Planning for Health Systems to Meet the Millennium Development Goals: Opportunity at the Second Conference of African Ministers of Health

October 2005

A Call to Action

Physicians for Human Rights and our partners[1] respectfully urge you, the African Ministers of Health, to decide at your October 2005 conference that African Union countries will develop: 1) targets for the development of health workforces and other elements of health systems to enable the achievement of the Millennium Development Goals and other national, regional, and international health aims; 2) specific plans on how to reach these targets, and; 3) budgets to accompany the plans.

The plans may need to change as the evidence base grows, and may be less detailed in more distant years. Similarly, complete budgets for the entire ten year period to 2015 may not be possible. But it is a process that we encourage you to initiate as soon as possible, incorporating this effort into national development planning processes as appropriate.

We further encourage the African Union health ministers to prioritize significantly increasing access to health services, especially in rural and other hard-to-reach areas, and especially for the poorest and most vulnerable members of society.

Background

From frontline health workers to the United Nations Secretary-General, it is now well-known that many countries in Africa are facing a human resource crisis. Indeed, Secretary-General Kofi Annan recently called for a million more health workers for Africa.[2] The Aide Mémoire prepared for the African Union's Second Conference of African Ministers of Health (CAMH2) recognizes that a "health policy must . . . address the health sector in a holistic and integrated approach rather than through fragmented disease specific interventions," and that the brain drain of medical personnel "has become a major constraint to any development and improvement of the health status in most communities on the continent."

An expanded, highly motivated health workforce, as well as significant strengthening of fragile health systems in African countries, is necessary to achieve health targets in AIDS and other areas. These include individual country targets, regional targets such as the African commitment to ensure all children access to basic health services by 2015, and international targets. Such international targets include the Millennium Development Goals (MDGs), as well

[1] PHR's partners in this effort include Health Gap and Global AIDS Alliance. PHR owes a special thanks to Rob Lovelace.

[2] "Annan calls for renewed efforts to improve health care systems in the developing world." *UN News Service*, June 30, 2005.

as UN mandates to achieve near universal access to AIDS treatment by 2010, and to provide universal access to reproductive health care by 2015.[3]

As stated in the Aide Mémoire, CAMH2 aims to make "specific, viable and implementable decisions." One area to be discussed is "how to address challenges in the implementation of the MDGs." We respectfully suggest that a crucial step in successfully implementing the MDGs is to determine the composition of the health workforce and number of health workers necessary, create a plan to develop such a workforce, calculate the cost needed to implement this plan, and identify other health system elements required to achieve the MDGs, as well as the cost of these other needs.

The Challenges and the Possibilities

Making plans to meet the MDGs and other health goals will be challenging. We recognize that it may appear an unaffordable luxury to plan for vast expansions of the health workforce when it is a struggle to simply keep the workforce from shrinking, or to imagine the budgets required to develop such workforces when one may be hard-pressed to secure even small budget increases or moderate improvements in workers' salaries and working conditions. The plethora of other urgent health crises, such as AIDS, tuberculosis, and malaria, may make it difficult to devote limited human and financial resources to developing comprehensive plans to address long-term, complex problems like the human resource crisis.

We recognize, too, that building health systems and human resources is difficult. There has been less of an effort to gather evidence of successful policies in these areas than for combating diseases like AIDS and malaria. The long-term, multi-sectoral nature of these issues adds to the challenge. So does the difficult fact that these challenges have, in many countries, reached a level of crisis, an emergency that needs to be dealt with now, though the best solutions must be sustainable and part of a long-term vision.

And we recognize that development partners have contributed to the difficulties of long-term planning by rarely offering the long-term support required for building health systems. The unpredictability of external funds may make planning for the next year, much less the next decade, a difficult and frustrating process. And of course, external funds are not only unpredictable, but often insufficient.

And yet, despite these challenges, we believe that the time has arrived for the long-term planning in human resource and health system development necessary to achieve the MDGs and other health goals.

Increasing knowledge and capacity

While much still remains to be learned about how to effectively and rapidly scale-up health workforces and create effective health systems with broad reach, the past several years have seen experiences and advances that make the challenge of developing an implementable plan to do this increasingly feasible. National experiences in strengthening human resources and other health system components are growing, providing models and lessons that other countries can build on.

