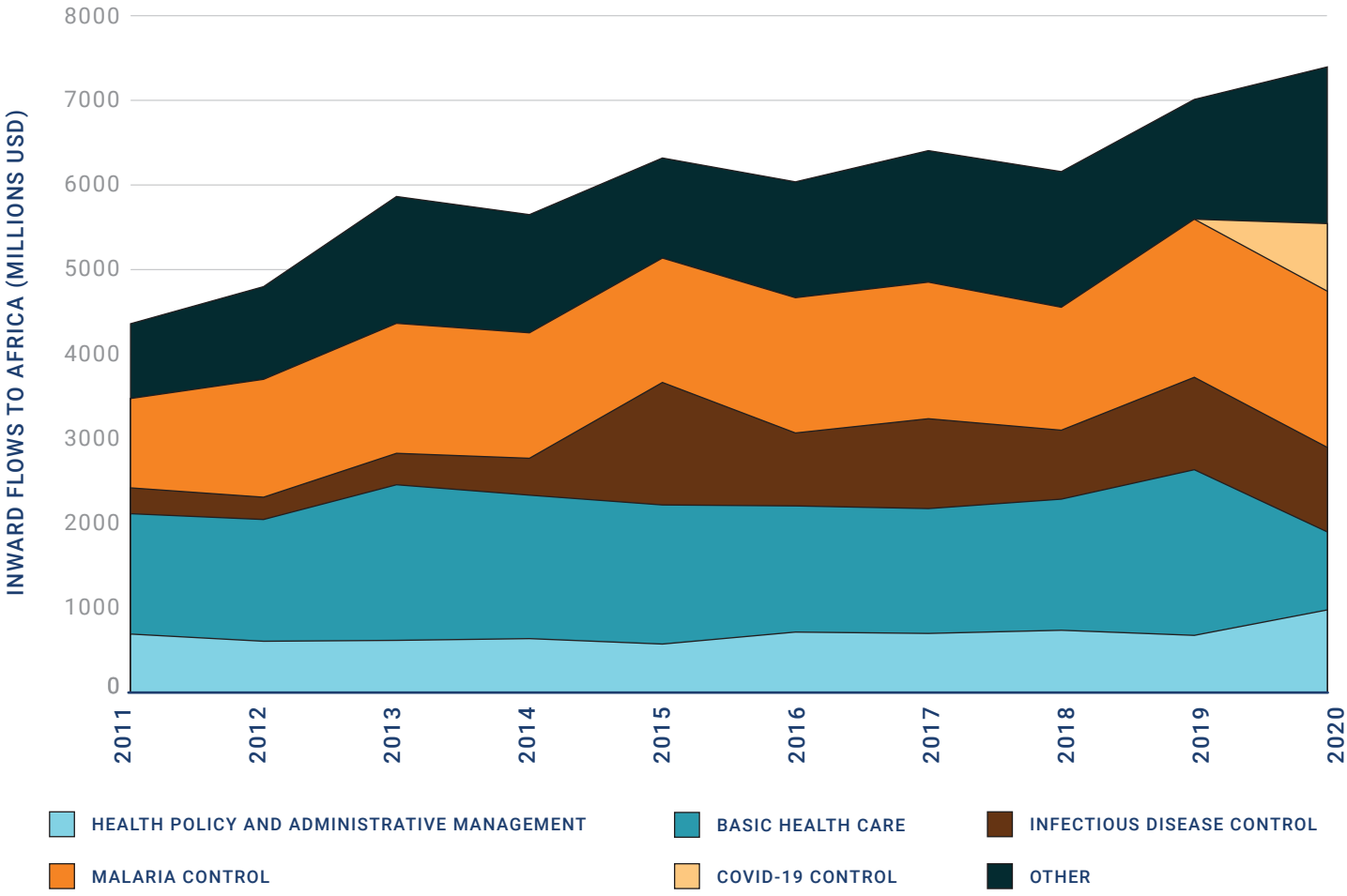
Private development financing for Africa's health care sector has increasingly been focused on preventing and treating infectious diseases. It received a significant jump in 2020 to prevent the spread of COVID-19. COVID-19 control initiatives accounted for more than 11 percent of all health-related private development finance in Africa in 2020.



