

**AFRICAN UNION**

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**Department of Social Affairs**

**ASSESSMENT REPORT**

**Of The**

**AFRICA HEALTH STRATEGY 2007-2015**

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## II. LIST OF ACRONYMS

AfDB	African Development Bank
AIDS	Acquired Immunodeficiency Syndrome
ARVs	Anti-Retroviral Drugs
ART	Anti-Retroviral Therapy for HIV/AIDS
AU	African Union
AUC	African Union Commission
BCC	Behavior Change and Communication
CBOs	Community Based Organizations
EPI	Expanded Program for Immunization
FBOs	Faith Based Organizations
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDs, Tuberculosis and Malaria
HHA	Harmonization for Health in Africa
HIV	Human Immunodeficiency Virus
HSS	Health System Strengthening
ICT	Information, Communication and Technology
IDU	Injecting Drug Use
IEC	Information, Education and Communication
LLITNs	Long-lasting insecticide impregnated bed nets
MDGs	Millennium Development Goals
MDR-TB	Multiple Drug-Resistant Tuberculosis
M & E	Monitoring and Evaluation
NCDs	Non-Communicable Diseases
NEPAD	New Partnership for Africa's Development
NGOs	Non-Governmental Organization
NTDs	Neglected Tropical Diseases
UN	United Nations
OECD	Organization for Economic Co-operation and Development
PHC	Primary Health Care
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
PPP	Public Private Partnerships
PRS	Poverty Reduction Strategy
RECs	Regional Economic Communities
SRMNCH	Sexual, reproductive, maternal, neonatal and child health
SWAPs	Sector Wide Approaches
TB	Tuberculosis
TM	Traditional Medicine
UNAIDS	Jointed United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WB	World Bank Group
WHO	World Health Organization
XDR-TB	Extremely Drug-Resistant Tuberculosis

### **III.ACKNOWLEDGEMENTS**

The Commission of the African Union wishes to thank Member States and Regional Economic Communities for providing the necessary information and guidance towards the assessment of the African Health Strategy 2007 - 2015 and finalization of this assessment report. The role of the private sector and Civil Society Organizations in representing the non-governmental views is also appreciated.

The assessment of the African Health Strategy 2007 - 2015, would not have been accomplished without technical and financial support from the National Department of Health of Government of Republic of South Africa, New Partnership for Africa's Development (NEPAD), The United Nations Population Fund (UNFPA), World Health Organization (WHO), United Nations Children's Fund (UNICEF), and Joint United Nations Program on HIV/AIDS (UNAIDS) for which the Commission remains greatly indebted.

Finally, the Commission wishes to thank in a special way all the members of the technical secretariat for their technical support to the assessment of the AHS 2007 – 2015.

## **IV. EXECUTIVE SUMMARY**

In 2007, the African Union developed the first Africa Health Strategy 2007–2015 endorsed by the 3rd Conference of African Ministers of Health held in the same year and the 11<sup>th</sup> Session of the Ordinary Executive Council in 2008. In 2015, the meeting of the 1<sup>st</sup> African Union Specialized Technical Committee on Health, Population and Drug Control (STC-HPDC) recommended that a revised Africa Health Strategy be developed for the period 2016 - 2030 based on an assessment of the previous strategy and the relevant AU health policy instruments. In addition, the revised strategy should integrate research and innovation for health.

The assessment was mainly undertaken through a desk review of key literature, documentation and review reports related to other healthy policy instruments. Under the auspices of the Department of Social Affairs of the African Union Commission (AUC), a Technical Secretariat provided guidance and technical support to the assessment. The assessment was guided by two objectives namely to: determine the extent to which the AHS 2007 - 2015 was utilized in guiding the health policy, plans and program of the Member States, Regional Economic Communities (RECs) and their partners; and identify gaps, lessons learned, challenges and opportunities during the implementation of the AHS 2007 - 2015, with a particular focus on progress towards achieving the Millennium Development Goals (MDGs) and other continental health policy commitments and strategies.

The assessment findings revealed considerable efforts to improve health sector performance in Africa but also recognized that many formidable challenges still remain. Strong leadership to implement relevant AU policy instruments and commitments resulted in the ability of the AHS 2007-2015 to increase the attention and resource investments by Member States, RECs and their partners in key strategic areas with some remarkable achievements.

The continent was able to eradicate polio and was the first region globally to achieve MDG (6b) related to HIV/AIDS. The continent also significantly reduced mortality from maternal causes, among children, from AIDS, TB and malaria in addition to making significant progress in reducing malnutrition. In particular, the influence of the AHS 2007-2015 and the continental political commitments reflected in Abuja Call, Maputo Plan of Action and campaigns/platform such as Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA), numerous Ministerial and AU Assembly decisions and declarations was evident in its ability to galvanize Member States, RECs and African communities to make good progress in reducing HIV related deaths, maternal and child mortality among others. Similarly, the influence of international initiatives has been important in realizing the progress made in the health and health related MDGs. The ability of Member States and RECs to leverage on the remarkable economic growth combined with their ability to build on successful lessons learned as well as local and global innovations were an important impetus for the achieved results.

Faced with the largest HIV epidemics in the world, many countries in Africa overcame formidable constraints and mounted robust public health responses to HIV powerful enough to turn the tide against their epidemics and comprehensive enough to address prevention,

treatment, care; becoming the first region worldwide to achieve MDG 6b prior to the December 2015 deadline.

The assessment findings revealed that the AHS 2007-2015 focus on women and children's health was included by most Member States and RECs, even if less than 40% of Member States appeared to directly reference the AHS 2007-2015 priorities in the formulation of their national health policy frameworks, strategies and plans.

The roots of health sector performance in Africa's situation continue to lie in the overall level of socio-economic development; placing a particular importance on addressing the social economic and environmental determinants of health. Aside from a handful of countries, little progress has been achieved in access to water supply and sanitation (with access to water supply improving slightly better than access to proper sanitation facilities), poverty and hunger reduction and empowerment of women - the three socio-economic determinants closely associated with improvements in health. Although health funding has increased in Africa since 2001, it has not yet reached the Abuja target of allocating 15% of total government expenditure on health.

Several factors impacted (both positively and negatively) on the degree to which Member States and RECs articulated and addressed the health sector priorities of the AHS 2007-2015. Key among these was the humanitarian crises in Africa that have had a negative effect on proper health sector planning and implementation. During the period 2007-15 there were major natural disasters, public health emergencies as well as armed conflicts that were significant enough to impact the ability of Member States to address the AHS 2007-2015 priorities.

The continent's progress on reducing pediatric HIV/AIDS mortality and adolescent rates of new infections has lagged behind. Although mortality from malaria and TB has been drastically reduced, there are still major challenges to ensure sufficient access to prevention and treatment in order to reduce morbidity from these two diseases. While some progress has been made in achieving MDGs 4 and 5 (reducing child and maternal mortality, respectively), Africa still has a disproportionately high share of global child and maternal mortality.

The assessment recommends key strategic directions to guide the development of AHS 2016-2030. These include strengthening health sector **leadership** to reinforce harmonisation, integration and coordination at all levels in order to ensure greater ownership, stewardship and accountability; emphasizing **equity** and prioritise **human rights-based responses** to health challenges, particularly among the most vulnerable segments of society; increasing investments which **address the social, economic and environmental determinants of health**; prioritizing efforts to strengthen health **and community systems**; re-doubling Africa's effort **to ensure equitable access to sexual, reproductive, maternal, neonatal, adolescent and child** health services; expanding integrated services responsive to non-communicable disease control, mental health, disability, accidents, violence (particularly gender-based), injuries, substance abuse, urban and environmental health challenges; dramatically increasing domestic and international **resource mobilization**, while emphasizing efficiency and strategic investments with sound management of mobilised resources; leveraging global commitments to end preventable maternal and child deaths, AIDS, TB and malaria by 2030; developing a

robust **disaster preparedness and response management** paradigm and system, based on the International Health Regulations (IHR 2005), to better manage risks and building national and continental **disease surveillance and response** capacities; creatively-leveraging of **public-private partnerships** (PPP) to support health sector performance; building country-led **strategic health research and innovation** capacity; and improving **monitoring, reporting and accountability systems**.

This assessment provides the basis for the revision of the African Health Strategy 2007 - 2015 to guide the continent's health agenda in the next 15 years, particularly by synergizing these recommended strategic directions with the current continental and global commitments in the post-2015 period. As such, both this assessment and the AHS 2016 - 2030 draw heavily upon the "Agenda 2063: The Africa We Want", the Sustainable Development Goals, the recommended priorities established by the formal reviews of previous continental commitments such as the review of the Abuja Call, Maputo Plan of Action, the African Regional Nutritional Strategy among others.

## V. INTRODUCTION

The Africa Health Strategy 2007 – 2015 (AHS 2007-2015) was endorsed by the 3rd Conference of African Ministers of Health in 2007 and the 11<sup>th</sup> Session of the Ordinary Executive Council in 2008 to enrich and complement Member States strategies by adding value in terms of health systems strengthening from the unique continental perspective.

The AHS 2007-2015 provided strategic direction to Africa's efforts in creating better health for all and recognized that Member States and regions and indeed the continent had previously set health goals in addition to the Millennium Development Goals to which they had committed. The AHS 2007-2015 explored challenges and opportunities related to efforts which could decrease the continent's burden of disease, strengthen its health systems and increase human capital for health. It highlighted strategic directions that could be helpful if approached in a multi-sectoral fashion, adequately resourced, implemented and monitored. In this context, the AHS 2007-2015 was not meant to be a stand-alone document nor an additional commitment but rather, it was intended to be a consolidative framework for policy-level action leveraging other continental commitments.

Consequent to the decision of the 1<sup>st</sup> African Union Specialized Technical Committee on Health, Population and Drug Control (STC-HPDC), the Commission embarked on the assessment of the of the AHS 2007 – 2015. A Technical Secretariat led by the AUC Department of Social Affairs (DSA) was established to carry out the assessment as well as to develop a new strategy for the period 2016 - 2030. The Secretariat consists of AUC, NEPAD, UN agencies and National Department of Health of the Republic of South Africa.

The purpose of the AHS 2007 - 2015 assessment was to determine the extent to which it achieved its vision, mission, goals and objectives. Specifically, the objectives of the assessment were as follows:

1. To determine extent to which the AHS 2007-2015 was utilized to guide the health policy, plans and program of the Member States, RECs and Partners;
2. To identify gaps, learned lessons, challenges and opportunities in implementation of the AHS 2007-2015 in general, particularly in relation to the Millennium Development Goals and other continental health policy commitments and strategies.



## **VI. AHS 2007-2015 BACKGROUND**

The AHS 2007-2015 provided strategic direction to Africa's efforts in creating better health for all and recognized that Member States have previously set health goals in addition to the Millennium Development Goals (MDGs) to which they have committed. The AHS 2007-2015 explored challenges and opportunities related to efforts which can decrease the continent's burden of disease, strengthen its health systems and increase human capital for improved health. It highlighted strategic directions that could be helpful if approached in a multi-sectoral fashion, adequately resourced, implemented and monitored. As an inspirational framework within which Member States and the Regional Economic Communities (RECs) were to fulfill their roles, the AHS 2007-2015 also created a continental strategic platform upon which health sector partners such as multilateral agencies, bilateral development partners and civil society could harmonize and align their health contributions to support health sector priorities at the country, regional and continental levels.

The AHS 2007-2015 had proposed strengthening of health systems with the goal of reducing disease burden through improved resources, systems, policies and management. Its guiding principles were deliberately pro-poor with a strong focus on disadvantaged groups, including women and children. It also promoted evidence-based decision-making by encouraging better generation and use of sound data on health system inputs, processes, outputs and outcomes in order to manage, monitor and evaluate health system performance.

Since the endorsement of the AHS 2007-2015, significant momentum and progress has been gained in support of a range of health sector priorities. A range of continental commitments have provided much needed focus on certain health priorities that had been prioritized in the AHS 2007-2015. Moreover, the AHS 2007-2015's period of implementation coincided with a formidable injection of additional financial and technical resources to address theme-specific health sector priorities such as HIV/AIDS, TB, malaria and immunization programs. Thus, the policy environment that influenced the development and implementation of the AHS 2007-2015, included, but was not limited to the following key policy instruments:

- 2000 UN Millennium Development Goals (MDGs);
- 2001 UN Declaration of Commitment towards Universal Access to HIV/AIDS Services;
- 2003 AU Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa
- 2005 AU African Regional Nutritional Strategy 2005-2015;
- 2005 AU Sirte Declaration on Child Survival;
- 2005 AU Continental Policy Framework for Sexual and Reproductive Health and Rights (SRHR);
- 2006 UN Political Declaration to Achieve Universal Access to HIV/AIDS Services
- 2006 AU Abuja Call for Accelerated Action towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa;
- 2006 Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights, 2007-2010 (MPoA);

- 2009; AU Decision on the Report of the Special Session of the African Union Conference of Ministers of Health (CAMH4) on Maternal, Infant and Child Health in Africa;
- 2009 AU Campaign on Accelerated Reduction in Maternal and Child Mortality in Africa (CARMMA);
- 2010 AU Declaration of the 15<sup>th</sup> Ordinary Session of AU Assembly; Actions on Maternal, New-born and Child Health and Development in Africa by 2015;
- 2010 AU Decision on the Partnership for the Eradication of Mother to Child Transmission of HIV/AIDS, African Heads of State Summit
- 2010 UNSG's Global Strategy for Women's, children's and Adolescent Health
- 2011 AU Common African Position to the UN General Assembly Special Session on Universal Access to HIV/AIDS, 5<sup>th</sup> Conference of African Ministers of Health (CAMH5);
- 2013 "AU Declaration of the Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria: Abuja Actions Towards the Elimination of HIV and AIDS, Tuberculosis and Malaria in Africa by 2030";
- 2014 AU "Common African Position on the Sustainable Development Agenda";
- 2014 Agenda 2063 "The Africa We want"
- 2015 AU "Review of the Abuja call for accelerated action towards universal access to HIV/AIDS, TB and Malaria services and the AU Road Map on shared responsibility and global solidarity for HIV/AIDS, TB and malaria";
- 2015 AU "Review of the Maputo Plan of Action"
- Various WHO AFRO Regional Committee Resolutions adopted by Member States between 2007 and 2015 (see Annex 4 for full list).

