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Department of Social Affairs

AFRICA HEALTH STRATEGY 2016 – 2030

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II. LIST OF ACRONYMS

AfDB	African Development Bank
Africa CDC	Africa Centres for Diseases Control and Prevention
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
MS	Member States
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
SAPs	Structural Adjustment Programs
SDGs	Sustainable Development World
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	The World Bank Group
WHO	World Health Organization
XDR-TB	Extensively Drug-Resistant Tuberculosis

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IV. EXECUTIVE SUMMARY

In 2007, the African Union developed the first Africa Health Strategy (AHS) 2007 - 2015 endorsed by the 3rd Conference of African Ministers of Health held in the same year and adopted by the 11th Session of the Ordinary Executive Council in 2008. In 2015, the meeting of the 1st 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, the relevant AU health policy instruments and integrating research and innovation for health. The Assessment Report of AHS 2007 - 2015 is attached as an integral part of this document.

The policy framework for AHS 2016 - 2030 is premised on a number of continental and global health policy commitments and instruments. Chief among these are Agenda 2063: The Africa We Want" and 2030 Agenda for Sustainable Development, including its Sustainable Development Goals. Other policy frameworks from which AHS 2016 - 2030 reinforces include the Sexual and Reproductive Health and Rights Continental Policy Framework and its extended Maputo Plan of Action (2016-2030), the Pharmaceutical Manufacturing Plan for Africa (PMPA), African Regional Nutrition Strategy 2015 - 2025 (ARNS), the various AU Abuja commitments, calls, declarations aimed at combatting AIDS, tuberculosis and malaria in Africa, the Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa By 2030 as well as the Global Strategy for Women's, Children's and Adolescent Health 2016 - 2030.

It is important to emphasize that the AHS 2016 - 2030 is an overarching document inspired by other continental and global commitments which it does not seek to replace nor duplicate but is intended to enhance further the commitments reflected in these global and continental instruments. It aims to do so by offering a cohesive and consolidative platform encompassing all such commitments and strategies in the health sector.

AHS 2016 - 2030 provides strategic direction to Africa's Member States in their efforts in creating better performing health sectors, recognizes existing continental commitments and addresses key challenges facing efforts to reduce the continent's burden of disease mainly by drawing on lessons learned and taking advantage of the existing opportunities. Its strategic directions require multi-sectoral collaboration, adequate resources along with leadership to champion its implementation and to ensure effective accountability for its results.

As the primary consolidative document for all African commitments in the health sector, the added value of AHS 2016 - 2030 is its ability to inspire, guide and highlight strategic directions relevant to all Member States. AHS 2016 - 2030 achieves this by its emphasis on addressing issues that reflect upstream strategic roles best suited for the African Union Commission and the Regional Economic Communities (RECs) through which Member States can derive direct benefits such as economies of scale, collaborative

efforts and other advantages.

Technically, the AHS 2016 - 2030 advocates for and promotes Member State action to prioritize and invest in specific social determinants of health through better inter-sectorial collaboration, highlights the central importance of health systems strengthening priorities, calls for better leveraging of community strengths, public private and other partnerships as well as recommending a major paradigm shift that helps Member States more effectively manage the risks of disasters in a more systematic manner.

Towards a vision of an integrated and prosperous Africa free of its heavy burden of disease, disability and premature death, the goal of AHS 2016 - 2030 is to ensure healthy lives and promote the well-being for all in Africa in the context of "Agenda 2063: The Africa We Want" and the Sustainable Development Goals. The overall objective is to strengthen health systems performance, increase investments in health, improve equity and address social determinants of health to reduce priority diseases burden by 2030.

The strategic approaches are drawn from those whose validity and success has been demonstrated in global and continental experience as well as emerging ones whose important is beyond doubt. They include strengthening health systems to sustain the gains in performance; ensuring strong leadership and good governance; forging multi-sectoral partnerships to address the socio-economic and environmental determinants of health; refocusing service delivery and empowering communities; expanding social protection to address equity; prioritizing human resources for health; ensuring commodity security; building the regulatory and support environment for provision of quality medicines and technologies, including to nurture African Traditional Medicine; establishing effective systems for disease surveillance and disaster management, investing in youth and adolescents as well as improving intercountry collaboration to achieve efficiencies.