Note: Private flows tend to target Malaria, COVID-19, and other infectious diseases (60 percent of all private flows).
Source: OECD.Stat. 2022. Total flows by donor (ODA+OOF+Private) [DAC1]. Organisation for Economic Cooperation and Development.

FIG.28 OFFICIAL DEVELOPMENT ASSISTANCE (ODA) FOR AFRICA'S HEALTHCARE SECTOR

Official Development Assistance (ODA) going to Africa's health care sector has tended to be more broad-based, focusing on a wide range of health subsectors including infectious diseases, basic healthcare delivery, supporting policy and administration, and investing in training health care professionals.



Note: Official flows target a range of activities, from infectious diseases to policy and administrative support.
Source: OECD.Stat. 2022. Total flows by donor (ODA+OOF+Private) [DAC1]. Organisation for Economic Cooperation and Development.

Empowering frontline workers to develop and deliver health care solutions

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Around the world, we are finally starting to recognize that addressing some of the biggest health challenges we face today—from antimicrobial resistance and communicable diseases to climate change and health disparities—requires not just investing in, but also elevating the voices of, frontline workers who for too long have been overlooked, undertrained, and denied a seat at the policy table.

Nurses and midwives, for example, have enormous capacity to reach broad populations with preventive care, health education, family medicine, and treatments for both acute and chronic diseases. Yet, we are not investing in them as we must. In 2020, the World Health Organization (WHO) recommended that countries educate six million more nurses to offset long-predicted shortages that threaten healthcare delivery worldwide.[1] The pandemic has made the situation more dire. According to the International Council of Nurses, due to an anticipated avalanche of resignations and retirements, the world will need 13 million more nurses by 2030.[2]

And we do not just need more nurses—we need more nurses in leadership positions. They have the insights, experience, and relationships to shape smart policy, carry out effective population health programs, and respond nimbly to health crises. This is why the Harvard T.H. Chan School of Public Health has worked with other partners, including the Africa Centres for Disease Control and Prevention (Africa CDC), the African Union, and the Burdett Trust for Nursing to launch a Global Nursing Leadership Program. We just welcomed our first cohort of practicing nurses and midwives from across Africa with the goal of teaching them how to lead projects, manage health systems, and engage confidently with national political leaders.

Last month, the African Union Commission and Africa CDC urged governments, international organizations, nonprofits, and philanthropists to invest in the long-term building of the continent's public health systems. In particular, the "New Public Health Order" for Africa calls for a stronger public health workforce and increased manufacturing capability of vaccines and drugs, to make African countries less dependent on foreign assistance.[3]

We know from experience that such an approach leads to scientific breakthroughs and better population health. In 1996, for example, Harvard helped launch the Botswana-Harvard AIDS Institute Partnership in Gaborone. The laboratory quickly

1 WHO. 2020. "State of the world's nursing 2020: Investing in education, jobs, and leadership." World Health Organization.

2 ICN. 2022. "International Nurses Day demands action on investment in nursing, protection and safety of nurses." International Council of Nurses.

3 Africa CDC. 2022. "Call to Action: Africa's New Public Health Order." Africa Center for Disease Control and Prevention.

Investing in frontline workers also means directly funding innovation in the Global South, so local institutions can ramp up their capacity, and frontline workers can develop programs tailored to their specific communities' needs.

pivoted to genomic surveillance when the COVID-19 pandemic struck, and it was here that researcher Dr. Sikhulile Moyo first sequenced and then alerted the world about the existence of the highly contagious Omicron variant. Anyone who has ever visited the Institut Pasteur in Dakar has seen its advanced capabilities; and thanks to global investments in such laboratories, Africa is on its way to meet its ambitious goal of locally manufacturing at least 60 percent of the vaccines needed across the continent.

There is plenty of untapped talent among frontline workers around the world and we must do more to nurture and support them. Community workers, nurses, and midwives can help us reimagine healthcare delivery. Microbiologists, epidemiologists, and genomic sequencing researchers can warn us when a new pathogen emerges. Vaccine developers and manufacturers can protect people all over the world from new and old diseases.