Some of these global and continental policy commitments will continue to guide the AHS 2016 - 2030 during its implementation, particularly the Agenda 2063: The Africa We Want, the Abuja Declaration, The continental SRHR Policy Framework, Maputo Plan of Action 2016 – 2030, African Regional Nutritional Strategy for 2015 - 2025, Pharmaceutical Manufacturing Plan, Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa By 2030 and the International Health Partnerships (IHP+; JANS) among others.

The impact of strong Member State political commitment mobilized by the AUC in support of the health sector has been palpable in terms of achieving good progress and impact. In the context of the MDGs, this massive continental mobilization and political support was particularly consequential in driving the progress made in improving maternal and child health as well as in combatting AIDS, TB and malaria.

The Continental Policy Framework for Sexual and Reproductive Health and Rights (SRHR) and the Maputo Plan of Action (MPoA) 2007 - 2015 for its operationalization were adopted in recognition of the fact that African countries were unlikely to achieve the Millennium Development Goals (MDGs) without significant improvements in the sexual and reproductive health. Since the adoption of the plan in 2006, a number of developments have taken place to situate maternal, new-born and child health at the centre of national policy, strategy and programming. As documented by the final evaluation of the MPoA the continent has witnessed strong political commitment and leadership to address the health needs of children and women. The review indeed confirmed that the tremendous improvements witnessed in child and maternal health such as declines in under-five and maternal mortality by nearly half of the

1990 rates can be attributed to the political commitment and leadership at country level to domesticate the MPoA and implement Campaign for Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA).

Despite this tremendous decline, the continent fell short of the required rate of decline to achieve MDG 4 and 5 targets. In spite of these, a number of African countries made firm progress and managed to attain MDG 4 and 5 targets. However, much still need to be done as over 70% of women and children continue to die from preventable causes; reductions in neonatal mortality rates are still very low and inequities in access to and utilization of health services still persist.

Addressing the health needs and opportunities for Africa's youth remains a key challenge over the next few decades. This is, both, because of the demographic bulge which will see this age category increasing in size across Africa as well as the fact that they are currently amongst the most underserved of Africa's populations for example adolescents in Africa are disproportionately affected by and have less access to services for HIV/AIDS, mental health, gender-based violence (particularly girls) and substance abuse. Gender-based violence remains a pervasive and under-reported problem in Africa. The proportion of women reporting intimate partner violence and non-partner sexual violence is high (ranging from 29.7% in the Southern African region to 65.6% in the Central African region).

The growth in Africa's adolescent population and the high-prevalence of gender-based violence are closely intertwined. A particular source of danger to the health and lives of girls and young women is the prevalence of child marriage in those countries where the young are most prevalent in populations. Worldwide, 39,000 girls become child brides every day, or about 140 million in a decade. Moreover, this practice is becoming not less but more common and partly for demographic reasons. The problem threatens to increase with the expanding youth population in the developing world (UNFPA, 2012). Child marriage usually results in early pregnancy linked to deaths from complications of pregnancy and childbirth. In addition married girls are more likely than married women to suffer violence and other abuse at the hands of their husbands (PMNCH, 2012).

The Abuja Call committed AU Member States to put in place measures to increase access to affordable medicines and technologies for AIDS, TB and malaria through among others appropriate legislation and utilising international trade regulations and flexibilities. At the 3<sup>rd</sup> session of the African Union Conference of Ministers of Health in April 2007, Member States adopted the Pharmaceutical Manufacturing Plan for Africa (PMPA) to strengthen Africa's ability to locally manufacture and supply essential drugs and commodities to respond to AIDS, tuberculosis, and malaria. PMPA aims to reduce Africa's dependence on external suppliers and the financial burden of diagnosis, prevention and care while simultaneously improving commodities supply.

The PMPA business plan recognises the existence of initiatives on the continent geared towards strengthening the pharmaceutical industry. In support of the objectives of the PMPA, RECs are being supported to develop and implement medicines harmonisation projects as a key intervention to strengthen regulation of pharmaceuticals on the continent and to promote the expansion of potential markets for quality assured medicines. Complementary regional

initiatives include the Southern African Development Community (SADC) Pharmaceutical Business Plan 2007-2013 and the EAC Regional Pharmaceutical Manufacturing Plan of Action 2012-2016. The Economic Community of Western African States (ECOWAS) is formulating a charter to facilitate Public Private Partnerships for the local production of ARVs and other essential medicines. Achieving the PMPA's vision of a competitive, sustainable and self-reliant industry will demand increased human resource capacity, access to affordable financing, strong regulatory systems, strategic partnerships and business linkages. It will also require enhanced market data and information systems. Various challenges that will need to be overcome include engaging with unfavourable international trade policies and a lack of support to implement TRIPS flexibilities. All these hinder local production of essential medicines.

In an effort to minimise fragmentation with respect to the regulation of essential medicines and devices, NEPAD is collaborating with partners to coordinate the African Medicines Regulatory Harmonisation (AMRH) initiative. AMRH aims to accelerate progress towards the health-related MDGs by generating a sound regulatory environment for the development of the pharmaceutical sector in Africa. AMRH is assisting Regional Economic Communities (RECs) and countries in (i) developing harmonised, effective and efficient regulatory approval processes and (ii) instituting governance and accountability mechanisms to ensure transparency in regulatory services delivery. AMRH's first project on harmonisation of medicines registration was successfully launched in the East African Community. The development of a model law on medicines regulations is also being pursued within the same framework and with the support of relevant AU organs. The AUC is also in the process of establishing the African Medicines Agency (AMA) that will further enhance the regulatory environment and curtail proliferation of Substandard, Spurious, Falsely-labelled, Falsified Counterfeit (SSFFCs) medical products.

The 2013 Abuja Declaration<sup>1</sup> accords priority to the area of health in the Post-2015 Development Agenda and the AU Agenda 2063. The Declaration sets the targets of ending AIDS, TB and Malaria in Africa by 2030. It further highlights the importance of fully implementing the AU Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa. Furthermore, it supports the reinforcement of the policy environment and regulatory systems, including active cooperation among Member States to boost investment in the local production of quality essential medicines. The framework directs the AU Commission, the UN system and other development partners to cooperate with Member States for implementation of these commitments.

The 2015 first Ministerial Meeting of the Specialized Technical Committee on Health, Population and Drug Control (STC-HPDC-1) reinforced the commitment to intensify efforts to end AIDS, TB and Malaria by 2030. The STC-HPDC-1 requested the AU Commission to prepare a Roadmap for the implementation of the Abuja+12 Declaration to be submitted to the 2nd Meeting of Africa Ministers of Health jointly organized by the AU and WHO in 2016.

The AIDS Watch Africa (AWA) Decision<sup>2</sup> of the AU Assembly in June 2015 in Johannesburg

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<sup>1</sup> Declaration of the Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria- Abuja; "Actions Towards the Elimination of HIV and AIDS, Tuberculosis and Malaria in Africa by 2030".

<sup>2</sup> Decision on the Report of the AIDS Watch Africa (AWA) Doc. Assembly/AU/14(XXV)

requested the Commission working with the New Partnership for Africa's Development (NEPAD) Agency and in consultation with Member States and partners to develop a “Catalytic Framework” detailing milestones towards ending AIDS, TB and malaria in line with the Abuja +12 targets. The Decision further requested the Commission to work in consultation with Member States and partners to develop accountability framework with clear targets and indicators to monitor and measure progress. The Catalytic Framework is aligned with the set goals and targets in the Sustainable Development Goals (SDGs)<sup>3</sup> and AU Agenda 2063.

In addition to AIDS, TB and malaria, Africa continues to suffer a severe burden from other, readily preventable, communicable diseases, including pneumonia, diarrhea and measles in children. Similarly, there has been slow progress in reducing the burden and socio-economic impact of neglected tropical diseases (NTDs) such as Onchocerciasis, Trypanosomiasis, Schistosomiasis, Guinea Worm and Filariasis. Cholera, Meningitis, Ebola and Marburg outbreaks also continue.

Mortality and disability from non-communicable diseases (including mental health conditions) in Africa is increasing. A major factor is the demographic, behavioral and socio-economic changes associated with higher income, urbanization and other factors. Hypertension, stroke, diabetes, chronic respiratory disease and the consequences of tobacco use, alcohol abuse and illicit drugs continue to pose serious public health challenges in many African countries. Injuries from accidents especially traffic related, environmental and indoor pollution, violence and wars are also contributing to morbidity and mortality from non-communicable disease.

The Ebola crisis which gripped the continent demonstrated the importance of implementing strategies that anticipate, prepare, mitigate and respond to disasters. In 2013, the AU Assembly of Heads of State and Government (under Assembly Decision/AU/Dec.499 (XXII)) requested the AUC to establish an African Centres for Diseases Control and Prevention (ACDC) and by 2014, the 16th Extraordinary Session of the AU Executive Council meeting on Ebola requested the AUC to ensure the functioning of the ACDC, together with the establishment of regional centres by mid-2015. The AUC, World Health Organization (WHO) and other identified relevant stakeholders were tasked to provide technical support towards the establishment of the African CDC. The Commission has made significant progress in the establishment of the ACDC which is set to be launched in 2016.

All African Countries have adopted the global targets for nutrition improvements as agreed by the World Health Assembly in 2011. These targets were adopted as the Impact Objectives of the revised African Regional Nutritional Strategy for 2015-2025 (ARNS 2015-2025), including achieving by 2030 a 40% reduction of the number of African children under five who are stunted; 50% reduction of anemia in women of child-bearing age in Africa; 30% reduction of low birth-weight in Africa; increasing exclusive breast-feeding rates during the first six months to at least 50%, reducing and maintaining childhood wasting to less than 5% and ensuring there is no increase of overweight in African children under 5 years of age.

The ARNS 2015-25 aims to achieve these targets through a combination of ‘nutrition-specific’ and ‘nutrition-sensitive’ interventions. The strategy lists 10 nutrition specific interventions and

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<sup>3</sup> Transforming our World: the 2030 Agenda for Sustainable Development: Resolution adopted by the General Assembly on 25 September 2015 A/RES/70/1

proposes the need to make other national development sectors sensitive to nutrition, whilst at the same time building an enabling environment to promote nutrition.

**Figure 1: Nutrition-specific and nutrition sensitive interventions**



Africa's health worker challenges represent one of the weakest parts of its health systems. Insufficient production, weak pre-service education, poor deployment and retention strategies as well as the absence of an overall national human resource framework are among the key features of the human resource problems in many countries.

The number of countries with national policies on traditional and complementary medicines (T&CM) has increased from eight in 1999/2000 to 39 in 2010, and those with national T&CM strategic plans rose from zero to 18. National regulatory frameworks increased from one in 1999/2000 to 28 in 2010, including various instruments such as the code of ethics and the legal framework for T&CM practitioners (WHO AFRO Regional Committee; September 2013). By 2010, eight African countries had institutionalized training programs for T&CM practitioners, 13 countries developed training programs for health science students and T&CM, while 22 countries were conducting research on traditional medicines for malaria, HIV/AIDS, sickle-cell anemia, diabetes and hypertension using WHO guidelines. Subsequently four African countries included traditional medicines in their National Essential Medicines Lists. Guidelines for the protection of intellectual property rights (IPR) and traditional medicine knowledge (TMK) have also been developed by several Member States and six African countries had national tools for IPR and TMK protection by 2010. Eight countries have established databases on traditional medicine practitioners, TMK and access to biological resources (WHO AFRO Regional Committee; September 2013).

In summary, the comparative advantage of the AHS 2007-2015 was to provide an over-riding set of strategic priorities and directions for Member States and RECs to address. Framed in the context of a number of key continental and global policy commitments, the AHS 2007-2015 provided the required impetus for Member States and RECs. At the same time, new

realities in Africa and new global and continental commitments are now emerging in order to address the health priorities of African people in the post-2015 era. Key among these are the “Agenda 2063: The Africa We Want” and the Sustainable Development Goals. In order to sustain the gains and address remaining health challenges, it is essential that the performance of AHS 2007-2015 be analyzed in order to inform the new AHS 2016-2030.

## VII. ASSESSMENT METHODOLOGY

### 1. Methods:

The assessment was undertaken through a desk review of key literature, policy instruments and outcomes of review reports which had analyzed progress relevant to the African Health Strategy 2007-2015.

The desk review involved:

- a. Review of the assessment reports of the other expiring AU health policy instruments, UN health review reports and any related documents;
- b. Review of all available national health sector policies, strategies or plans of AU Member States (accessed through WHO's global data base <http://www.nationalplanningcycles.org/>);
- c. Review of all documentation on regional health sector policies covering the period May 2007 until December 2015. The regional documents covered the eight Regional Economic Communities namely:
  - i. Arab Maghreb Union (AMU/UMA),
  - ii. Common Market for Eastern and Southern Africa (COMESA),
  - iii. Community of Sahel-Saharan States (CENSAD)
  - iv. East African Community (EAC),
  - v. Economic Community of Central African States (ECCAS),
  - vi. Economic Community of West African States (ECOWAS),
  - vii. Intergovernmental Authority on Development (IGAD),
  - viii. Southern African Development Community (SADC).

### 2. Analytical Framework:

To address the key questions stated in the objectives of this assessment, analysis was undertaken at two levels. The first level was aimed at addressing the assessment objective seeking to identify gaps, challenges, opportunities and lessons learned. It drew upon the available literature, particularly the reviews of progress in Africa towards achieving the MDGs and reviews of continental health policies and commitments, in order to gauge their impact.