[3] United Nations World Summit outcome document (Sept. 2005), at para. 57(d) (near universal treatment), 57(g) (reproductive health care). A commitment to make accessible "reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015" was first made in 1994 at the International Conference on Population and Development. Programme of Action of the United Nations International Conference on Population and Development (1994), at para. 7.6.

Malawi, for example, has begun to implement a six-year emergency human resource program. Zambia and other countries are implementing successful measures to improve rural deployment. The health ministers of the Eastern, Central and Southern African (ECSA) Health Community have recognized as a "good practice" Kenya's project to develop a computerized nurse workforce database. Ghana and other countries are beginning to benefit from increasing health workers' salaries and allowances. This is only a small sampling of what is happening now in many African countries.

The level of experience is only growing, and the capacity to capture that experience is growing as well. For example, the World Health Organization's planned human resources for health observatory for the African Region will help gather and disseminate experiences and evidence on developing and implementing human resource strategies. It will also help build local capacity in human resource planning and management, helping equip health ministries with the tools needed to become leaders in this area.

A set of "good practices" in health worker retention, among the most challenging parts of the health worker issue, is emerging and can be incorporated into planning processes. These include:

- Ensuring strong human resource management and supervision;
- Creating a safe working environment for health workers;
- Ensuring that health workers receive continuing education and opportunities for professional development, and benefit from a clear career structure;
- Making available psychosocial support to health workers;
- Developing health workplace HIV prevention and management programs, and;
- Ensuring adequate health facility communication and transportation capacity.

Further, home and community caregivers, who have become de facto health workers, require compensation, training, and support from the formal health sector.

Meanwhile, an expanding number of experienced individuals and groups are becoming available to provide technical support and build local capacity in the areas of health workforce planning and management, such as the USAID-funded Capacity Project. Frameworks and tools now exist to develop systematic strategies to address both short- and long-term challenges.

Increasingly conducive international environment

- Connection to the fight against AIDS and other diseases

National governments and development partners increasingly invest in disease-specific programs, especially those to fight AIDS. It has become apparent that the shortage of human resources and fragile health systems are a major obstacle to scaling up health interventions. Given the level of funds being devoted to fighting AIDS, governments and development partners have an extra incentive – beyond fighting AIDS – to make sure these funds work: they do not want the money to be wasted because it cannot be spent effectively. Slowly but undoubtedly, disease-specific programs are beginning to adjust to these realities by increasing their scope for investing in human resources and health systems.

For example, in its recently completed Round 5, the Global Fund to Fight AIDS, Tuberculosis and Malaria permitted proposals focused directly on health system strengthening. While only a few of

these proposals were approved,[4] the fact that the Global Fund permitted such proposals demonstrates the growing recognition of the need for health system investment. Similarly, some funding from the U.S. President's Emergency Plan for AIDS Relief is being used to strengthen health systems, including human capacity development. The U.S. Senate, recognizing the interplay between human resources and the fight against AIDS, has requested that the U.S. Global AIDS Coordinator report back on a strategy for meeting the shortfall in health workforce capacity required to achieve the Emergency Plan's goals without reducing the capacity of the health system to deliver other health interventions.[5]

Ironically, even as this new understanding is creating space for badly needed investments in health workers and infrastructure, it also poses a risk. As long as much of the available human resource and health system funding is tied to AIDS, countries will lack the flexibility and money to address the larger health system problems. The development of plans and budgets linked to a range of health goals, including the MDGs, can help change this dynamic by creating a clear statement of need that goes beyond, though incorporates, HIV/AIDS, and by putting forward the strategy for achieving that need.

- International commitments

In recent months, there has been new, high-level commitment to the need to strengthen human resources and health systems in order to achieve the MDGs. In 2005, the G8 countries committed to invest "in improved health systems in partnership with African governments, by helping Africa train and retain doctors, nurses and community health workers. . . . [and to] ensure our actions strengthen health systems at national and local level and across all sectors."[6] And at the 2005 UN World Summit, the nations of the world pledged "to improve health systems in developing countries and those with economies in transition, with the aim of providing sufficient health workers, infrastructure, management systems and supplies to achieve the health-related Millennium Development Goals."[7]

This commitment creates new potential. In order to achieve the MDGs, it is necessary to know just how many, and what types, of health workers are "sufficient." Yet in most African countries, the number of health workers and the level of investment in health workforces required to achieve the MDGs and other health goals are unknown. In part, this is because it is difficult to project the numbers of health workers needed due to the many variables involved – shifting disease burdens, changing levels of health worker efficiency, different possible skills mixes, and so forth. But it is also because the necessary projections, with accompanying detailed planning and budgeting, are not being made. For example, in many countries, health facility staffing ratios are outdated and not based on actual workloads at different facilities. Nor are they based on the increased use of health services that often will be required to achieve the MDGs, especially in rural and other underserved areas. Even if the vacancy level based on current staffing norms were reduced to zero, the health workforce still might not have the capacity to meet health goals.