We must empower frontline workers, both to shape global health policy and design and carry out programs tailored to their communities. Only with their help can we build a healthier, more resilient world.

Ethiopia's lessons from COVID-19

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As we commence 2023, the world is still grappling with the direct and indirect effects of the COVID-19 pandemic. In retrospect, the pandemic tested Ethiopia's health system like no other challenge in recent history and amplified its existing strengths and weaknesses. The crisis also gave us an opportunity to rebuild our system with new insights, gained from the response to this once-in-a-generation pandemic.

I was appointed as Minister of Health in Ethiopia the day our health system detected the first COVID-19 case[1] in the country, 70 days after the first case was detected in Wuhan. Two to three months following this, we noticed a significant decline in the utilization of essential health services like vaccines, antenatal care, HIV care, and others. The Ministry's identification and awareness of this worrying trend was made possible through our District Health Information System, which enabled health officials to plan for—and execute—mitigation measures including non-visit care through tele-consulting; multi-month dispensing; and strong effective community monitoring. These measures helped Ethiopia to be among the few African countries that have maintained essential health services during the pandemic.[2]

I was appointed as Minister of Health in Ethiopia the day our health system detected the first COVID-19 case.

However, there were also pitfalls and lessons for improvement. The health system was aware of only a proportion of the cases and deaths from COVID-19, even though the Government rapidly expanded testing[3] sites from zero to 85, in less than six months. During these first few months, we implemented strict public health and social distancing measures that were being recommended globally and used by many countries in the region. We quarantined travellers, contacts, and suspects in health facilities, schools, and other public facilities and admitted all positive cases. In hindsight, there was already community spread by the time we were implementing these interventions, making our response ineffective and less appropriate for the stage of the outbreak. We also quickly learned that we did not have the physical infrastructure, nor the resources required for isolating thousands of people and had to make a shift.

As I look forward to 2023, I single out two priority investment areas that are required to build a more resilient system that will be better equipped to handle future health shocks.

Investing in health information systems and epidemiological surveillance networks to guide an apt and timely response plan. Investing in health information systems that generate individual-level patient data should be a priority in 2023. This will support vital registration efforts, enable contact tracing, assessment of the quality of care, and provide near-real time outcome data to guide the health system with evidence.

Investing in a strong primary health care (PHC) providing diverse care. Ethiopia has prioritized investment in PHC, but to date, most of these investments have

1 IHME.2020. "Dr. Lia Tadesse Gebremedhin: Minister of Health, Ethiopia."

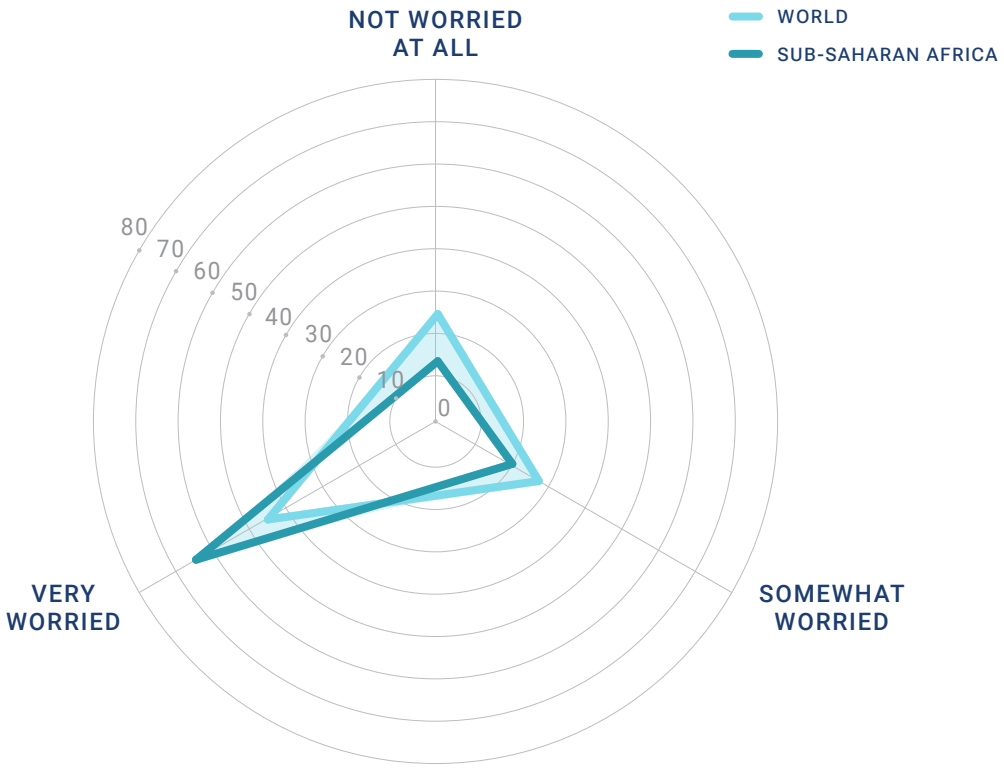
2 McCann et al. 2022. "COVID-19 disruptions of food systems and nutrition services in Ethiopia: Evidence of the impacts and policy responses."