The second level was aimed at addressing the assessment objective seeking to determine the extent to which national and regional health policy frameworks had utilized the AHS 2007-2015's strategic directions. Thus, this second analysis reviewed all existing national (Member States) and regional (RECs) health policy frameworks to determine the extent to which they factored the following key seven strategic directions of the AHS 2007-2015:

- a) Strengthening the **national health systems** for a sustainable health sector



response; particularly **commodity procurement/supply, human resources for health and health information systems** as core components of an effective health system;

- b) Creating clear **multi-sectorial policy linkages and integrated approaches** in addressing communicable, non-communicable and reproductive, maternal and child health challenges with sectors that have a proven influence on the social, economic and environmental determinants of health
- c) Improving **national and sub-national governance systems** to increase community ownership and strengthen partnerships with the community, private sector and/or traditional institutions (e.g. faith-based institutions, traditional healers, etc);
- d) Broad **resource mobilization towards sustainable health sector financing** options
- e) Aid effectiveness through enhanced **harmonization** among international development partners as well as better **alignment** between them and the national health policy and strategic frameworks;
- f) Prioritizing the **health of women, children and other groups in need of social protection**;
- g) Investing in **research** which strengthens the health system's response to national challenges, including research on African Traditional Medicine, strengthen national health sector monitoring and evaluation capacity, improve disease surveillance and response, strengthen disaster risk management and other areas.

### **3. Methodological limitations:**

There are specific limitations in the methodology adopted for this assessment which should be taken into consideration when interpreting the findings and conclusions. The extent to which AHS 2007-2015 had guided Member States and RECs in implementing their health policy frameworks is not meant to reflect the success of the member states in tackling the key health issues outlined in the strategy. Rather, it is a general gauge of whether they used AHS 2007-2015 as they developed and implemented their frameworks.

The desk review may not accurately determine the extent to which the AHS was domesticated by the Member States nor adequately answer the question of whether or not such domestication led to any changes in the health status of the people. It is hoped that this limitation could be partially compensated by the fact that literature consulted in this assessment included the 2015 review of the progress made towards achieving the MDGs in Africa, the 2015 review of the Abuja Call and the 2015 review of the Maputo Plan of Action.

## **VIII. KEY FINDINGS**

### **1. Africa's health situation**

Significant progress has been achieved in Africa towards achieving the MDGs. The drastic reductions in maternal and child mortality, dramatic reductions in mortality due to AIDS, tuberculosis and malaria as well as the total eradication of polio from Africa are accomplishments which demonstrated keen resolve and strong leadership in the continent.

However, much more remains to be done and the 2015 reviews of health policy instruments of the African Union Commission and the information from other health reports, have indicated the need for sustaining the effort to address the high disease burden in Africa.

In comparison to other regions of the world, Africa still has largest number of countries with the worst indicators for maternal mortality, infant mortality, communicable disease morbidity and mortality. The triple burden from communicable and non-communicable diseases and injury and trauma, including the socio-economic impact of these, has adversely affected development in Africa. Unless a stronger and deliberate effort to reduce this disease burden is made through long-term investments in health systems and human capital, the gains achieved in the economic and political spheres will likely be eroded.

#### **a. Progress in improving the social determinants of health**

Poverty, nutrition, women's empowerment, education as well as water supply and sanitation are important MDG themes from the health sector viewpoint, as they are most closely associated with improvements in health. Responding to the youth unemployment challenge is also vital if Africa is to derive a dividend from the youth bulge.

Poverty and hunger reduction (MDG 1) have seen little progress in Africa. Owing to a lack of decent jobs, most of the population in Africa is engaged in vulnerable employment, which is largely concentrated in the informal sector. Despite positive GDP growth since 2001 (averaging at least 5% above the global average of 3%; driven by extractive industries, particularly minerals, oil and gas), this growth has resulted in improvements which are either insufficient or inclusive enough to provide decent job opportunities for the majority of the labor force. Indeed, the employment to population ratio has declined on average from 57.7% in 2005 to 44.4% in 2012. Unemployment rates are in the double digits in some sub-regions (though these are masked, in some cases, by high levels of informality). Southern Africa had the highest unemployment rates in 2013 (21.6%), followed by North Africa (13.2%), Central Africa (8.5%), and East Africa (7.9% per cent), whereas West Africa had the lowest unemployment rates (6.9%). Youth and female unemployment are persistently higher than male unemployment rates in all regions. While there have been significant reductions in stunting among children under-5 years of age, the levels of stunting remain high. (AUC/UNECA/UNDP; September 2015).

The 2015 Africa MDG Progress Report indicates some progress achieved collectively by the continent in some MDGs, notably in primary education enrollment (MDG 2). Overall, most African countries have made significant progress as a result of policy reforms using participatory approaches, improved service delivery and governance. Progress has been slower in meeting the needs of out-of-school youth, children with disabilities, children living in conflict-affected States, nomadic people and some ethnic minorities. At 67% primary completion rate, Africa is still far from the achieving primary completion rates for all by 2015. Barely 20 per cent of African countries reached the target in 2012. Between 2000 and 2012, some countries, for example, three countries registered fast progress, while others stagnated or experienced severe declines.

Gender equality (MDG 3) has only slightly improved in terms of the proportion of women in the workforce. Africa's growth has had a limited impact on the welfare of women and youth, and several constraints perpetuate significant gender gaps in women's participation in gainful employment in the formal sector, including access to inputs, credit, land, capital and technology.

Aside from a handful of countries, little progress has been achieved in access to water supply and sanitation (Target 10 of MDG 7), with access to water supply improving slightly better than access to proper sanitation facilities. In Africa, only 24% of the current population has gained access to an improved source of drinking-water source since 2000, which is the lowest globally. Furthermore, only 16 per cent of the population has access to piped drinking water, which is also the lowest in the world. There are wide rural-urban disparities in access to safe drinking water that tend to pull down national aggregate figures in some countries. Similarly, the proportion of people with access to improved sanitation has increased only moderately in Africa (excluding North Africa), from 24% in 1990 to 30% in 2012. The rural-urban disparities and the poor situation of slum dwellers (in a continent witnessing high rates of unplanned urbanization) further compound this slow progress in achieving better access to, both, improved and piped water as well as adequate sanitation facilities.

## **b. Progress in achieving the health-related MDGs**

The continent made considerable efforts to improve the health outcomes of its people. Key achievements included impressive reductions in under-five mortality, significant reductions in mortality from maternal causes and dramatic reductions in mortality due to AIDS, tuberculosis and malaria. Faced with the largest HIV epidemics in the world, many countries in Africa overcame formidable constraints and mounted robust public health responses to HIV powerful enough to turn the tide against the epidemic to achieve MDG 6b prior to the December 2015 deadline.

### **i. Child Health**

Overall, African countries have made substantial progress towards achieving MDG 4 (Reduce child mortality). Indeed, 43 countries in Africa have achieved more significant decreases in child mortality during the period 2000-2013 than during the period 1990-2000. While Africa excluding North Africa has the world's highest child mortality rate, the absolute decline in child mortality has been the largest over the past two decades. The under-five mortality rate has

fallen from 179 deaths per 1,000 live births in 1990 to 86 in 2015 (UN, July 2015). Infant mortality rate (IMR) fell from 90 deaths per 1,000 live births in 1990 to 54 deaths per 1,000 live births in 2014; representing an average decline of 40%. However, by comparison, Africa excluding North Africa saw only a 32% reduction in neonatal mortality from 46 deaths per 1,000 live births in 1990 to 31 in 2013 (UNICEF et al, in AUC, 2014).

Although impressive reduction rates for under-five, infant and neonatal mortality have been achieved in Africa, there is clearly a need to intensify the effort in order to achieve more dramatic impact. The first day and week of life are the most critical for newborn survival. In 2013, 36% of all newborn deaths occurred during the first 24 hours of life, while another 37% occurred within the next six days. In 2013, deaths within the first 28 days of life accounted for nearly 44% of all under-five deaths globally and 34% of all under-five deaths in Africa (excluding North Africa). Most of these deaths derive from complications from preterm birth, newborn infections, and complications arising during childbirth. Infectious diseases (including malaria, acute respiratory infections, pneumonia, measles, and diarrhea) contribute to nearly a third of all deaths in children under five globally. Pneumonia, diarrhea, and malaria accounted for approximately 1.3 million, or 40%, of under-five deaths in Africa excluding North Africa in 2013. Furthermore, the effects of malnutrition take a large toll on child health and it was estimated that undernutrition (including fetal growth restriction, stunting, wasting, and vitamin deficiencies) contributed to 45% of all under-five deaths in 2011 (UNICEF et al in AUC, 2014).

The neonatal mortality rates in particular is lagging far behind the other child mortality rates and its persistence seems to be affected by a few key constraints. These include limited access to antenatal and post-partum care, limited access to Emergency Obstetric and Newborn Care, limited immunization coverage as well as the wider social and economic determinants such as maternal poverty, maternal malnutrition, low educational attainment among women and girls. The situation is worse for the large rural populations of Africa that have poor access to and utilization of maternal and newborn health services.

## **ii. Maternal Health**

Africa made significant progress in maternal health between 1990 and 2013 yet, the continent accounts for approximately 66% of global maternal deaths. The average maternal mortality ratio (MMR) in Africa excluding North Africa declined from 990 deaths per 100,000 live births in 1990 to 510 per 100,000 live births in 2013, with variation across the continent (WHO/UNICEF/UNFPA/WB/UNPD, 2014). Some Member States reduced their maternal mortality ratio by more than 75% between 1990 and 2013, hence meeting MDG 5 Target.

The skilled birth attendance rate for the continent generally increased to an average of nearly 60% between 2006 and 2013 but fell short of the 80% skilled birth attendance rate proposed by the WHO. Africa is still one of the regions with the lowest proportion of births attended by skilled health personnel (68%), although it has performed better than Southern Asia (51%) in 2012. In North Africa, the proportion of pregnant women who received four or more ante-natal visits increased from 50 per cent to 89 percent between 1990 and 2014 (UN, July 2015) whereas four countries registered an impressive performance, with over 95 per cent of the births being attended by skilled health personnel (AUC/UNECA/UNDP, 2015).

Among the major contributing factors to the high maternal mortality ratio in the continent includes low proportions of births attended by skilled health personnel, low contraceptive prevalence rates, high adolescent birth rates, limited antenatal care coverage, high unmet need for family planning and poor access to contraceptives (UN, July 2015). The fact that almost one in two of all women dying in child birth in Africa excluding North Africa are dying in a humanitarian setting also highlights the disruptive effect of disasters upon access to health services. There are also major challenges in the health information system of most countries in Africa. Less than two fifths of African countries have a complete civil registration and vital statistics system with good attribution of cause of death, which is necessary for the accurate measurement of maternal mortality.

### **iii. Sexual and Reproductive Health Services**

The 2015 Africa MDG Progress Report states that the average unmet need for modern contraceptives for the periods 1990-2005 and 2006-2013 remains high at 24.5% and 26.2%, respectively, while the average contraceptive prevalence rate rose only slightly from 24.3% between 1990 and 2005 to 25.9% between 2006 and 2013.

In most of Africa excluding North Africa, fertility is barely declining, while the number of women of childbearing age is rising significantly leading to larger cohorts of children, adolescents and youth. The needs of this growing proportion of children, adolescents and youth are barely addressed. Moreover, very little recognition exists of the formidable “demographic dividend” which Africa can realize by implementing and scaling up interventions in human capital (health and education) which are proven to have a high return on investments, alongside sound economic and governance policies. In this context, it is important to note that the dividend is not automatic and requires a set of investments and policy commitments, including policies and programs that promote and protect equity and human rights.

Annually, it would cost \$17.2 billion dollars (\$76 per woman of reproductive age), to provide all women and girls in Africa with a total package of SRH services including modern contraceptive services; maternal and newborn health services; HIV testing and counseling and antiretroviral treatment for women during pregnancy and after delivery; HIV testing and treatment for newborns; and treatment for four major curable STIs. This is five times current investment levels and gives an indication that Africa is not spending enough on sexual and reproductive health and rights (SRHR).

### **iv. Nutrition**

Africa, excluding North Africa, remains the most food-deficient of all regions of the world, with 25 per cent of its population having faced hunger and malnutrition during the period 2011-2013, a modest 8 per cent improvement from the level experienced during the 1990-1992 period. Persistent conflicts in Central Africa and unfavorable weather conditions such as droughts and flooding in the Sahel, the Horn of Africa and Southern Africa continue to exert pressure on food and nutrition security.

Ensuring good and adequate nutrition is important for child and adolescent growth and health, particularly among adolescent girls, pregnant women and pregnant girls. In Africa south of the

Sahara, the proportion of children under 5 years of age who are underweight has fallen by only one third since 1990. However, due to the region's growing population, the number of underweight children has actually risen (UN, July 2015). The proportion of stunted children was reduced from 41.6 per cent in 1990 to an average of 34.1% between 2006 and 2013. However, the number of stunted children has actually risen in Africa south of the Sahara where the numbers increased by about one third between 1990 and 2013. Stunting therefore still remains a major problem on the continent due to a number of factors that include socio-cultural barriers, chronic poverty, food insecurity, inadequate supply of safe and nutritious food in quantity and quality as well as poor access to clean water supply and sanitation facilities.

#### **v. Youth and Adolescents**

Complications during pregnancy and childbirth are a common cause of death among girls and young women in developing countries. Every day in developing countries, 20 000 girls under age 18 give birth (UNFPA, 2013). Girls under 15 account for two million of the annual total of 7.3 million new adolescent mothers and, if current trends continue, the number of births to girls under 15 could rise to three million a year in 2030.

Around 11% of births worldwide, or an estimated 16 million, are to girls aged 15-19, and very young mothers are the most likely to experience complications and die of pregnancy-related causes. Adolescent girls have high rates of complications from pregnancy, delivery, and unsafe abortion; maternal causes are the second leading causes of mortality in 15–19 year old females globally. The consequences have implications for future generations, as newborns and infants of adolescent mothers are at higher risk of low birth-weight and mortality.