The UN Millennium Project has forcefully placed the issue in context: "Low-income countries and their development partners now plan around modest incremental expansions of social services

[4] Only 3 of 30 of the Round 5 health system strengthening proposals were approved. "Round 5 Decisions," *Global Fund Observer*, Issue 51, Oct. 3, 2005. Steps must be taken to ensure more successful proposals in Round 6.

[5] Senate Report 109-096, Department of State, Foreign Operations, and Related Programs Appropriations Bill, 2006, at "Report on HIV/AIDS Health Workforce Strategy."

[6] G8 Africa communiqué (July 2005), at para. 18(c). Available at: http://www.fco.gov.uk/Files/kfile/PostG8_Gleneagles_Africa,0.pdf.

[7] United Nations World Summit outcome document (Sept. 2005), at para. 57(a).

and infrastructure."[8] This type of planning is insufficient to achieving the MDGs and other goals. At the UN World Summit, countries committed themselves to "[a]dopt, by 2006, and implement comprehensive national development strategies to achieve the internationally agreed development goals and objectives, including the Millennium Development Goals."[9] If the international community is serious about its recent commitments, assistance in developing the plans required to meet the MDGs and the financial and technical support required to implement these plans must be forthcoming.

By committing to develop these plans, African governments will be creating a window of opportunity. They will be able to request that development partners provide technical support that they have mapped out as necessary. Given that these plans are fundamental to achieving recent commitments, partners may be hard-pressed to refuse needed support.

Plans and budgets linked to MDGs and health goals could create new, positive dynamics

- Help ensure fiscal space to make necessary investments in health workforce and health systems

A health system plan and an accompanying budget could help lead to more predictable development assistance. If countries have a sound, long-term, budgeted plan, development partners will be able to commit to supporting that strategy over the course of many years. Sustainability is an essential aspect of human resource planning. A comparable commitment is simply not possible where the long-term plan does not exist. A long-term plan can also secure the confidence of development partners that national governments are committed to health workforce and health system strengthening. Such commitment is necessary if external support is to create sustainable results.

A reasonable estimate of the funds required to build the health systems needed to achieve the Millennium Development Goals could also impact policies of finance ministries and international financial institutions that are publicly committed to the MDGs, such as the International Monetary Fund and the World Bank. African finance ministers, of course, also support the MDGs.[10] A strong case that the level of investment in human resources and health systems necessary to achieve the MDGs is incompatible with existing monetary and fiscal policies will create pressure on these institutions to reconsider their policies. These policies must enable more room in national budgets for health and more flexibility in how much a government may spend in wages.

- Improve success of disease-specific programs

Disease-specific programs, such as those for AIDS, may suffer because their design presupposes – and requires – a level of human resources and health system functionality that does not yet exist. Human resource and health system planning will bring into sharp relief the mismatch between what disease-specific programs require of health workers and health systems, and what overburdened health workers and overstretched health systems are able to accomplish. This mismatch should assist health ministers to advocate for more balanced programs from external funders, and greater investment in health system strengthening both from external partners and from their own finance ministries. It will turn anecdotes about the need for investments in human

[8] UN Millennium Project, *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals* (2005), at 56.

[9] United Nations World Summit outcome document, at para. 22(a).

[10] Conference of African Health Ministers, Ministerial Statement, May 15, 2005, Abuja, Nigeria. Available at: http://www.uneca.org/conferenceofministers/2005/ministerial_statement.htm.

resources and health systems into hard data. This could be used to convince development partners investing in disease-specific programs that these programs will only succeed – and the money invested will only create a sustainable benefit – if they also invest in health system strengthening.

Since the development of the targets requires gaining an understanding of the human resource and health system elements required to fight specific diseases, the process of developing targets should create a better understanding of the health workforce requirements of disease-specific programs. This understanding and the targets themselves should help empower health ministries to insist that a set portion of funds for disease-specific programs be used for health systems in order for the programs to achieve sustainable success.