3 Kebede et al. 2021. "Expanding molecular diagnostic capacity for COVID-19 in Ethiopia: operational implications, challenges and lessons learnt."

been narrowly focused on preventing and treating infectious diseases and maternal and childhood illnesses and only recently expanded to noncommunicable diseases (NCDs). However, in order to respond effectively to future outbreaks, our PHC should have the capacity to address a broader range of health challenges like NCDs, mental health, emergencies, and others. The benefits of community outreach through house-to-house surveillance by health extension workers, was also a valuable lesson to continue investing in community health for a strong PHC.

FIG.29 **SUB-SAHARAN AFRICANS ARE MORE WORRIED THAN OTHER WORLD REGIONS ABOUT PAYING FOR MEDICAL COSTS IN CASE OF A SERIOUS ILLNESS**

In a recent multi-country survey of sub-Saharan Africans, nearly two-thirds of respondents reported being "very worried" about having to pay for medical bills resulting from a serious illness. This number is significantly higher than the global average of 46 percent. In sub-Saharan Africa, only 14 percent of respondents reported being not worried.



Note: Dataset includes respondents age 15+ from 153 countries, including 41 from sub-Saharan Africa. The countries included in sub-Saharan Africa include Angola; Benin; Botswana; Burkina Faso; Burundi; Cameroon; Central African Republic; Chad; Comoros; Democratic Republicof Congo; Republic of Congo; Côte d'Ivoire; Eswatini; Ethiopia; Gabon; The Gambia; Ghana; Guinea; Kenya; Lesotho; Liberia; Madagascar; Malawi; Mali; Mauritania; Mauritius; Mozambique; Namibia; Niger; Nigeria; Rwanda; Senegal; Sierra Leone; Somalia; South Africa; South Sudan; Sudan; Tanzania; Togo; Uganda; Zambia" Zimbabwe.
Source: World Bank. 2021. Global Findex Dataset. World Bank Group.

Building Africa's capacity for pandemic and epidemic intelligence

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The COVID-19 pandemic revealed that coordination and collaboration between countries on surveillance and epidemic intelligence were poor and led to ineffective and inefficient decision-making.[1] This poor collaboration was not limited to countries with poor capacity but applied also to countries with advanced capacities and good socio-economic relations.

While many countries generate data, the potential for meaningful analysis remains underutilized as the data are collected in ad hoc ways, with differing standards that are not sufficiently connected to answer complex questions. The pandemic also revealed that channels of coordination for countries to learn from each other and produce global models, or share national insights was limited. Moreover, many countries have not prioritized the development of public health surveillance and intelligence systems on account of limited capacities and scarce resources.

Clearly, there are immense benefits to be gained from better sharing of data related to health risks, vulnerabilities, and outcomes. The sharing of data can facilitate timely response, robust research, and overall, better-informed policy outcomes. Despite these benefits, several barriers and challenges to data sharing persist.