HIV is today the second leading cause of deaths for adolescents, and in contrast to the case with maternal mortality. Given girls' and young women's greater risk of exposure to HIV, this increase in HIV-related deaths is a clear case of failure to respond to young people's needs particularly the sexual and reproductive health needs of girls and young women.

Access to appropriate health information and services is at the core of the ability of young men and women to realize their sexual and reproductive health and reproductive rights. Tragically, despite all the recent attention to their needs, most adolescents and young people are still not getting what they need in the way of information and services. Access to quality comprehensive sexuality education remains elusive for most adolescents (United Nations Commission on Population and Development, 2014; UNESCO, 2014a). Although many countries have a comprehensive sexuality education policy and program, most do not implement it widely or in a way that adheres to international standards (UNFPA, 2014c; UNFPA, 2013b). In addition access to contraceptives is very low for example only 22 per cent of adolescents access contraceptives compared to 60 per cent for women older than 30.

The percentage of young people with comprehensive knowledge of HIV was just 39% cent for young men and 28% for young women aged 15 to 24 years in sub-Saharan Africa (United Nations, 2014a). To complement this knowledge, young people require a wide range of sexual and reproductive health services, including for the prevention of adolescent pregnancy, care for pregnant adolescents, HIV prevention, testing, counselling, treatment and care, the provision of HPV vaccines, access to pregnancy prevention means, and safe abortion care

(World Health Organization, 2014b).

#### **vi. Immunization**

Immunization remains one of the most cost-effective public health interventions for reducing child morbidity and mortality and is also an effective intervention targeting adolescents in combatting cervical cancer caused by the human papilloma virus.

Immunization coverage of the diphtheria, tetanus, pertussis vaccine (DTP3, which is often used as a proxy for routine immunization coverage) was 84% globally in 2013.<sup>10</sup> In Africa excluding North Africa, the 2014 DTP3 coverage was 77% with wide disparities across countries (WHO in AUC, 2014).

Between 2000 and 2009, global coverage with the first dose of measles containing vaccine (MCV1) increased from 73 per cent to 83 per cent, but it stagnated at 83–84 per cent from 2010 to 2013. The most impressive progress was made in Africa excluding North Africa, where coverage increased from 53 per cent in 2000 to 74 per cent in 2013 (UN, July 2015).

#### **vii. HIV and AIDS, Tuberculosis and Malaria**

The African continent has made significant progress in responding to AIDS, TB and Malaria since the 2000 Abuja Declaration on Roll Back Malaria and 2001 Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. The 2006 Abuja Call, the 2012 African Union Roadmap for Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response and the 2013 Abuja declaration demonstrated sustained commitment at the highest level.

Africa (except North Africa) became the first region in the world to achieve the MDG 6 target for HIV prior to the December 2015 deadline (WHO, DG Press Statement, December 2015). Faced with the largest HIV epidemics in the world, many countries in Africa overcame formidable constraints and mounted robust public health responses to HIV which were powerful enough to turn the tide against their epidemics and comprehensive enough to address prevention, treatment, care. As a result, the number of people newly infected with HIV declined by an estimated 41% during 2000–2014 (more than in any other region in the world) and the extraordinary rollout of HIV treatment to almost 11 million people by 2014 has averted an estimated 5.4 million deaths, with AIDS-related deaths being reduced by nearly half since 2005.

In spite of all these impressive achievements, Africa (except North Africa) continues to be the region most affected by the HIV/AIDS pandemic with nearly 26 million people living with the infection and nine out of ten of all children living with HIV/AIDS in the world found in the region. In addition, 1.4 million individuals get infected with the disease every year and there were almost 800,000 deaths due to HIV in 2014 alone. Moreover, and while mortality from malaria and TB has been drastically reduced, there are still major challenges to ensure sufficient access to prevention and treatment in order to reduce morbidity from these two diseases. Key among these challenges are the pervasive stigma and discrimination still associated with HIV/AIDS and TB in Africa, particularly towards key populations living with

these diseases. The coverage of anti-retroviral therapy (ART), the integration of various programs addressing comorbid conditions (e.g. TB/HIV, TB/Hepatitis, injecting drug use among people living with HIV, HIV and sexually transmitted illnesses, reproductive health with PMTCT+, etc) is a key gap in Africa's health sector response. More broadly, the association between vulnerability to HIV with gender-based violence, poverty, conflict and other factors needs to be addressed.

According to the Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030 (AUC, 2015), access to HIV treatment in Africa has increased more than 100-fold between 2000 and 2013. Approximately 10 million people are now on treatment. New HIV infections and AIDS-related deaths in Africa south of the Sahara declined by 33% and 30% respectively (Ibid).

Over 6.2 million malaria deaths have been averted between 2000 and 2015, primarily of children under five years of age in Africa south of the Sahara. More than 900 million insecticide-treated mosquito nets were delivered to malaria-endemic countries in sub-Saharan Africa between 2004 and 2014. Between 2000 and 2013, tuberculosis prevention, diagnosis and treatment interventions saved an estimated 37 million lives. The tuberculosis mortality rate fell by 45 per cent and the prevalence rate by 41 per cent between 1990 and 2013. (UN, July 2015).

Yet, Africa still accounts for more than half of all global cases and death rates of HIV/AIDS, malaria and tuberculosis. Africa (except North Africa) continues to be the region most affected by the HIV/AIDS pandemic with nearly 26 million people living with the infection and nine out of ten of all children living with HIV/AIDS in the world found in the region. In addition, 1.4 million individuals get infected with the disease every year and there were almost 800,000 deaths due to HIV in 2014 alone.

While mortality from malaria and TB has been drastically reduced, there are still major challenges to ensure sufficient access to prevention and treatment in order to reduce morbidity from these two diseases

WHO's Global TB Report; 2015 indicates that 74% of HIV cases that developed TB are in Africa. The WHO Africa Region failed to meet the MDG goal of reducing TB prevalence and mortality by 50%. Nine of the 22 highest TB burden countries which contribute 80% of the global disease burden are in Africa.

Similarly, WHO's World Health Malaria Report; 2014 indicates that of the 584 000 deaths related to malaria in 2013, 525 000 occurred in Africa, of which 410 000 (78%) were children under five years of age. In Africa of the 786 million people at risk of Malaria, only 7% (55 million) were protected with indoor residual spraying which declined from 11 % in 2010. In 2013, 49% of the population at risk had access to Insecticides Treated Nets in their household, but only 44% slept under the nets. There is a serious concern over a growing resistance to insecticides, particularly the pyrethroids.

### **viii. Other Communicable Conditions**



Furthermore, it is crucial to highlight the severe burden from other, readily preventable, communicable diseases, including pneumonia, diarrhea and measles in children. Similarly, there has been slow progress in reducing the burden and socio-economic impact of neglected tropical diseases (NTDs) such as Onchocerciasis, Trypanosomiasis, Schistosomiasis, Guinea Worm and Filariasis. Other communicable diseases of public health importance such Cholera, Meningitis, Ebola and Marburg continue to cause outbreaks.

#### **ix. Non-Communicable Diseases (NCDs), Mental Health, Injuries & Disability**

Africa is now dealing with the triple burden of both communicable, non-communicable and a range of health conditions related to reproductive, maternal, adolescent and child health as well as injuries, accidents, mental health and substance abuse. These are often occurring at the same time in the same country. Non Communicable Diseases (NCDs), primarily cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, are responsible for 63% of all deaths worldwide (36 million out of 57 million global deaths). 80% of NCDs related deaths occur in low- and middle-income countries. NCDs are not only a health problem but a development challenge as well. Eliminating major risk factors could prevent around three-quarters of heart disease, stroke and type 2 diabetes and 40% of cancer.

The rate of growth of mortality and disability from non-communicable diseases (including mental health conditions, injuries and disability) in Africa is increasing, with chronic diseases becoming ever more prevalent. A major factor is the demographic, behavioral and socio-economic changes associated with higher income, urbanization and other factors. Hypertension, stroke, diabetes, chronic respiratory disease and the consequences of tobacco use, alcohol abuse and illicit drugs continue to pose serious public health challenges in many Member States. Injuries from accidents, environmental and indoor pollution, violence, wars and traffic accidents are contributing to morbidity and mortality from non-communicable disease. Mental health conditions, including substance abuse, are a particularly serious concern among adolescents and young people. The prevalence of disability in Africa suffers from the lack of reliable current data to better describe the problem, but it is thought to be high. Contributing factors are associated with the effects of armed conflicts, violence, rapid rates of urbanization as well as the persistence of debilitating neglected tropical diseases.

#### **x. Gender Based Violence and Harmful Traditional Practices**

Gender-based violence (GBV) includes sexual violence; domestic violence; child, forced and early marriage; harmful traditional practices such as Female Genital Mutilation; honor crimes; and trafficking. As at 2010, nearly 70% of Member States had laws/legal instruments that deal with GBV (AUC, 2015). The proportion of women reporting intimate partner violence and non-partner sexual violence is high (ranging from 29.7% in the Southern African region to 65.6% in the Central African region).

A particular source of danger to the health and lives of girls and young women is the prevalence of child marriage in those countries where the young are most prevalent in populations. Worldwide, 39,000 girls become child brides every day, —or about 140 million in a decade. Moreover, this practice is becoming not less but more common—and partly for

demographic reasons. “The problem threatens to increase with the expanding youth population in the developing world,” notes UNFPA (2012). Child marriage, because it usually results in early pregnancy, is linked to deaths from complications of pregnancy and childbirth, and married girls are more likely than married women to suffer violence and other abuse at the hands of their husbands (PMNCH, 2012).

### **c. Disasters and Humanitarian Situations**

Armed conflict has exacted a massive toll on the health and well-being of affected populations, causing death, injuries, gender-based violence, disruption of social support networks, disruption of livelihood means, mass population displacement, health infrastructure destruction, disruption of health service, disability, malnutrition, mental health conditions and communicable diseases as well as diversion of the necessary resources and political will needed to address health priorities.

The Ebola crisis is a reminder of how quickly progress can unravel when health systems are not resilient to shocks. It has underlined the importance of complementing targeted health interventions with integrated approaches which strengthen health systems overall. Moreover, it emphasized the importance of rebuilding health systems of fragile Member States in order to build their resilience against such risks. In addition, the Ebola outbreak in West Africa has increased food inflation in the affected countries and the sub-region, threatening to push many people below the minimum level of dietary energy consumption. The Ebola epidemic not only underscores the weak investment in health systems, including the ill-preparedness to respond to outbreaks, but also highlighted systemic weaknesses at every level, including the global operational response.

### **d. Health Sector Weaknesses**

Although not an MDG target, a key pre-requisite for achieving health-related MDGs is a strong health system; a fact that is now better recognized in the SDGs seeking to achieve universal health coverage. Absence of a strong health system platform can undermine efforts to sustainably and cost-effectively address specific disease burdens or health problems (WHO; “Strengthening Health systems: Everyone’s Business”, 2010). In the continent, the ratio of health workers (doctors, nurses, midwives, dentists, pharmacists and psychiatrists) to every 10,000 people was 6 times worse than the global average. Very high levels of out-of-pocket expenses, low coverage of national health insurance systems, low levels of governmental expenditure on health and very high proportions of international assistance as a percent of total health expenditure.

The weak health system performance on specific health challenges has its roots in the cross-cutting six building blocks of health systems, according to continental reviews by the AUC (2014 Status Report on MNCH), WHO (various reviews of the health system weaknesses in the African Region) and other sources. Yet, very few Member States are investing the effort and resources needed to systematically strengthen health systems in order to achieve better health outcomes at the individual and population levels.

- *Stewardship, governance:*

Insufficient harmonization, weak multi-sectorial approaches and inadequate regulatory control appear to be the key features of Africa's stewardship and governance challenges. The challenges are evident even when compared to many Member States legislative and constitutional promises which state that health is a right for their citizens. Universal access to health services seems a distant goal rather than a measurable, achievable and established objective for most national health policies.

There is lack of cohesiveness within the national health sector policy frameworks in many Member States. For instance, most countries had national health policies and strategies that were disconnected in content from the theme-specific or vertical programs such as immunization, HIV/AIDS, malaria. The 2015 Review of the Maputo Plan of Action reported that only 43% of AU member states had in existence national health policies that integrated SRHR, HIV/AIDS/STI and Malaria services.

Other challenges related to governance and stewardship affecting the health sector cut across all development sectors. Some have been exacerbated, rather than mitigated, by the economic successes and their results in some Member States. The cost of poorly-managed economic growth has resulted in the failure of social and municipal service systems to keep up with the rapid rates of urbanization. The subsequent population increases and dislocation from unplanned urbanization is associated with vulnerability to disease related to poverty, inadequate housing, poor water and sanitation as well as to increased risks from non-communicable diseases.

Similarly, weak governance and regulatory control has increased environmental degradation attributable to increased use of agricultural inputs, industrial waste, environmental pollution resulting from the extractive industries, drought and food insecurity due to land disputes (often armed) as well as excessive deforestation driven by agricultural and infrastructural investments associated with economic growth. Only in few Member States has health sector reform of the governance element led to improvements in performance, notably in Rwanda where decentralization of authority was accompanied by concomitant delegation of responsibility for resource management at the local district level.

- *Human Resources for Health:*

Various reviews have cited the crucial challenges facing Africa's health work force. Africa's health work force suffers from insufficient production, inadequate pre-service training, insufficient skills, inappropriate skill-mix, poor deployment and distribution practices, insufficient workplace support, motivation and retention strategies, weak regulatory frameworks and imbalanced distribution of health workers. The latter involves imbalance between the various medical disciplines, between urban and rural settings, between the levels of care (primary, secondary and tertiary) as well as between the public and private sectors.

- *Health Care Financing:*

Although health funding has increased in Africa since 2001, it has not yet reached the Abuja target of allocating 15% of total government expenditure on health. This notwithstanding, significant progress has been made towards achieving this target. For instance between 2001 and 2013 health budgets in AU Member States increased from 9% to 11%. Only six AU

Member States achieved the Abuja target of allocating 15% of public expenditure to health and a number of other countries are within reach of the 15% target.