The AHS 2016-2030 outlines the key policy frameworks, accountability mechanisms as well as the roles and responsibilities in relation to its implementation. Given its nature – a continental instrument aimed at guiding Member States, the latter bear the main responsibility for its implementation. Accordingly, the lead role for coordinating and overseeing the AHS 2016-2030 rests with the Member States, with facilitation, coordination and support by the AU organs, RECs, UN agencies and other partners.

Following the AHS 2016 - 2030's endorsement during the first half of 2016, a comprehensive result-based monitoring and evaluation frame will be developed to support implementation and monitoring of the strategy.

V. INTRODUCTION

Concerned by Africa's increasing disease burden, despite good plans, strategies and progress, the African Union developed the Africa Health Strategy (AHS) 2007 - 2015 endorsed by the 3rd Conference of African Ministers of Health in 2007 and the 11th Session of the Ordinary Executive Council in 2008. The goal of the strategy was 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 had provided strategic direction to Africa's efforts in creating better health for all and had recognized that Africa had previously established health goals in addition to the Millennium Development Goals (MDGs) to which it has 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 enhance human capital by improving health. It highlighted strategic directions that can be helpful if approached in a multi-sectoral and multi-stakeholder fashion, adequately resourced, implemented and monitored.

In April 2015, the 1st Session of the African Union Specialized Technical Committee on Health, Population and Drug Control (STC-HPDC) recommended that the revision of the strategy be predicated upon and informed by the revised AU health policy instruments and that it integrates the research and innovation for health.

Consequent to the decision of the 1st 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 Technical Secretariat conducted 4 meetings since it began its work in in July 2015. Literature review, stakeholder consultations and site visits represented the key methodology used by the Technical Secretariat (please see annex describing the methodology more early).

The AHS 2016 - 2030 is similar to some extent to its predecessor in that it also seeks to provide strategic direction to Africa's efforts in creating better performing health sectors, recognizes existing continental commitments and addresses key challenges to reducing the continent's burden of disease, while also drawing on lessons learned and existing opportunities. Its strategic directions require multi-sectoral collaboration, adequate resources and leadership to champion its implementation coupled with effective accountability frameworks. In this light, the AHS 2016 - 2030 seeks to complete the unfinished agenda, adjust the course based on lessons learned from implementing AHS 2007 - 2015 and build on MS and RECs achievements.

AHS 2016-2030 adds value to Member States' and RECs health sector policy

frameworks and strategies by its emphasis on addressing issues that reflect upstream strategic roles best suited for the African Union Commission and the Regional Economic Communities (RECs) through which Member States can derive direct benefits such as economies of scale, collaborative efforts and other advantages.

Technically, the AHS 2016-2030 helps advocate for the importance of specific health priorities relevant to the continent and its commitments. These include the necessity of investing in health systems strengthening and specific social determinants of health through better inter-sectorial collaboration, drawing on recent African and global lessons learned. Additionally, AHS 2016-2030 calls for vibrant ways of leveraging community involvement and integration, public private and inter-country partnerships as well as recommending a paradigm shift to assist Member States in addressing the effects of public health emergencies in a more systematic and comprehensive manner.

It is hoped that AHS 2016-2030 will create a more comprehensive, actionable and strong yet flexible platform around which Member States, RECs, multilateral agencies, bilateral development agencies and other partners in Africa can converge and align to improve coherence and synergy in improving health in Africa.

VI. BACKGROUND

In addition to the assessment report of the AHS 2007 – 2015, the development of the AHS 2016 – 2030 has been informed by existing continental and global policy frameworks. The Agenda 2063: The Africa We Want" is a particularly important policy framework which outlines the developmental vision for the continent over the coming few decades. Other key part of the policy environment on which AHS 2016-2030 is based include the global Sustainable Development Goals (SDGs); the 2015 Addis Ababa Action Agenda on the Third High Level Conference on Financing for Development; the Global Strategy for Women's, Children's and Adolescent Health 2016-2030; the AU Roadmap; the Catalytic Framework to End AIDS, TB and eliminate Malaria by 2030; the SRHR Continental Policy Framework For Sexual and Reproductive Health and Rights (SRHR) and its Maputo Plan of Action 2016-2030; the Pharmaceutical Manufacturing Plan for Africa; the African Regional Nutrition Strategy 2015 – 2025 and the AU Decade on Traditional Medicines and other policy frameworks. The implementation of the AHS 2016-2030 is thus contingent upon the implementation of these related health sector commitments and frameworks.