- Promote international funding, focus, and advocacy

The existence of human resource and health system targets could help garner lasting international attention and financing. Other programs have shown the value in health-related targets, such as the World Health Organization's 3 by 5 initiative. Concerted WHO promotion of the 3 by 5 initiative led to a major increase in AIDS treatment, even as it appears that the 3 by 5 target itself will be missed.

Similarly, human resource and health system targets, and plans with budgets, should enhance international attention and funding for these crucial areas. Long-range targets with long timeframes may promote sustained, long-term investment in health systems, while short-term benchmarks can show quick impact.

- Increase control over foreign assistance

In many areas, large amounts of assistance are not invested in the areas that will make the greatest difference in health outcomes, such as health workers and medicines. The clearer and more detailed a national government's own priorities are regarding human resources and health systems, the more leverage national governments will have with partners to ensure that external funds are directed to these priorities.

- Reveal and inform policy changes needed now to achieve goals by 2015

Since human resources and health systems cannot be built overnight, understanding now what is needed to achieve the MDGs will enhance the possibility that these needs will be met by 2015. Using the case of human resources, many of the examples of "good practices" outlined earlier would likely be part of any plan.

Other investments and policies depend on the number of health workers needed. But how many will be needed and how much will this cost? Now is the time to begin to find out, since these investments may have to begin immediately if the targets are to be achieved.

Listed below are some elements that must be considered in making a long-range plan.

- Health worker training: How many new health workers – whose education often takes many years – will need training? Will it be enough to expand capacity of health training institutions – and if so, by how much? – or will greater investments in math and science be necessary at the secondary school level, or even the primary school level, so that enough students are qualified to enter medical, nursing, and pharmacy schools, and other health

training institutions? Investments may have to start now to ensure that sufficient numbers of health workers graduate over the next decade.

- Salary increases: Some incentives being used to increase health worker retention, such as providing medical allowances and improving continuing education, are inherently valuable. But if a large proportion of health workers will have to be retained to meet the overall need, more incentives may be necessary, including salary increases. Given the number of health workers who must be retained, these salary increases may be necessary starting now, so that retention is sufficiently improved immediately, not five or ten years from now. This is particularly true because more evidence is needed on successful retention strategies, including the role of salary increases. It may take several years to discover what level of salary increases and other incentives, such as housing and transportation allowances, are needed to significantly impact retention. It will be difficult to evaluate whether such incentives are sufficient without an understanding of what level of retention is necessary. A retention strategy may increase retention by 50%, but is that enough?

- Incentives to serve in hard-to-reach areas: The level of incentives needed to increase access to health services in hard-to-reach areas depends in part on how many more health workers are needed in these areas, both to make significant progress immediately and to enable universal access to quality health services in these regions in the longer term. This requires an understanding of the health workforce needed to reach this longer-term goal (and other equity goals that a country may consider, such as ensuring that the MDGs are achieved on a regional or district-by-district basis). Incentives, which can include various allowances (such as hardship, housing, transportation, and education) and will likely be a significant aspect of a plan to increase coverage in underserved areas, can then be set at a level expected to achieve this health worker coverage. Incentives may well have to be altered as evidence accumulates.

- Skills mix: There are different ways to provide high-quality health care. By understanding health workforce needs to achieve the MDGs and other health goals– including the vital needs to extend quality health services to rural and other underserved areas– and by evaluating strategies to meet these needs, health ministries can make the best possible decisions regarding the skills mix and the use of mid-level and community-level health workers.

For example, a country might currently rely heavily on physicians and limit the authority of nurses and other health workers. Upon examining the significant expansion in health services required to achieve the MDGs and other goals, planners may determine that it is desirable to enhance the roles and responsibilities of other health workers, including community health workers, as well as to provide comparable compensation, training, supervision, and support.

Developing and integrating new cadres into the health workforce, or significantly altering the skills mix, takes time and planning. The sooner health planners incorporate the need for change in their work, the sooner the necessary changes can be implemented, and the sooner health outcomes will begin to improve.

By developing targets and plans that demonstrate the need for investments now, health ministers will be better positioned to argue for funding for these interventions, both from their own finance ministries and from development partners.