Moreover, health care finance suffers from high out-of-pocket expenses as insurance coverage lagged behind population expansion. Value for money and returns on investments are not routinely part of government policies in selecting the most cost-effective interventions or policy priorities. Other inefficiencies in Africa's health systems can also be found in the low level of leveraging of the private sector potentials in innovation, co-financing and coverage.

Most national health sectors' experience high donor dependency, limited exploitation of the private sector, inappropriate allocation of available health finances as well as insufficient attention to the importance of equity in making investment decisions. The weak investments in prevention and public health systems as well as the focus on secondary and tertiary care at the expense of basic primary health care and prevention have exacerbated the problem.

Health sector investments, however, are not the only determinants of health and, here too, the poor performance of many African Member States in terms of investing in sectors which influence health has been reported. The marginalization of new segments of the population due to the absence of social protection systems and cyclical disasters has meant that the high proportion of out-of-pocket payments in most Member States are driving poor and disenfranchised people further into poverty and ill health.

- *Health Service Organization:*

The challenges of health service organization in Africa are intertwined with governance, health care financing and the health workforce. Very few countries have created decentralized approaches that are more suitable to their health and demographic realities in ways that increase access to services. With few exceptions, many Member States are still struggling to complete their decentralization processes, while repeating errors such as insufficient devolution of authority and resources to lower administrative units to whom additional responsibility has been delegated. The service delivery organization challenges are also evident in the weak staffing standards (or their enforcement), unsuitable skill mix in health facilities, absence of standardized referral services that ensure a seamless continuum of care for patients, inequities in the distribution of new health facilities (in comparison with demographic density and disease burdens) and poor management, supervision and support.

- *Health Information Systems:*

There are major challenges in the health information system of most countries in Africa. Less than two fifths of African countries have a complete civil registration system with good attribution of cause of death, vital statistics on births. These are essential for the accurate measurement of different health indicators like maternal mortality. The poor strategic information base in most Member States has resulted in weak utilization of data and evidence for decision-making, including national policy and strategy development and sub-national planning and management of health services.

In close association with weak governance capacity, the AU's evaluation of the response to the Ebola outbreak revealed how key information was missing, data indicating the serious situations was suppressed and the legal obligation of a Member States (in accordance with

the International Health Regulations; IHR 2005) to transparently share the data on the rapidly-deteriorating situation was neglected.

- *Essential medical products and health Commodities & Supplies security:*  
The procurement, supply chain management system, regulatory and legislative environment are inadequate to ensure access to quality assured, safe and efficacious medical products in the continent. The current efforts to strengthen local capacities and capabilities for the manufacture, regulatory, smart procurement and supply chain managements systems will go a long way in achieving medicines and commodity supplies security in Africa. The focus should be maintained on removing the main hurdles through developing required human resources, skills innovation and technologies, building institutions financial capacities for improved access to capital, strengthening support industries and sectors, fostering strategic partnerships, while creating a robust and favorable regulatory, legislative and policy environment.

## **2. Analysis of Gaps and Challenges**

Causes of preventable death and ill-health include communicable and non-communicable diseases, mental illness, injuries and violence, malnutrition, complications of pregnancy and childbirth, unwanted pregnancy and lack of access to, or use of, quality health-care services and life-saving commodities. Underlying structural causes include poverty, gender inequality (manifested in discrimination in laws, policies and practice) and marginalization (based on age, ethnicity, race, caste, national origin, immigration status, disability, sexual orientation and other grounds) that are all human rights violations. Other factors that significantly influence health and well-being include: genetics; families, communities and institutions; underlying unequal gender norms within households; income and education levels; social and political contexts; the workplace; and the environment.

In implementing their health sector plans, the AU Member States, RECs, civil society organizations as well as international partners have clearly made considerable efforts to address key gaps in the health delivery systems, including improved generation of health information, improved human resource policies and better quality standards for health service delivery. Yet, the health sector challenges in Africa still pose onerous burdens on the lives, livelihoods and socio-economic development potential of many communities and Member States in the continent. The “Agenda 2063: The Africa We Want” in conjunction with the SDG Agenda are evident opportunities to reframe and re-energize this continental effort.

The key remaining challenges that require attention according to recent reviews include the persistently high maternal and child mortality, high levels of acute and chronic malnutrition, high morbidity and mortality from NCDs and wide equity gaps in access to health services among the poor, women, adolescents and youth, disabled persons, migrants and other vulnerable populations.

### **a. Equity analysis**

Perceptions of inequity and disenfranchisement are at least one of several factors that have led to considerable political destabilization in several Member States in Africa. In this light,

equity could be seen as not merely a moral value but, also, as a pragmatic pre-requisite to both sustainable economic development as well as political stability. The AU “Agenda 2063: The Africa We Want”, highlights the vital role social security and protection can play in ensuring that growth leads to reduced poverty and inequality, as experiences from Europe, Latin America and Asia has shown. Furthermore, addressing inequality through social protection makes growth more inclusive by contributing to domestic demand-led growth. It is also important to underline that social security is both a human right, and an economic and social necessity.

In Africa, employment-based contributory social security system hardly covers 10% of workers, as a result of the dominance of the informal economy and rural sector. This results in a significant social security coverage gap in the labor market despite the efforts of some African countries to establish non-contributory social protection programs using cash transfers, public works and a range of safety nets for the poor and vulnerable. The main challenges in Africa’s social protection systems (both contributory and non-contributory) are that they are underfunded, ineffectively organized and inefficiently managed with resulting to low coverage and weak value of their benefits. Without robust social protection systems that target those with inequitable access to health, there can be little progress in achieving better health outcomes at national level and much less, achieving sustained economic growth driven by human capital development.

For the most vulnerable populations in most Member States, social protection systems are ill-defined or too dysfunctional to reduce out-of-pocket and other catastrophic payments associated with seeking health care. In response, and at the continental level, the African Union has adopted the Social Policy Framework (SPF), which aims to encourage Member States to extend coverage and provide a minimum package of services to the poor and vulnerable. Social protection plans have generally targeted the informal economy and rural workers since the huge majority of the labor force is engaged in the informal economy and rural sector with low social security coverage.

The number of African countries with social protection programs increased from 21 in 2010 to 37 in 2013, nearly doubling in number in a space of just three years<sup>19</sup>. These include 123 cash transfer programs in 34 countries and over 500 public works programs. In addition almost all African countries have safety nets programs – out of 48 countries sampled 45 had conditional in-kind transfers, 13 had conditional cash transfers, 39 had unconditional in-kind transfers, 37 had unconditional cash transfers and 39 had public works programs in addition to other country programs which provide emergency food assistance to vulnerable groups.

While it is not the sole requirement for achieving results, sustainable health financing is one of the most crucial pillars of building viable health systems and an important measure for improving equitable access to health care and reducing poverty. However, and despite increases in donor funds available for the health sector in some Member States, and despite policy level continental commitments in Abuja and Maputo, the per capita health sector expenditures by some Member States have actually suffered a decline. The Abuja Call of 2006 proposed that at least 15% of a country’s annual budget be allocated to the health sector. However, only an average 10.5% of public expenditure is currently allocated to health on the continent while only seven Member States have achieved the Abuja target. At the

same time, and while the Abuja Call also called upon donor countries to fulfill the yet to be met target of 0.7% in overseas development assistance as a proportion of their GNP, a number of donors continue to provide assistance at well below this level.

It is also important to consider what equitable investments can achieve and what the absence of equity in health sector investments can lead to. The UNICEF 2010 Report entitled “Narrowing the Gap” has analyzed how better impact and returns on investments are made at national level when the most vulnerable people are reached with the services that they need. The report states that although widespread progress has been made in recent decades, women, children and adolescents still face numerous health challenges, with many factors often affecting each other.

Despite progress, societies are still failing women, most acutely in poor countries and among the poorest women in all settings. Gender-based discrimination leads to economic, social and health disadvantages for women, affecting their own and their families’ well-being in complex ways throughout the life course and into the next generation. Gender equality is vital to health and to development.

Health outcomes among women, children and adolescents are worse when people are marginalized or excluded from society, affected by discrimination, or live in underserved communities - especially among the poorest and least educated and in the most remote areas. In low- and middle-income countries there can be:

- Up to three times more pregnancies among teenage girls in rural and indigenous populations than in urban populations
- Up to an 80 percentage point difference in the proportion of births attended by skilled health personnel between the richest and poorest groups within countries
- At least a 25 percentage point difference in antenatal care coverage (at least four visits) between the most and least educated and the richest and poorest groups within countries
- At least an 18 percentage point gap in care-seeking for children with pneumonia symptoms between the poorest and richest groups within countries, with low care-seeking rates overall
- Up to 39 percentage points higher stunting prevalence in children of mothers with no formal education compared with those children whose mothers completed secondary school or higher education.

Thus, the importance of investing in equity to achieve better results for all and children in particular cannot be emphasized. It is more cost-effective to invest with a deliberate focus on equity. The benefits achieved will be consistent with, both a rights-based as well as pragmatic economic returns on the investments (UNICEF; Narrowing the Gap; 2010). Across all country settings and deprivation patterns, the equity-focused approach has the best results in reducing child and maternal mortality, diminishing stunting, and increasing coverage of measures to prevent mother- to-child transmission of HIV. In low-income, high-mortality countries, every additional \$1 million invested through this approach averts 60 per cent more deaths than the current path (UNICEF; Narrowing the Gap; 2010). With Africa having one of the worst global patterns of income distribution, considerable structural, socio-cultural and situational factors

that constrain many communities and individuals from accessing health services, it is crucial to address equity gaps if universal access to services is to be achieved beyond the MDGs.

### **b. Weaknesses in leveraging multi-sectoral and multi-stakeholder partnerships**

Very little evidence exists of systematic and sustained cross-sectorial collaboration and partnerships which can address health needs more holistically. One dimension of such missed partnership opportunities is the persistently weak linkage between the health sector and highly-relevant sectors such as education, agriculture, urban planning, social affairs and others, despite the abundant evidence requiring such collaboration in support of the social determinants of health.

Another dimension of the missed opportunity for multi-stakeholder collaboration is the lack of public private partnerships (PPP) which work to address health challenges and priorities at scale. Africa is already incurring a high opportunity cost by failing to sufficiently expand utilization of its PPP potential to strengthen the health sector performance. This is particularly true when the increase in revenues and profits of the private sector (in association with the continent's economic growth) are taken into account, along with the innovative solutions which have become everyday realities elsewhere in the world. Most PPPs supporting the health sector are either not yet generating sufficient interest among policy-makers to scale them up (often even after the evidence for their cost-effectiveness is available), operate as isolated success stories disconnected from the formal health sector governance structures or are project-specific with no sustainability strategy that can guide them through future phases of replication and scale-up.

### **c. Global health sector initiatives and investments**

Several global initiatives have indeed impacted (both positively and negatively) on the degree to which Member States and RECs had articulated and addressed the health sector priorities reflected in the AHS 2007-2015. On the positive side, much needed additional financing was invested in Africa's health sector through the global initiatives to address maternal and child mortality (MDG Fund, Bill & Melinda Gates Foundation, bilateral commitments arising from the G8 Muskoka Summit Declaration, etc), to combat HIV/AIDS, TB and malaria (notably through investments from Roll Back Malaria, Stop TB Partnership, Global Fund to Fight AIDS, TB and Malaria, World Bank as well as US Government's PEPFAR and PMI investments), immunization and polio eradication (mainly through GAVI and the Global Polio Eradication Campaign), South-South collaboration such as the Republic of Cuba's provision of doctors to help AIDS-affected countries.

Global initiatives were also used as an opportunity by some Member States as a driver for improved aid effectiveness practices. At least two Member States, for example, have harmonized all their global HIV/AIDS investments from their multiple donors and aligned them with one national framework for controlling HIV/AIDS. Other Member States have also utilized GAVI and Global Fund investments to align them with broader health sector needs and national plans, including investments in developing human resources. Moreover, an increasing number of African countries are part of the International Health Partnership Plus (IHP+) compact in which over 30 countries are working to, on the one hand, harmonize all resource



streams being invested in the health sector from bilateral and multi-lateral donors as well as aligning them to a single national health sector policy and planning framework. The effort is a major improvement in governance and is already showing results in terms of increased transparency, accountability and better-informed resource allocation.

However, some global investments were associated with negative effects on Africa's health systems. For instance, high degree of donor dependence along with poor harmonization, alignment or coordination between health sector investors and MS national health authorities have raised key questions on the sustainability of such investments. There was also some distortion of how the investments are made, as many donors picked and chose specific interventions, sectors, districts or themes in which to invest, drawing away and detracting from integrated, health system focused approaches to strengthening national capacity. In a bid to rectify the situation, strong global and continental calls have focused on MS leadership, ownership and coordination as well as better donor harmonization, alignment to strengthen integrated policy, strategy, planning and program delivery frameworks when addressing specific sub-themes in health.

#### **d. Impact of humanitarian crises and public health emergencies on the health sector**

It is evident that the humanitarian crises in Africa have had a negative effect on proper health sector planning and implementation. While the number of manmade humanitarian crises has diminished in Africa during the period 2007-15, there were natural disasters, public health emergencies as well as armed conflicts which were significant enough to impact the ability of Member States to address the AHS 2007-2015 priorities.

Persistent conflicts and unfavorable weather conditions such as storms, droughts and flooding in Africa have continued to exert pressure on health and nutrition. The combined effect often traps countries and communities in a vicious cycle of fragile coping capacities, disaster events and further fragility; to the extent that their developmental potential seems perpetually undermined and eroded.

While the AU, RECs and some Member States have made advances in conflict prevention, peace and restitution of law and order across the continent, there has not been a commensurate effort to address the socio-economic consequences of conflict on affected communities. For instance, the health sector leadership in Africa has a natural vested interest in peace and in the protection of civilians and infrastructure during armed conflict. Yet very little involvement occurred by health sector leaders to reduce the effect of armed hostilities upon health systems and civilian communities in Africa. Worse yet, the continued use of food, child soldiers, rape, dismemberment and denial of access to basic health services as tools and weapons in Africa's wars is contributing to the already high morbidity and mortality from malnutrition, mental conditions, sexual and reproductive conditions, disability and others.