Synergy and linkages are ensured in the different sub-strategies and global commitments, particularly in the elements which relate to the health sector. For instance, the synergy is seen between the African Union's Agenda 2063" and its 10-year Plan of Action, as a strategic framework for ensuring a positive socioeconomic transformation in Africa with the resolutions of the General Assembly on the New Partnership for Africa's Development (NEPAD). The Addis Ababa Action Agenda also "reaffirms the importance of supporting the new development framework". Similarly, the targets established in the Global Strategy for Women, Children and Adolescents 2016-2030 are in line with those for Sustainable Development Goal 3 (SDG 3), the Maputo Plan of Action 2016 - 2030 as well as the Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa By 2030.

The NEPAD Agency has contributed to the development of the Strategy for Science, Technology and Innovation for Africa (STISA: 2024), as a continental framework for accelerating Africa's transition to an innovation-led, knowledge-based economy within the overall framework of the AU Agenda 2063. The Strategy which was adopted by Assembly/AU/Dec.520(XXIII)[1] also outlines the need to 'consolidate African initiatives and strategies on accelerated human capital development, science and technology and innovation, with a focus on issues related to Food Security, Built Environment, Water and Energy.

The key areas of strategic convergence in these policy frameworks emphasize the importance of delivering social protection and essential public services for all; scaling up efforts to end hunger and malnutrition; strengthening national health systems to enable achievement of universal health coverage (UHC); improving early warning, risk

[1] Assembly/AU/Dec.520 (XXIII) on Strategy for Science Technology and Innovation in Africa 2024, adopted at the 23rd AU Summit in Malabo in June 2014.

reduction and disaster management capacity; substantially increasing funding for health; addressing health workforce challenges; addressing non-communicable diseases; prioritizing women, children and adolescents; supporting research and development of vaccines, medicines and technologies to address both communicable and non-communicable diseases; expanding access to immunization; taking advantage of trade agreements and enhancing partnerships within and between countries to achieve higher aid effectiveness.

Both the AHS 2007-2015 Assessment Report and the recent reviews of some of Africa's most significant health sector commitments have provided important insights into the situation analysis and the strategic directions for the AHS 2016-2030. Such recent milestones include the Africa Regional Nutrition Strategy (2015-2025), Maputo Plan of Action 2016-2030, the Catalytic Framework to End AIDS, TB and eliminate Malaria by 2030, the Review of the Maputo Plan of Action (2015), the Review of the Abuja Call to Action (April 2015), the 2015 MDG Progress Report for Africa, various specific thematic reviews endorsed by WHO's Regional Committees for the Africa Region as well as key regional and global reviews or strategies commissioned by other partners such as the Health Investment Case for Africa (Harmonization for Health in Africa; 2011), Status Report on Maternal, Newborn & Child Health in Africa (AUC, 2014), Narrowing the gaps to meet the goals (UNICEF, 2010); State of the World Population: The Power of 1.8 Billion: Adolescents, Youth and the Transformation of the future (UNFPA, 2014) among others.

The Ebola epidemic's legacy and its subsequent evaluation by the AU have demonstrated the importance of developing new paradigms in disaster response management in Africa, the urgent need to rebuild and strengthen health security in all countries (particularly those that are fragile or prone to recurrent disasters) and to address the multi-dimensional consequences which disasters can have at local, national, regional, continental and global levels if not properly addressed. The AHS 2016-2030 adopts and promote such a paradigm shift in addressing public health threats from natural and man-made disasters, including through building national, regional and continental capacity to address disasters.

VII. SITUATION ANALYSIS

More detailed analysis of disease burdens and cross-cutting challenges can be found in the Assessment Report for AHS 2007-2015. This section highlights the progress and some of the challenges affecting Africa's health sector performance.

In comparison to other regions of the world, Africa still has the majority of countries with the worst indicators for maternal mortality, infant mortality as well as 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.