- Monitor progress and promote accountability

Agreed upon targets for health systems will greatly enhance stakeholders' ability – including ministries of health – to monitor progress towards the MDGs and other goals. This will make it easier to determine where progress is inadequate, indicating that investments must be increased and policies changed. Meanwhile, demonstrated progress can help generate political will to justify more funding. Such progress, and an ability to change course, may help secure the confidence of finance ministries and development partners, who are always keen that their funds produce results. Targets will also enable various partners to hold one another accountability for their commitments. Lack of required progress that can be attributed to under-funding could aid health ministries in efforts to secure additional funds from the finance ministry and development partners.

Other possible health system target areas

The examples above have focused mostly on human resources. Targets should be developed for other aspects of health systems as well. These could include health information, health system financing,[11] health system management, physical infrastructure, and the availability of essential medicines and other health care supplies.

In the area of health system financing, Physicians for Human Rights recommends that African health ministers renew their call in the 2003 NEPAD Health Strategy for a timetable to reach the benchmark of allocating at least 15% of public spending to health.[12] We encourage the African health ministers to urge their governments to meet this target as rapidly as possible, even proposing a near-term deadline for its achievement, such as 2007.

Another vital area in which to develop targets is access to health care, physical and financial access, with an ultimate goal of 100% access. All targets should include an equity component, such as equity in access or equity among different regions of the country or population sub-groups (such as the poor).

Promote policies that respect human rights

Physicians for Human Rights urges that in setting targets and developing plans, ministries of health and governments in Africa adhere to international human rights standards.

Right to best attainable state of health

In some countries, developing the health workforce and health systems required to reach the health-related Millennium Development Goals will require a massive effort and mobilization of resources, and the MDGs will be the most that can be achieved under the best of circumstances. In other countries, where the present situation is less dire, it may be that the necessary advances can be made in less than a decade. In that case, as countries set targets and develop plans to achieve them, we urge countries to bear in mind their obligations under regional and international human rights conventions.

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[11] Global Health Watch 2005-2006, a civil society alternative to WHO's annual World Health Report, offers several possible targets for health system financing. *Global Health Watch 2005-2006* (2005), at 85, box B1.8. Available at: http://www.ghwatch.org/2005report/B1.pdf.

[12] The New Partnership for Africa's Development (NEPAD) Health Strategy – Initial Programme of Action (2003), at 19. Available at: http://www.sarpn.org.za/documents/d0000588/NEPAD_Health_Action.pdf. African heads of state agreed to the 15% target in 2001. *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*, Organization of African Unity summit, adopted April 27, 2001, Abuja, Nigeria, at para. 26. Available at: http://www.uneca.org/adf2000/Abuja%20Declaration.htm.

In combination with the MDGs and other health goals, obligations under international human rights law should guide target setting. The African Charter for Human and People's Rights codifies a right to health: "1. Every individual shall have the right to enjoy the best attainable state of physical and mental health. 2. States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."[13]

Similarly, the International Covenant on Economic, Social and Cultural Rights (ICESCR) provides a right "to the enjoyment of the highest attainable standard of physical and mental health." Further, the ICESCR requires countries to spend the maximum of their available resources towards the achievement of the rights in the ICESCR, and to take steps to progressively realize those rights.[14] As explained by the Committee on Economic, Social and Cultural Rights, this progressive realization clause imposes "specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of" the right to the highest attainable standard of health.[15] If further health system and human resource strengthening beyond that required to achieve the Millennium Development Goals and other health goals will continue to yield health benefits, and this strengthening can be achieved, we urge countries to develop the targets that will yield this additional benefits, and so fulfill their obligations under international human rights law.

Equitable distribution of health services and equity in health care access

We respectfully urge that a drive towards equality and increased access to health services be a central part of health workforce and health system targets and plans. There is a tremendous disparity in access to health care between urban areas and rural and other hard-to-reach areas. Human resource and health system targets and plans should address this issue to achieve health goals and observe human rights. As part of the right to the highest attainable standard of health, people have the right to an equitable distribution of health facilities, goods, and services. Indeed, this is one of the core obligations of the right to health.[16]

Equity targets might take several forms. They could, for instance:

- Target a specific and significant reduction in disparities among regions (ideally, the elimination);
- Target a certain number of health workers to be deployed to underserved regions, perhaps to enable those regions of the countries, considered in and of themselves, to meet the MDGs;
- Target a minimum health worker density in all regions;
- Target the health worker distribution required to enable everyone in the country to have access to a country-defined basic set of health interventions, along with a functioning referral system for higher level care; or
- Target at least one nurse for every village.