The AUC-led AESOWA (African Union Support to Ebola Outbreak in Western Africa) mission's deployment was rapid and achieved many successes within record time and in extremely harsh circumstances. However, according to the AUC's "ASEOWA Exit Report – October 2015" many challenges arose that are sadly familiar in many humanitarian response

operations. Such challenges included weak response coordination by host countries, weak resource harmonization amongst partners, inadequate national human resources, insufficient supplies (including personal protective equipment; or PPE), inadequate safe water and sanitation facilities, inaccessibility of some affected communities, porous borders and communal violence (often directed against the responders themselves).

Climate change continues to have deleterious impact on health in Africa, by increasing disease burdens, undermining food security, destroying housing, health, water and other infrastructure. In both, slow-onset as well as sudden onset disasters, the effects of climate change may have appeared as environmental consequences of economic development, such as pressures on food supply. For instance, droughts, floods and famines in the Sahel region, Horn of Africa and southern Africa, have significantly increased the disease burdens such as vaccine-preventable illnesses and routine primary health care conditions as well as disruption of access to services and worsened food and nutrition security resulting in increased incidents of malnutrition. The economic consequences such as disruptions in productivity, market networks and community resilience have most likely affected the ability of the concerned Member States to properly address the AHS 2007-2015 strategic directions.

Major communicable disease outbreaks (e.g. H1N1), re-emerging (e.g. TB, including MDR and XDR-TB) and emerging diseases (e.g. Ebola) have further exacerbated the ability of health systems to cope while continuing to improve the delivery of routine services relevant to the AHS 2007-2015.

#### **e. Gaps in health research, innovation and technology**

One of the key challenges for African policymakers is implementation of strategies for ensuring that research on national health challenges and global research programs are integrated and aligned to increase their potential for sustainability. Furthermore, the limited interactions among government institutions, private sector and end users at national, regional and international level negatively impact on the utilization of health research products. In the global context of economic and technological competition, a key challenge is also the fact that very little emphasis or investments are made to advance African medical/health research in ways that addresses key health and social development priorities or local market needs. Much of the research collaboration represents research agenda originating in industrialized countries (testing medical products through clinical trials, adapting interventions to the African context, basic regulatory quality control for some imported medical and food products). The tendency is to view Africa as a consumer, and not as an active producer of technological innovations that are based upon African research priorities and capacities.

Many African countries are still heavily dependent on external funding for research and international development assistance for health services (EDCTP, 2012). In most countries, government funding appears to be limited to indirect (i.e. in-kind) support such as staff salaries, infrastructure and provision of subsidized equipment rather than funding health research programs. The existence of large-scale training programs in the areas of clinical research and related areas such as laboratory capacity, regulatory strengthening and pharmacovigilance is limited.

### 3. Assessment Findings and Summary Analysis on the Degree of Utilization of AHS 2007-2015 in Member States and RECs Health Policy Frameworks

In order to determine the extent to which Member States were guided by AHS 2007-2015, the following seven strategic directions of the AHS 2007-2015 were reviewed against the accessed national health policies, strategies and plans:

- a) Strengthening the **national health systems** for a sustainable health sector response; particularly **commodity procurement/supply, human resources for health and health information systems** as core components of an effective health system;
- b) Creating clear **multi-sectorial policy linkages and integrated approaches** in addressing communicable, non-communicable and reproductive, maternal and child health challenges with sectors that have a proven influence on the social, economic and environmental determinants of health
- c) Improving **national and sub-national governance systems** to increase community ownership and strengthen partnerships with the community, private sector and/or traditional institutions (e.g. faith-based institutions, traditional healers, etc);
- d) Broad **resource mobilization towards sustainable health sector financing** options
- e) Aid effectiveness through enhanced **harmonization** among international development partners as well as better **alignment** between them and the national health policy and strategic frameworks;
- f) Prioritizing the **health of women, children and other groups in need of social protection**;
- g) Investing in **research** which strengthens the health system's response to national challenges, including research on African Traditional Medicine, strengthen national health sector monitoring and evaluation capacity, improve disease surveillance and response, strengthen disaster risk management and other areas;

The assessment determined that there has apparently been a relatively low level of domestication by Member States and RECS of these seven main strategic directions.

Among these seven main strategic directions of AHS 2007-2015, the one prioritizing health challenges among women, children and other groups in need of social protection was the most frequently cited directions in Member States' national health policy frameworks, with 74% of countries fully reflecting it in their frameworks.

Next in its degree of utilization by Member States was the AHS 2007-2015 strategic directions calling for strengthening national health systems (56%), while approximately one third (33%) of Member States reflected the strategic directions calling for the creation of clear integrated multi-sectorial policy linkages, improving governance in addition to improving harmonization and alignment. Only 28% of Member States reflected the AHS 2007-2015 strategic direction calling for broader resource mobilization for sustaining health sector finance while only 19% of Member States reflected the strategic direction calling for enhanced investments and focus to

strengthen health-related research systems.

On average, across these seven strategic directions, only 39% of Member States appear to have utilized AHS 2007-2015 in developing their national health policy frameworks. While it is difficult at this stage to accurately pinpoint all the reasons why less than 40% of Member States managed to explicitly reflect the AHS 2007-2015 strategic directions in their national priorities, some possible factors and assumptions should be taken into consideration. The first is that there might have been limited advocacy for the domestication of the AHS as well as weak mechanisms to track and report on the implementation of the strategy among others. The second is that the methodology used in this assessment relied solely on accessing Member States frameworks through a single WHO website to which they are usually uploaded, while there might have been missing policy frameworks not yet uploaded in that website. As such, the low level of utilization is to be taken with extreme caution.

Some of the possible reasons for the assessment finding that over 70% of Member States had reflected the focus by AHS 2001-2015 on women and children's health could include the following:

- i. Strong leadership shown by the AUC, UN and other development partners in advancing Reproductive, Maternal, Newborn and Child Health (RMNCH) through the adoption of policy instruments such as the Continental Policy Framework for Sexual and Reproductive Health Rights (SRHR), its Maputo Plan of Action (MPoA) for its implementation and focused campaigns such as the Campaign on Accelerated Reduction in Maternal Mortality in Africa (CARMMA). This advocacy effort has clearly helped galvanize the attention around RMNCH.
- ii. Indicators on RMNCH (status, access and coverage) in Africa are among the worst globally. The magnitude of RMNCH problems in the continent would have rendered RMNCH obviously visible as a developmental challenge for most Member States and RECs.
- iii. RMNCH has received the attention of a number of global financing and technical support initiatives (e.g. G8 Muskoka Summit, Bill & Melinda Gates Foundation, Partnership for Maternal, Neonatal and Child Health, GAVI, etc). This has helped to further focus the attention of Member States and RECs on these challenges, including by prioritizing them in their policy, strategy and planning frameworks.
- iv. Five of the MDGs focus on women and children globally either because they are disproportionately affected by poverty, hunger, gender equality/women empowerment and AIDS/TB/other diseases or are directly-relevant MDGs on child health and maternal health. Hence, it was natural that many Member States and RECs have deliberately and wisely linked their scale-up of access to HIV/AIDS, TB and malaria services to integrated service delivery platforms which leveraged global and local financial resources related to MDG 6 in order to concomitantly strengthen health systems and address MDGs 4 and 5. This strategic approach to RMNCH in the context of strengthening national responses to HIV/AIDS may have resulted in such a large

number of countries addressing the maternal and child health directions contained in the AHS 2007-2015.

## **IX. LESSONS LEARNED AND OPPORTUNITIES**

### **1. Lessons Learned**

#### **a. Reaching the most vulnerable through social protection schemes**

AU “Agenda 2063: The Africa We Want” provides some good lessons from African countries which have established non-contributory social protection strategies and programs, including cash transfers, public works programs and a range of safety nets for the poor and vulnerable. The social safety nets and national health insurance in some Member States have been a central factor in the strong performance by these Member States in achieving the health-related MDGs. Their efforts have yielded some results in terms of reducing poverty and inequality, including extensive health insurance coverage which (in at least one Member State) has often reached up to 90% of the total population.

#### **b. Managing disaster risks, not the crises**

A paradigm shift is needed to establish effective continental, RECs and Member States disaster preparedness and response management systems. Country-level, cross-border/transnational, regional and continental disease surveillance, preparedness and response should be framed within the International Health Regulations (IHR 2005), draw upon disaster risk management concepts and supported by a strong evidence base generated by country-led research and data systems.

In the most recent outbreak of Ebola, it is believed that the epidemic was worsened by extremely fragile health systems resulting from prolonged armed conflict. The epidemic was one of the most catastrophic public health emergencies facing Africa and the world. The AU response yielded some important lessons including the need for rapidly-deployable public health leadership expertise, a trained reserve response capacity, reserve funding to address damaged health infrastructure as well as improved management, logistic and personnel systems.

The AHS 2007-2015 had laid emphasis on the need to strengthen national health systems and community resilience in order to prevent, better manage and mitigate the effects of outbreaks such as the Ebola epidemic. These events and their impact point clearly to the importance of addressing, both, disaster management capacity as well as the urgency of building resilient health systems capable of better detecting and responding to outbreaks.

Streamlined chains of command, clearer lines of communication and authority, standard operating procedures, a stand-by volunteer corps as well as the exploration of prepositioning buffer stocks of humanitarian commodities are all key components of a sound disaster response management strategy.

#### **c. Economic growth does not necessarily translate to improved health outcomes**

Historically, countries that have attained improved health status had done so mainly by investing in the social determinants of health as well as in the health sector itself. The economic growth witnessed by many Member States in Africa over the past decade has not necessarily translated to improvements in the health outcomes for the African people. Deliberate efforts should therefore be made to take advantage of the economic boom to invest more resources in the health and health related sectors. The business case for health should be advocated to ensure that the health sector is viewed as a productive rather than a consumptive sector.

#### **d. Medical commodity security**

The key lessons learned in achieving Africa's medical commodity security include the need to strengthen the continent's ability to manufacture, distribute and regulate its own pharmaceutical products. Another important lesson is the efficiencies with which this can be done if Member States collaborate together in the context of RECs and continentally. The AU, NEPAD and a number of RECs are already building on these lessons by further developing the Pharmaceutical Manufacturing Plan for Africa as well as developing continental and RECs-based institutional frameworks to advance Africa's ability to produce and regulate its own medical commodities. A third lesson also draws on the ability of some Member States to collaborate in importing their medical commodity needs from outside the continent, whereby the ability of such Member States to pool their procurement, to standardize their regulatory systems and to harmonize their national case management algorithms for certain diseases has enabled them to collectively bargain for lower prices and achieve considerable volume discounts. Further strengthening of the Africa's manufacturing base, strengthening of its regulatory framework and collaborative efforts have the potential to further advance commodity security.

## **2. Opportunities**

While excellent progress has been made by Africa's Member States as part of the global efforts to address the devastating consequences of certain emerging and re-emerging disease burdens, maintaining the momentum on these disease interventions as well as addressing remaining disease patterns is a major challenge. Thus, maintaining an Africa mostly polio-free, halting the spread of HIV and AIDS, sustaining the gains made in reducing preventable maternal and childhood mortality and in eradicating key neglected tropical diseases such as guinea worm and onchocerciasis will require much more effort and strategic investments across all AU Member States. Such investments will not only be needed within the health sector's disease surveillance and response capacities but, importantly at the level of social, economic and environmental determinants of health. Most importantly, the type of transformative vision established by Agenda 2063 and the SDGs is critically needed to provide the impetus for building on success, premising the push towards universal health coverage upon a rights-based, innovative and forward-facing movement. The momentum generated by existing continental and global political commitments in support of the health sector is enormous, particularly in light of Agenda 2063: The Africa We Want, the SDGs, the Global Strategy for Women's, Children's and Adolescent Health 2016-2030, the Maputo Plan of

Action 2016-2030, the African Regional Nutritional Strategy 2015-2025, the Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa By 2030 and others.

#### **a. Maximizing the benefits of strong leadership and political will**

Good governance is a central component of the stewardship element of health systems strengthening. It enables better decisions to be made by policy makers and managers in strategic prioritization, resource allocation, policy matters, cost-effective intervention priorities and cost-efficiencies in implementing health services. The trust and confidence by the public in the health sector is reinforced when its governance is accountable, transparent and participatory.

The effects of strong continental and national leadership in support of health sector priorities cannot be overemphasized. One note-worthy example highlighted in the Assessment of AHS 2015-2030 is how continental, national and local leadership made a positive impact on some maternal and child health indicators. Almost, all countries that made significant progress towards the attainment of MDG 4, 5 and 6 exhibited high level political commitment and leadership. The post 2015 period should therefore focus on consolidating and maintaining the political momentum.

#### **b. Utilizing the compelling evidence showing high returns from investing in health**

There is increasing recognition that investing in health creates wealth and increases economic growth; while there is gradual recognition about the importance of reducing health care expenditure by investing in social determinants of health and in disease prevention. A strong body of global literature has evidenced how countries can achieve high returns when they invest in women's, children's and adolescents' health. Investment cases have provided compelling evidence on the benefits for investing in the fight HIV/AIDS (UNAIDS, 2012), health systems (Harmonization for Health in Africa, 2011) and RMNCH (PMNCH, 2013). The following illustrate some of these investment cases:

- *Modern contraception and good quality care for pregnant women and newborns:* If all women who want to avoid a pregnancy used modern contraceptives and all pregnant women and newborns received care at the standards recommended by the World Health Organization (WHO), the benefits would be dramatic. Compared with the situation in 2014, there would be a reduction in: unintended pregnancies by 70 per cent; abortions by 67 per cent; maternal deaths by 67 per cent; newborn deaths by 77 per cent; and transmission of HIV from mothers to newborns would be nearly eliminated. The return on investment would be an estimated US\$120 for every US\$1 spent. Population stability would enhance economic sustainability and reduce the risks of climate change.
- *Good quality care at child birth:* This produces a triple return on investment, saving mothers and newborns and preventing stillbirths. The provision of effective care for all women and babies at the time of birth in facilities could prevent an estimated 113,000 maternal deaths, 531,000 stillbirths and 1.3 million neonatal deaths annually by 2020 at an estimated running cost of US\$4.5 billion per year (US\$0.9 per person).
- *Immunization:* This is among the most cost-effective of health interventions. Ten vaccines,



representing an estimated cost of US\$42 billion between 2011 and 2020, have the potential to avert between 24 and 26 million future deaths as compared with a hypothetical scenario under which these vaccines have zero coverage during this time.