However, despite these challenges, Africa south of the Sahara became the first region in the world to have achieved one of the sub-targets of MDG 6 in relation to HIV&AIDS, ahead of the deadline of 31 December 2015 (WHO Press Release, World AIDS Day, 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 (WHO, 2015). Malaria incidence in children aged 2–10 years fell from 26% in 2000 to 14% in 2013, a relative decline of 48%. This drop was more pronounced in regions of stable transmission with a reduction from 35% to 18% for the same period (WHO, 2015). Between the year 2000 and 2015, the estimated number of cases per 1000 persons at risk of malaria declined by 42% in Africa, excluding North Africa (AUC/UNECA/UNDP, 2015). The malaria mortality rate on the continent has declined by 66% during the same period.**Error! Bookmark not defined.** Africa's TB treatment success rate reached 86% in 2013. The TB case detection rate slightly improved at 52% as Africa outpaced other regions in determining the HIV status of all people with TB (WHO, 2015) Multiple-drug resistant tuberculosis (MDR-TB) and extensive drug-resistant tuberculosis (XDR-TB) in Africa threaten to reverse the gains in combating TB and thus a cause of continuous concern. It is hoped that newly-introduced rapid tests for both, TB and HIV as well as strengthening of DOTS implementation can begin to improve this challenging situation.

Africa made some progress in maternal health between 1990 and 2013. 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).

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.Increases in U5MR during this period in some countries of Southern Africa are largely attributed to HIV-related deaths (AUC/UNECA/UNDP, 2015).

Yet the region still faces an urgent need to accelerate progress (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). The neonatal mortality rates in particular is lagging far behind the other child mortality rates and it persistence seems to be affected by constraints including limited access to antenatal post-partum care and Emergency Obstetric and Newborn Care.

The average continental unmet need for modern contraceptives for the period 2006 to 2013 remains high at 26.2%, while the average contraceptive prevalence rate rose only slightly from 24.3% between 1990 and 2005 to 25.9% between 2006 and 2013 (AUC/UNECA/UNDP, 2015). With persistently-high fertility rates and growing numbers of women of child-bearing age, the needs of the resultant growing proportion of children, adolescents and young people are barely addressed, while there is very little recognition of the formidable "demographic dividend" (AUC/UNECA/UNDP, 2015). It is critical that Africa addresses the enormous advantages as well as the high opportunity costs of addressing the health needs for adolescents and young people. The State of the World Population Report ("The Power of 1.8 Billion") highlights how the remaining few decades will see a "bulge" in the adolescent and young people's segment of Africa's population and how critical it is to invest in them in order to support both their rights to health as well as to harness their significant potential in advancing Africa's social stability and economic growth (UNFPA, 2014). Currently, however, they remain amongst the most underserved of Africa's populations, particularly female adolescents and young women.

Twenty five percent of population of Africa (excluding North Africa) has experienced hunger and malnutrition during the period 2011-2013. 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, stunting remains a major problem in Africa due to a number of factors including socio-cultural barriers, chronic poverty, insufficient water, sanitation and hygiene, supply of safe and nutritious food (AUC/UNECA/UNDP, 2015). Only a few African countries have made good progress in improving access to water supply and a lesser number have made some progress in increasing access to sanitation (AUC/UNECA/UNDP, 2015). Although North Africa has made some progress in achieving the MDGs 4, 5 and 6, the higher level economic development in these countries was expected to drive better advances in health. On average, between 2000 and 2015, under-five mortality fell by 37% while infant mortality declined by 36% and maternal mortality was reduced by 51% in North Africa (WHO EMRO, 2015). Mortality from TB and malaria were reduced, but HIV incidence, HIV prevalence and deaths from AIDS have actually increased in some countries of North Africa (UNAIDS, 2014).

According to the 2015 Review of the Abuja Call, a majority of Member States did not allocate sufficient resources for health. Out-of-pocket expenditure on health remains high while social protection systems and health insurance coverage lag behind population expansion. Value for money and returns on investments are not routinely considered when selecting priority interventions, policy priorities or strategic options. For instance, investment is skewed towards urban secondary or tertiary health facilities as opposed to primary care and towards curative care as opposed to prevention. Other

inefficiencies in Africa's health systems can also be found in the low level of leveraging of the private sector potential in innovation, co-financing and expanding coverage of essential interventions.

Although the majority of African countries have put in place policy framework to improve the availability of skilled human resource for health, the health work force suffers from insufficient production, inadequate pre-service training, inappropriate skills-mix, maldistribution, unsatisfactory workplace support, low motivation, weak retention strategies and regulatory frameworks. The poor distribution of health facilities and medical commodity shortages has impacted negatively on the quality of care and subsequently health outcomes. Health sector governance remains challenged by weak transparency and accountability mechanisms as well as by inadequate engagement of stakeholders in policies, strategies and plans development. The weak regulation of the private sector and the quality of medical product stocks has resulted in widespread availability of substandard, counterfeit or fake medications. 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 (CRVS) systems (WHO, 2013). 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.