In response to an increased number of disease outbreaks affecting African countries, the World Health Organization (WHO) Africa Regional Office (AFRO) introduced the Integrated Disease Surveillance and Response (IDSR) framework in 1998.[2] IDSR was introduced to strengthen data collection, analysis, and use in African countries. The overall goal is to improve the detection and response to the leading causes of illness, death, and disability in the region. Regrettably, this strategy never received the due investments it needed, and implementation was very poor. Both local and global resource streams favored vertical disease programs over an integrated approach. Nevertheless, in some countries, its introduction led to improvements, including improved timeliness and completeness of surveillance data, increased national-level review, and better use of surveillance data for outbreak preparedness and response.[3]

In addition to data on disease occurrence, and outcome, there is also a complex web of interconnected biological, public health, and economic factors that contribute to the emergence and spread of diseases. Yet, data collected from these other drivers are often not systematically connected or shared with health data, leading to limited

1 Gavi. 2022. "Data-sharing in a pandemic: even though scientists shared more than ever, it still wasn't enough." Gavi, the Vaccine Alliance.

2 Fall, Ibrahima Socé et al. 2019. "Integrated Disease Surveillance and Response (IDSR) strategy: Current status, challenges and perspectives for the future in Africa." BMJ Global Health, 4(4), e001427.

3 Mremi, Irene R., Janeth George, Susan F. Rumisha, Calvin Sindato, Sharadhuli I. Kimera, and Leonard EG Mboera. 2021. "Twenty years of integrated disease surveillance and response in Sub-Saharan Africa: challenges and opportunities for effective management of infectious disease epidemics." One Health Outlook 3, no. 1: 1-15.

opportunities to determine their impact on risk. For example, in many African countries, there are limited platforms for data sharing and cross-sector analysis between human and animal health sectors, despite the increased occurrence of zoonotic diseases.

Several countries in Africa are at different phases in building their data collection, analysis, and broader epidemic intelligence capabilities. Many are in the process of digitalizing their surveillance systems. However, these processes are proceeding in an organic, uncoordinated manner.

Several countries in Africa are at different phases in building their data collecation, analysis, and broader epidemic intelligence capabilities. Many are in the process of digitalizing their surveillance systems. However, these processes are proceeding in an organic, uncoordinated manner as countries make critical decisions on what software and hardware to use, without getting appropriate strategic and technical advice.

The WHO through its new Pandemic and Epidemic Intelligence Hub in Berlin, working in collaboration with the Africa Regional Office (AFRO) is putting together processes, guidelines, and tools to support African countries in developing their surveillance and intelligence infrastructure. A peer-to-peer learning environment will also be created and nurtured to enable sharing between countries.

Several African countries face competing priorities—from frequent infectious disease outbreaks to an increasing prevalence of non-communicable diseases, as well as challenging socio-economic indicators. The available resources are limited, and areas such as surveillance system and epidemic intelligence strengthening are under-resourced. Factors such as the limited availability of health workers and infrastructure often affect the ability to collect, analyze, report, and use data.

Despite the challenges, there remains immense potential for the region. The increased focus on these capabilities by the WHO Hub for Pandemic and Epidemic Intelligence, and the growth of regional health organizations such as the Africa CDC, present an opportunity to strengthen epidemic intelligence in the region. In addition, recognizing the challenges facing African countries, the Hub is developing a collaborative intelligence approach clustered around three activities: Connect data, solutions, and communities of practice globally; innovate solutions and processes; and strengthen capabilities for forecasting, detection, and assessment of risks to provide actionable insights for prevention, preparedness, response, and recovery from health threats and emergencies.

The future of public health in Africa, and indeed across the world, rests in large part on the ability of countries to leverage the use of data through sharing and linking data and learning from each other.