- *Breastfeeding and nutrition:* Promoting and supporting breastfeeding in the first two years of life could avert almost 12 per cent of deaths in children under five, prevent undernutrition and ensure a good start for every child. Scaling up nutrition interventions has a benefit-cost ratio of 16. Eliminating undernutrition in Asia and Africa would increase gross domestic product (GDP) by 11 per cent.
- *Early childhood development:* Enabling children to develop their physical, cognitive, language and socioemotional potential, particularly in the three first years of life, yields rates of return of 7-10 per cent across the life course through better education, health, social skills, economic outcomes and reduced crime.
- *Adolescents and young people:* If countries in demographic transition make the right human capital investments and adopt policies that expand opportunities for young people, their combined demographic dividends could be enormous. In Africa (except North Africa), for example, they would be at least US\$500 billion a year, equal to about one third of the region's current GDP, for as many as 30 years.
- *Health systems and workforce investments:* With enhanced investments to scale up existing and new health interventions and the systems and people to deliver them most low-income and lower-middle-income countries could reduce rates of deaths from infectious diseases, as well as child and maternal deaths to levels seen in the best-performing middle-income countries in 2014. A "grand convergence" in health is achievable by 2035. For women's and children's health, health system investments alongside investments in high-impact health interventions for reproductive, maternal, newborn and child health, at a cost of US\$5 per person per year up to 2035 in 74 high-burden countries, could yield up to nine times that value in economic and social benefits. These returns include greater GDP growth through improved productivity and preventing 32 million stillbirths and the deaths of 147 million children and 5 million women by 2035. The health workforce is a critical area for investment. An ambitious global scale-up would require at least an additional 675,000 nurses, doctors and midwives by 2035, along with at least 544,000 community health workers and other cadres of health professionals. Other key health systems investments include: program management; human resources; infrastructure, equipment and transport; logistics; health information systems; governance; and health financing.
- *Education:* Investments to ensure girls complete secondary school yield a high average rate of return (around 10 per cent) in low- and middle-income countries. The health and social benefits include, among others, delayed pregnancies and reduced fertility rates, improved nutrition for pregnant and lactating mothers and their infants, improved infant mortality rates and greater participation in the political process. School curricula should include elements to strengthen the self-esteem of girls and increase respect for girls among boys.
- *Gender equality:* Closing the gender gap in workforce participation by guaranteeing and

protecting women's equal rights to decent, productive work and equal pay for equal work would reduce poverty and increase global GDP by nearly 12 per cent by 2030.

- *Preventing child marriage:* A 10 per cent reduction in child marriage could contribute to a 70 per cent reduction in a country's maternal mortality rates and a 3 per cent decrease in infant mortality rates. High rates of child marriage are linked to lower use of family planning, higher fertility, unwanted pregnancies, higher risk for complications during childbirth, limited educational advancement, and reduced economic earnings potential.
- *Water, sanitation and hygiene:* Investments in these sectors return US\$4 for every US\$1 invested and result in US\$260 billion being returned to the global economy annually if universal access were achieved.

### **c. Investing in youth and adolescents**

The period of demographic transition between high fertility and mortality rates and low ones will happen at some point in virtually every country. But only those that make the appropriate choices and investments will reap a demographic dividend, taking full advantage of the point where there are fewer dependents and more people in their productive years. Investing in young people is not only more equitable and morally correct. It is also, a smart pragmatic economic intervention with a high return on investment. The returns include greater economic productivity, more resources for better quality infrastructure and services as fertility rates decline, increased political stability and transmission of achievements to coming generations. By contrast, shortsighted thinking that fails to recognize and grasp these benefits will result in the loss of an already-closing window of opportunity offered by the next generation. The current waste of human potential that young people experience, given the lack of protection, respect and targeted investments in them, is crucial especially at times of decreasing resources, growing threats from conflict, climate change and diseases.

Adolescents and youth are better equipped to reach their full potential when they are healthy and well-educated, and when they have opportunities to thrive and fulfil their aspirations. With appropriate support to achieve their potential, defined by decisions rooted in their participation, they can be an immense source of productivity, innovation and creative dynamism that accelerates development. Young people with jobs, for example, propel flourishing economies. A voice in decisions that affect them can lead to decisions that reflect their realities and leave them less likely to turn to alternative routes for expressing themselves through, for example, civil unrest. Full access to reproductive and sexual health means they can make informed choices about their lives and those of their families, and contribute to healthier societies overall.

### **d. Investing in research, innovation and technology to transform Africa**

The challenges facing Africa should not mask the enormous potential the continent has to go even beyond just addressing its own health problems by having a vision that enables Africa to play a major role in the global stage as well. Africa can and should serve not just as a consumer and of goods but, also, as a leader in innovation, access to new technologies and products which support health and socio-economic development. It is in this context that the

challenges currently faced in access to medical products and technologies should be addressed. Not only are they key for diagnosis, prevention and treatment of diseases and health conditions; they also represent a growth opportunity for Africa's private health sector and research institutions.

The AU Agenda 2063, through its Science, Technology and Innovation Strategy for Africa (STISA 2024), calls on African countries to position themselves strategically in shaping and driving new research and innovation necessary for health and well-being of the citizens. The continent must put in place systems to access and utilize relevant global health technologies and innovations from domestic and international sources. Focus must shift from the current successful but stagnant research results to product development and delivery. Furthermore, the research focus needs to go beyond determining prevalence to explore what social and psychological factors are behind health choices, and what factors lead to success of interventions.

Building on the ongoing efforts on health statistics at the continental, regional and national levels, standard information reflecting gender and age should be collected to monitor and evaluate health system performance. The district or hospital information systems should provide a framework of information for monitoring progress and taking corrective measures where necessary. The routine data has to be supplemented by other information, such as surveys. The AU Health Statistics Platform, [www.africanhealthstas.com](http://www.africanhealthstas.com), provides a continental platform on which to build on.

The "Agenda 2063: The Africa We Want", PMPA and other instruments call for a formidable effort to define, produce and utilize African research in ways that can transform the health sector as well as the economy and society as a whole. Africa can and should have locally driven and financed research which generates important information for policymaking and planning. The empowerment of local researchers and resource allocation for research are critical factors in developing innovative approaches and interventions, which are sensitive to the African context. The opportunity acquires further potential as Africa increasingly strengthens its tertiary education quality and sees its economic potential boosted by research and development. Achieving health goals and targets requires matched investment in research and innovation for improved access to medical technologies and products. Furthermore, data from health research and innovation must be collected and analyzed to inform evidence-based policy and decision-making at all levels of the healthcare system.

#### **e. Building the economic, scientific and regulatory base for Africa's medical industry**

The PMPA business plan recognizes the existence of initiatives on the continent geared towards strengthening the pharmaceutical industry. In support of the objectives of the PMPA, RECs are being supported to develop and implement medicines harmonization projects as a key intervention to strengthen regulation of pharmaceuticals on the continent and to promote the expansion of potential markets for quality assured medicines. Complementary regional initiatives include the Southern African Development Community (SADC) Pharmaceutical Business Plan 2007-2013 and the EAC Regional Pharmaceutical Manufacturing Plan of Action 2012-2016. ECOWAS is formulating a charter to facilitate Public Private Partnerships for the

local production of ARVs and other essential medicines. Achieving the PMPA's vision of a competitive, sustainable and self-reliant industry will demand increased human resource capacity, access to affordable financing, strong regulatory systems, strategic partnerships and business linkages. It will also require enhanced market data and information systems. A stronger regulatory system should enable Member States, RECs and the continent to encourage local scientific research, business entrepreneurship and enhanced manufacturing capacity for medical commodities. Such a framework, particularly when it is harmonized and made uniform across Member States (within or across RECs), could also guard Africa's competitive edge, protect its intellectual property and help ensure its markets are not infiltrated with substandard, counterfeit, fake or otherwise in appropriate medical products. Member States should ensure they benefit from RECs as collaborating platforms to pool their expertise, share good practices and develop RECs-based and, eventually, continental regulatory environment such as the African Medicines Regulatory Authority and the African Medicines Agency supporting the PMPA business plan. .

#### **f. Emerging platforms for continental and sub-regional collaborative action to combat communicable diseases health emergencies**

Through the establishment of the African Center for Disease Control, the AU has moved closer to the creating a collaborative platform for dealing with health emergencies in the continent. Other platforms at include institutionalized efforts by some RECs to address communicable diseases such as the IGAD, SADC and COMESA regional initiatives to combat HIV/AIDS, the ECOWAS/WAHO efforts to standardize disease surveillance systems across countries and the These are clear opportunities for Member State action that can harness mutual strengths, interests and capabilities in order to address communicable disease challenges in much more cost-effective ways than when Member States address them by themselves.

#### **g. Harnessing the power of Public Private Partnerships (PPP) for health**

The untapped potential of the private sector (PS) is enormous in Africa and it is important to detail where such opportunities exist for Member States, RECS and the AUC to leverage in support of the health sector. Such engagement could include the following illustrative roles for the private sector to play in the health sector:

- Encourage direct cash or in-kind (goods or services) donations as cost-share to public health sector programs;
- Engaging private health care providers to share patient load, enhance access for certain interventions;
- Engage with the banking and ICT private sector to use advanced technologies which improve financial transactions, health information systems, patient referral, M&E workload among health workers, behavior change, etc.
- Engaging PS in consumer-driven resource mobilization models (cross-subsidy on products, services or transactions, proportion-of-sales-revenue for products or services, "sin taxes" on tobacco and alcohol products, etc)
- Engaging private health teaching institutions to help develop health workforce (both during in- and pre-service education/training)

- Encouraging PS enterprises to create supportive workplaces for HIV, TB and malaria prevention/treatment/care, preferably within broader occupational health measures for their own workers, families, consumer communities
- Engage commercial insurance companies to explore/offer range of products, including (a) underwriting delivery delay risks in procurement orders for health products, (b) reducing out of pocket expenses through risk pooling by offering direct private insurance or participating in joint Government/Employer, national insurance and/or community-based insurance schemes for individuals/communities, (c) extend health insurance cover to large, medium and small enterprise workers.
- Negotiate with manufacturers (at national, regional, continental or international levels) to achieve price reduction strategies for select health commodities, using appropriate tools such as bulk purchase volume discounts, standardization of commodity specifications (e.g. ARV regimens, fixed-dose combinations, reduced/larger package sizes, etc), financial incentives (e.g. tax/customs deductions), trade instruments (e.g. TRIPS, compulsory licensing, etc);
- Develop micronutrient fortification partnerships with local African private sector producers of fortified foods such as salt, grains/bread, milk and other dietary items, including by working with global mechanisms such as GAIN to establish the right strategies and parameters.

#### **h. Leveraging the dividends of economic growth to invest in health and human development**

With many African countries enjoying unprecedented levels of macro-economic growth, there is a limited window of opportunity for re-investing the revenues from such growth into human development. Ways of accomplishing this include investing government revenue into increased per capita governmental health expenditure (alone or in combination with the public private partnership opportunities mentioned above), investing in the social determinants of diseases (such as education, employment, water supply, sanitation and housing) as well as by building the longer-term basis for sustaining Africa's growth and development. Countries with a particularly short window of opportunity are those whose recent economic growth is mainly due to time-limited extractive industries.

#### **i. Assimilating the lessons from Ebola**

The AU's Humanitarian Policy Framework presents a timely opportunity to help learn from the lessons gained in the Ebola epidemic in order to mount more effective continental, regional and national responses to disasters such as the Ebola crisis. Other key initiatives which strengthen Africa's disaster management capacity include the Regional Disaster Response Management Strategy (WHO AFRO, 2014) whose major paradigm shift is to emphasize the importance of routine risk mapping for all hazards, surveillance and early warning systems (for disease and other events) and proactively preparing communities and health sectors to respond to anticipated threats as well as the establishment of the African Centers for Disease Control.

## **X. CONCLUSIONS & RECOMMENDATIONS FOR AHS 2016-2030**

Based on the assessment's findings and analysis, certain conclusions and recommendations can be drawn to inform the revision of the AHS 2016 - 2030.

### **1. Conclusions of the Assessment of AHS 2007-2015**

- a. AHS 2007-2015 helped to increase the attention and resource investments in key strategic areas which resulted in some positive achievements.
- b. In comparison to global health sector initiatives, AHS 2007-2015 represented a continent-wide, home-grown effort which renewed and consolidated various African policy commitments.
- c. The influence by AHS 2007-2015 and its associated continental political commitments has been indispensable in improving the health outcomes of the African people.
- d. Member States have maintained strong emphasis on MDGs 4, 5 and 6 leading to increased coverage of RMNCH, HIV&AIDS, tuberculosis and malaria services.
- e. Globally, considerable resources were invested by the GFATM and US PEPFAR, among others to support RMNCH, the fight against HIV, TB and Malaria.
- f. Domestically, African civil society and the private sector also rose to the challenge and through multi-sectoral collaboration addressed the multi-faceted dimensions of the key health challenges.
- g. A transformative leadership, vision and commitment is needed if Africa is to reap the benefits of strong health sector performance, drawing on the fact that many African leaders have shown exemplary leadership and provided high-level support to improve the health of their people.
- h. Innovations in national programs have had the greatest impact in the African Region when lessons were assimilated and new ways were identified to overcome hurdles and to scale-up interventions.
- i. Intervention models which combined the respective strengths of health facilities and communities, involving participatory decision-making, integrated approaches to service delivery and appropriate decentralization of authority and responsibility appeared better able to improve health sector performance and led to positive impact.
- j. Premising disease and theme-specific responses upon a strengthened health system platform continues to be a successful strategy at policy, planning, management and service delivery levels.