[13] African [Banjul] Charter on Human and Peoples' Rights, at art. 16.

[14] International Covenant on Economic, Social and Cultural Rights, art. 2(1).

[15] Committee on Economic, Social and Cultural Rights, General Comment 14, The right to the highest attainable standard of health (Twenty-second session, 2000), U.N. Doc. E/C.12/2000/4 (2000), at para. 31.

[16] Committee on Economic, Social and Cultural Rights, General Comment 14, The right to the highest attainable standard of health, U.N. Doc. E/C.12/2000/4 (2000), at para. 43(e).

In order to understand the success of efforts to retain health workers in and recruit them to underserved areas, as well as the impact that foreign recruitment and other policies are having on the rural workforce, indicators should measure the flow of health workers into and out of hardship areas.

Possible sub-targets

Along with endorsing the development of human resource and health system targets, CAHM2 or, alternatively, individual health ministries, might endorse other targets that will promote human rights, such as the right of health workers to safe working conditions. These other targets could include the highest possible:

- Percentage of health workers with access to health care
- Percentage of health facilities with workplace HIV programs
- Percentage of health workers trained in HIV/AIDS prevention, care, and treatment
- Percentage of health facilities with supplies required to practice universal precautions and other forms of infection prevention and control, including safer devices
- Percentage of community health workers who have adequate compensation, training, supervision, and support
- Percentage of villages that have at least one nurse (or other health worker who has a specified set of skills)

Indicators should be developed to measure the extent to which human resource and other health system plans are succeeding in promoting human rights, such as measuring the proportion of health workers with access to protective gear and safer devices to prevent workplace infection.

Additional considerations on ensuring effectiveness and proper use of targets[17]

Determining ten years in advance the precise human resource and health system requirements for achieving the MDGs and other goals is difficult. Over time, a better understanding of need may develop. For example, where initial calculations might suggest that an additional 1,000 physicians and 4,000 nurses will be required to achieve the these goals, after several years it may become apparent that because of changing roles, efficiency gains from better management, and unanticipated effectiveness of non-traditional cadres, only 800 additional physicians and 3,200 additional nurses will be required. Or conversely, slower gains in HIV prevention may lead to higher than expected disease burden, thus increasing the number of health workers required. Or, a country might realize that a rush to meet certain numerical targets may lead to an unacceptable sacrifice in quality. In circumstances such as these, it would be appropriate, even desirable, to adjust targets, and therefore the strategy to meet them.

Also, numerical targets cannot capture all the needs and nuances of well-functioning health systems. A well-developed set of indicators can help capture these critical health system elements, such as the quality of the health workforce.[18] And achieving targets may well require attention to these more qualitative aspects of health systems, for it is doubtful that large improvements in retention are possible without, for example, improving human resource management. Further, targets should be understood in the larger context of improving health

[17] Our thanks to the Regional Network on Equity in Health in Southern Africa (EQUINET) for highlighting many of these issues.

[18] These indicators could include the percent of physicians (nurses, pharmacists) receiving continuing medical education a certain number of times per year, or the percent of community health workers who are trained, compensated, supervised, and supported by health professionals.

outcomes. If significant progress is being made towards achieving human resource and health system targets, but health outcomes are not making commensurate improvements, government policies might have to be re-evaluated.

Challenges and Possibilities: Conclusion

Even as the challenges are great, the rewards of meeting these challenges are even greater: the real potential to achieve momentous decreases in child and maternal mortality, to make sustainable gains against the diseases that are destroying lives and threatening communities and countries, and to vastly increase access to health services, especially for poor and marginalized populations. In a sense, creating plans and budgets to achieve these goals involves a leap of faith, faith that governments that have made bold commitments and pledges will take the steps necessary to meet them. The creation of plans and budgets will challenge governments to live up to those commitments. By contrast, the lack of such plans will create excuses for business as usual, which for many people means death.

We respectfully urge the health ministers of the African Union to lead the way to achieving these vital commitments, and to challenge the international community, and their own partners in government, to live up to them. And know that many members of civil society will be doing our best to ensure the same, as well as to help secure the funding and technical support, share the evidence, and develop the arguments that will enable bold plans to be implemented, and many lives to be saved.

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