Using information and communication technology to improve mental health in Africa

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Mental health is a crucial part of human capital development and yet, there remains sparse research on this important aspect of health and economic development—more so in Africa, a region which faces the joint challenge of high disease burden and a severely underfunded health sector. Moreover, addressing mental health disorders should be of pressing policy interest, especially since mental health disorders translate into staggeringly large economic losses, particularly in low-income countries where people are often faced with unexpected shocks to income and health.[1]

According to the 2014 WHO mental health atlas survey, 24 percent of countries in the world reported that they did not have (or had not implemented), standalone mental health policies.[2] In Africa, the share was almost double that at 46 percent. In addition, government spending is estimated at only 40 percent of total health spending for countries in sub-Saharan Africa, much lower than the world average of 60 percent.[3] Likewise, Africa's government spending on health is only 2 percent of GDP, lower than the world share of 3.5 percent, as of 2017. Out-of-pocket spending as a share of health spending in Africa was also among the highest in the world at 37 percent of health spending, compared to 18 percent in the rest of the world.[4]

When we add these statistics to the fact that Africa has the world's youngest population, with 60 percent of its population under the age of 25—and that young people are often identified in mental health literature as being at high risk for mental health disorders (including suicide and self-harm), then this presents a very worrying picture.[5]

At the same time, there are more people with global access to ICT (e.g., mobile phones) today than at any other point in human history, with the majority of the population in Africa having access to a mobile phone.[6] Whereas only 8 percent of Ghanaians said they owned a mobile phone in 2002, that figure surged to 83 percent by 2015, a more than tenfold increase. Today, cell phones are as common in South Africa and Nigeria as they are in the United States.[7]

1 American Economic Association. 2017. "Disease and Gender Gaps in Human Capital Investment: Evidence from Niger's 1986 Meningitis Epidemic." American Economic Review 107, no. 5, pp. 530-35.
2 Sankoh, Osman, Stephen Sevalie, and Mark Weston. 2018. "Mental health in Africa." The Lancet 6, issue 9, E954-E955.
3 WHO. 2022. Global Health Expenditure database. World Health Organization.
4 Abubakar, Ibrahim et al. 2022. "The Lancet Nigeria Commission: Investing in health and the future of the nation." The Lancet 399, no. 10330 (2022): 1155-1200.
5 Sankoh, Osman, Stephen Sevalie, and Mark Weston. 2018. "Mental health in Africa." The Lancet 6, issue 9, E954-E955.
6 Pew Research. 2015. "Cell Phones in Africa: Communication Lifeline." Pew Research Center.
7 Ibid.

The results further suggest that a major policy response to improve mental health in Africa should be, to leverage access to ICT and issue communication credits, that make it easier for people to communicate and stay connected to their networks.

This proliferation of mobile phone technology has created the opportunity to innovatively tackle various social and development challenges on the continent, ranging from financial inclusion to urban mobility, and even basic service delivery in areas like education and health.

So, can we leverage this near universal access to mobile phones to improve mental health? Our new paper aims to answer this question using evidence from Ghana, and analyzes what possible policy interventions could work to improve mental health in Africa.[8]

To answer the question, we use evidence from a communication intervention in Ghana to test whether improved communication, using information and communication technology like mobile phones, can improve mental health. In our study, we partner with a major telecommunications company and implement low-cost communication interventions that provide mobile calling credits to a nationally representative set of low-income adults in Ghana during the COVID-19 pandemic.

Our findings showed that for those individuals who received mobile calling credits, their inability to make unexpected calls; and their need to borrow SOS airtime, as well as to seek digital loans decreased significantly, relative to a control group. As a result, the program led to a significant decrease in mental distress (-9.8 percent) and the likelihood of severe mental distress by -2.3 percentage points (a quarter of the mean prevalence). The effects of the intervention were channeled only through a reduction in mental distress, and there was no impact on consumption spending. Moreover, a simple cost-benefit analysis shows that providing communication credit to low-income adults is a cost-effective policy for improving mental health.

Communication—defined broadly as the ability to stay connected—meaningfully improves mental wellbeing, and interventions involving communication are particularly valuable when implemented as several installments. The results further suggest that a major policy response to improve mental health in Africa should be, to leverage access to ICT and issue communication credits, that make it easier for people to communicate and stay connected to their networks. This is an effective and low cost means of improving mental health, especially in low-income settings where government spending on health and mental health is significantly low.

8 Annan, Francis and Belinda Archibong. 2022. "The value of communication for mental health." The Brookings Institution.