- k. Fostering broad multi-sectoral partnerships with all parts of government, society and the private sector is key to addressing both the roots and the outcomes of health sector challenges in Africa.
- l. It is critical that continental and national disaster preparedness, response and resilience systems be strengthened.
- m. Other than MDG 6, the majority of Member states fell short of achieving the other health MDGs and less than 50% of the Member States were on track to achieving the MDG targets as of end of 2015.
- n. Only 39 % of AU Member States have fully reflected the AHS 2007-2015 strategic directions in the text of their national policies, strategies and plans. The proportion becomes 73% when considering Member States which partially reflected the strategic directions in their national frameworks.

## **2. Recommendations to guide AHS 2016-2030**

Continental frameworks in Africa are aligned to and supportive of global health targets. Accordingly, the AHS 2016 - 2030 key strategic directions should also be derived from and reinforce both by the “Agenda 2063: The Africa We Want” as well as the SDGs. At the global level, AHS 2016 - 2030 will need to contribute to world’s agenda of ending preventable maternal and child deaths, HIV, TB and elimination of Malaria by 2030.

At the continental level, the AU’s “Agenda 2063: The Africa We Want” calls for optimal exploration of some opportunities that could effectively change the current scenario of health care financing. This includes creating pooled funding at the national level to finance health, which may involve corporate social responsibility contributions as well as taxation. Value for money will also need to be a critical component of health policy and processes will continuously need to be improved to ensure efficiency and curbing of wastages. Accountability mechanisms should be put in place at all levels to ensure that duty bearers remain accountable to the right holders with regards to responsibilities they have been assigned and resources over which they have custodial authority.

The Abuja Declaration related to Health and the African Leaders’ Malaria Alliance, point to strong political commitment to improving Africa’s health status and this momentum should be sustained, including the mobilization of the continent, under the auspices of the AU to address Ebola outbreak in West Africa. The commitments to integrate sexual and reproductive health and rights, family planning and HIV/AIDS services through reinforcing action on earlier commitments to enhance maternal, newborn and child health status, ensuring the integration necessary to facilitate synergies between HIV/AIDS, TB, Malaria and Maternal, Newborn and Child Health programs must be vigorously followed through.

The African health agenda of the millennium will need to cater for the younger population while focusing health services to effectively tackle the tertiary needs of the aged population, as well. The increasing changes of lifestyles, particularly the abandonment of the traditional high fiber diets for high sugar and refined diets, coupled with the increasing adoption of other habits

such as smoking and urban stress in rapidly urbanizing centers portends a conglomeration of risk factors for non-communicable diseases. The current emphasis on primary health care is consequently inadequate to respond to the projected health challenges. Thus African countries should develop policies to incorporate non-communicable diseases in primary health care while strengthening the technological base of secondary and tertiary health care services.

Improving the health of Africa's citizens also calls for broad-based strategies and a multifaceted approach that addresses access to water and sanitation, women's empowerment, nutrition, access to basic services and improved education, rather than narrow vertical approaches that characterize efforts so far."

The AU should continue to prioritize mothers, new-borns, children, adolescents, youth, the unemployed, the elderly and people with disabilities in its efforts to reduce the incidence and prevalence of communicable diseases, non-communicable diseases and emerging diseases, ending the epidemics of AIDS, tuberculosis and malaria; reducing malnutrition as well as improving hygiene and sanitation. Central to achieving this is to ensure universal and equitable access to quality healthcare, including universal access to comprehensive sexual reproductive health and reproductive rights; improving health systems and health financing, medical infrastructure, and the local manufacturing of medicines, health equipment and commodities; and setting up monitoring and evaluation, and quality assurance systems. In turn, this would also require strengthened governance in Africa to improve coordination, facilitate rapid dissemination of innovation, enhance local commitment and ownership and strengthen the region's voice on health issues with international partners and donors.

Thus, and for the AHS 2016-2030 to become organically linked to these transformative global and continental frameworks, it needs to address the following key commitments and directions:

- a. Strengthen **leadership** to reinforce greater ownership, stewardship and accountability harmonisation, integration and coordination at all levels and in all sectors;
- b. Emphasize **equity** and prioritise **human rights-based responses** to health, particularly among vulnerable and key populations;
- c. Strengthen the links between the health sector and other related sectors for better access to **social, economic and environmental determinants** of health through Health in All Policies, Whole-of-Government approaches;
- d. **Strengthen health and community** systems to ensure better performance and impact.
- e. Ensure that national, RECs and continental efforts to address the human resource challenges in the health sector are addressed in creative and collaborative ways, including common education, training, regulation and deployment systems.
- f. Maintain the thematic **focus on RMNCH and adolescent and youth health**.
- g. Develop and strengthen integrated non-communicable diseases (NCDs) prevention and



control systems, including for mental health conditions, violence, injuries and disabilities.

- h. Dramatically increase domestic **resource mobilization** supporting the health sector and ensure sustainability.
- i. Prioritize **health commodity security** by developing and strengthening integrated commodity management systems, creating enabling legal and policy environments for local manufacturing capacity, procurement and supply systems.
- j. Develop systems for effective continental, regional and country **disaster preparedness and response**, based upon strengthening IHR 2005 capacity, creation of the African Center for Disease Control and the lessons learned in managing disasters
- k. Creatively expand **public-private partnerships (PPP)** in support of the health sector.
- l. Incubate and **build upon existing successes, invest in strategic health research and innovation.**
- m. Strengthen national and regional **monitoring, reporting and accountability** systems at AUC, RECs and Member States levels to ensure stronger accountability for implementation of AHS 2016 - 2030.
- n. **Put in place a strong advocacy, communication and mobilization strategy** to increase ownership and to galvanize Member States, RECs and African communities around the AHS 2016 - 2030.

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### **XIII. ANNEXES**

- ANNEX 1.           AHS 2007-2015**
- ANNEX 2.           TERMS OF REFERENCE FOR THE ASSESSMENT AND REVISION OF  
AHS 2007-15**
- ANNEX 3.           KEY INFORMANT QUESTIONNAIRE FOR ASSESSMENT**
- ANNEX 4.           LIST OF SUBSTANTIVE W.H.O. AFRICAN REGIONAL OFFICE  
RESOLUTIONS ADOPTED BETWEEN 2007 AND 2015.**

## ANNEX 3. KEY INFORMANT QUESTIONNAIRE FOR ASSESSMENT

AFRICAN UNION

الاتحاد الأفريقي



UNION AFRICAINE

UNIÃO AFRICANA

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Department of Social Affairs

Assessment of the  
AFRICA HEALTH STRATEGY 2007-2015  
Questionnaire for Key Informants

### I. Context:

The African Union developed the Africa Health Strategy 2007 – 2015 (AHS; attached) endorsed by the 3rd Conference of African Ministers of Health in 2007 and the 11<sup>th</sup> Session of the Ordinary Executive Council in 2008. The purpose of the AHS was to enrich and complement Member States' strategies by adding value in terms of health systems strengthening from the unique continental perspective. The AHS provided strategic direction to Africa's efforts in creating better health for all in support of established Member States and Regional Economic Communities (RECs) health goals in addition to the Millennium Development Goals (MDGs)

As such, AHS is an inspirational framework within which Member States and the Regional Economic Communities (RECs) will fulfill their roles. It calls on multilateral agencies, bilateral development partners and other partners in Africa's development to build their health contribution around it, thus providing an overarching framework to enable coherence within and between countries, civil society and the international community.

Under the auspices and supervision of the AUC Department of Social Affairs (DSA) along with guidance and coordination by a Technical Secretariat consisting of AUC, NEPAD, UN and National Department of Health of the Republic of South Africa, an Assessment of AHS 2007-2015 is underway in order to establish the basis for revising the new AHS for 2016-2030.

The objective of the Assessment of the AHS 2007-2015 is to determine the extent to which it has achieved its vision, mission, goals and objectives. Specifically, the Assessment will determine the:

3. extent to which AHS was used to guide Member States, RECs and partners' health policy, plans and programs;
4. identify gaps, lessons learnt, challenges and opportunities in implementation of the AHS;

### I. Requested Partner Inputs for the AHS 2007-2015 Assessment Process:

To assist the AUC in addressing the above-mentioned objectives, the AUC kindly requests that the attached short questionnaire is completed and sent on a timely basis to the following email addresses by .....

Mr. Robert Ndieka, M&E Expert, Department of Social Affairs, African Union Commission.  
Email: [NdiekaR@africa-union.org](mailto:NdiekaR@africa-union.org)

**Thank you!**

### Questionnaire for Key Informants

Please fill in the blanks or circle all the responses which best reflect the reality in your Country:

A. Member State: .....

B. Name, title & institution of Respondent (Official completing the questionnaire)  
.....

C. After September 2007, what is the timeframe of your most recent National Health Policy(ies)/Plan(s) in your Country ?

D. Is(are) your Country's National Health Policy(ies)/Plan(s) attached to this questionnaire:

1. Yes
2. No

E. Please provide the website for the institution in your Country which posts the National Health Policy(ies)/Plan(s).....

F. In general, my Country's National Health Policy/Plan has specifically referenced the Africa Health Strategy 2007-15 as one of its sources of guidance:

1. Not true
2. True
3. Not Applicable (if no National Health Policy/Plan existed between 2007-2015)

G. My Country's National Health Policy/Plan has the following elements which are in common with the strategic directions of the Africa Health Strategy 2007-2015: (**Kindly tick applicable areas**)

- Strengthening **national health** systems as a platform for the health sector response
- Calling for **broad and effective multi-sectorial policy linkages and integrated approaches** with sectors that have a proven influence on social determinants of health
- Improving national and sub-national **governance** systems to increase community ownership and strengthen partnerships with private sector or traditional institutions
- Broadly mobilizing financial resources** to support the health sector
- Seeking **aid effectiveness** by engaging international development partners to better harmonize and align their support to the national health priorities and frameworks
- Strengthening **commodity security, human resources for health and health information systems** as core components of health system strengthening
- Prioritizing the health challenges among **women, children and other priority groups**
- Recognizing, promoting and engaging the key role played by **civil society and the private sector** in support of national health sector priorities.

## **ANNEX 4: LIST OF SUBSTANTIVE W.H.O. AFRO RESOLUTIONS ADOPTED 2007- 2015**

### **2007:**

- Resurgence of Cholera in the WHO African Region: Current Situation and Way Forward
- Food Strategy and Health: A Strategy for the WHO African Region
- Onchocerciasis Control in the WHO African Region: Current Situation and Way Forward
- Diabetes Prevention and Control: A Strategy for the WHO African Region

### **2008:**

- Women's Health in the WHO African Region: A Call for Action
- Strengthening Public Health Laboratories in the WHO African Region: A Critical need for Disease Control
- Ouagadougou Declaration on Primary Health Care and Health systems in Africa: Achieving Better Health for Africa in the New Millennium

### **2009:**

- Drug Resistance Related to AIDS, Tuberculosis and Malaria: Issues, Challenges and the Way Forward
- Accelerated Malaria Control: Towards Elimination in the African Region
- Policy Orientations on Establishment of Centers of Excellence for Disease Surveillance, Public Health Laboratories, Food and Medicines Regulation
- Strengthening Outbreak Preparedness and Response in the African Region in the Context of the Current Influenza Pandemic
- Migration of Health Personnel: Code of Practice for International Recruitment of Health Workers
- Call for Intensified Action for HIV Prevention and Tuberculosis/HIV Co-Infection Control in the African Region

### **2010:**

- A strategy for addressing the key determinants of health in the African Region
- Reduction of the harmful use of alcohol: A strategy for the WHO African Region
- E-Health solutions in the African Region: Current context and perspectives
- Current status of routine immunization and polio eradication in the African Region: Challenges and recommendations
- The African Public Health Emergency Fund

### **2011:**

- Measles elimination by 2020: A strategy for the African Region
- Framework for public health adaptation to climate change in the African Region
- Framework document for the African Public Health Emergency Fund
- Poliomyelitis eradication in the African Region



**2012:**

- Disaster risk management: A health sector strategy for the African Region
- HIV/AIDS: Strategy for the African Region
- Road map for scaling up the human resources for health for improved health service delivery in the African Region 2012–2025
- Health Promotion: Strategy for the African Region
- The African Health Observatory: Opportunity for strengthening health information systems through national health observatories
- Health and Human Rights: Current situation and way forward in the African Region
- Brazzaville Declaration on Non-communicable Diseases
- Implementation of International Health Regulations (2005) in the African Region

**2013:**

- Healthy ageing in the African Region: Situation analysis and way forward
- Enhancing the role of traditional medicine in health systems: A strategy for the African Region
- Addressing the challenge of Women's health in Africa: Report of the Commission on Women's health in the African Region
- Utilizing eHealth solutions to improve national health systems in the African Region
- Regional Strategy on neglected tropical diseases in the WHO African Region
- The WHO Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection; Recommendations for a public health approach - Implications for the African Region

**2014:**

- Progress towards the achievement of the health-related MDGs
- Regional Strategic Plan for Immunization 2014-2020
- Viral hepatitis- situation analysis and perspectives in the African Region
- African Public Health Emergency Fund

**2015:**

- Research for health: a strategy for the African Region, 2016–2025
- Global strategy on human resources for health: perspectives from the African Region
- Progress report on the establishment of the Africa Centre for Disease Control
- The African Public Health Emergency Fund (APHEF)
- The 2014 Ebola virus disease outbreak: lessons learnt and way forward
- Progress on the implementation of the Health Promotion Strategy for the African Region
- Progress on Strategy for Addressing Key Determinants of Health in the African Region
- Progress on the establishment of the African Medicines Agency.