Climate change and other environmental challenges have aggravated the public health situation of the Africa continent. The effects of climate change on agriculture and food security directly impacts food availability and nutrition, while changing rainfall and temperature patterns have created conducive environments for disease transmission. The effects of climate change have resulted to competition over shrinking resources fueling conflicts which, in turn, have led to further negative effects upon the health of African communities.

During the period 2007 - 2015, several humanitarian crises in Africa have had a negative impact on the capacity of health systems to deliver health services. Natural and man-made disasters such as droughts, floods, famine, communicable disease outbreaks and armed conflicts were significant enough to impact the ability of Member States in addressing the AHS 2007-2015 priorities. Such humanitarian crises resulted in increased death, injuries, disability, malnutrition, disease outbreaks, disruption of the health infrastructure and diversion of the necessary resources and political will needed to address health priorities. Weak implementation of the national core capacities required by the International Health Regulations (IHR 2005) has meant that there was no national capacity to deal with severe public health risks and health-related events until they assumed disaster proportions.

Various opportunities exist which can advance the implementation of AHS 2016-2030. In Africa, the untapped potential of the private sector is enormous and can enable Member States, RECS and the AUC to leverage financial, technological and other inputs to support the health sector. The AUC, NEPAD and a number of RECs have pioneered

excellent initiatives which add value to national efforts of their Member States and serve as models that could be replicated to enhance intra and inter-regional integration and cooperation.

Key lessons learned including the need to acquire a broader thematic spectrum encompassing non-communicable diseases, mental health and environmental health; the central importance of strengthening health systems; importance of achieving equity within and across countries; the intersection of health with sectors such as education; and the recognition that disease outbreaks, disasters and humanitarian crisis are a threat to sustainable development must be factored in this forward looking strategy. These key lessons should be addressed when implementing the AHS 2016- 2030 in order to achieve accelerated results.

VIII. GUIDING PRINCIPLES

In adopting the AHS 2016-2030, the AU and key stakeholders (RECs, CSOs and international development partners) will be guided by the following principles:

- Health is a human right that must be accessible to all
- Health is a developmental input and a result requiring multi-sectoral responses
- Health systems should provide for the continuum of services from conception to old age
- Health is a productive sector; investing in health brings positive economic returns
- Equity is important in accessing health services and addressing the determinants of health
- Effectiveness and efficiency are key in maximizing benefits from available resources
- Evidence is the basis for sound public health policy and practice
- Health systems should provide quality services, be people-centered, community-owned and accountable to all
- Respect for cultural diversity and gender equality is important to overcome access barriers to health
- Prevention is the most cost-effective way to reduce the burden of disease
- Diseases and disasters go beyond borders; cross border cooperation in disaster management and disease control is required.

IX. VISION, MISSION, GOAL, STRATEGIC OBJECTIVES & APPROACHES

The vision, mission, goal and objectives of the AHS (2016-2030) draw upon the existing continental and global commitments, particularly the AU "Agenda 2063: The Africa We Want" and the 2030 Agenda for Sustainable Development, including its Sustainable Development Goals. Annex 4 shows the hierarchy of goals and objectives.

1. Vision and Mission:

The **vision** for AHS 2016-2030 is an integrated, inclusive and prosperous Africa free from its heavy burden of disease, disability and premature death.

The **mission** is to build an effective, African-driven response to reduce the burden of disease through strengthened health systems, scaled-up health interventions, inter-sectoral action and empowered communities.

2. Goal:

Ensure long and healthy lives and promote the well-being for all in Africa in the context of "Agenda 2063: The Africa We Want" and the Sustainable Development Goals.

This goal will be people driven with a particular focus on the most productive segments of society as well as on women, youth, adolescents, children and persons in vulnerable positions[2].

3. Objectives and Strategic Priorities:

a. Overall Objective

To strengthen health systems performance, increase investments in health, improve equity and address social determinants of health to reduce priority disease burdens by 2030.

b. Strategic Objectives

Strategic Objective 1: By 2030, to achieve universal health coverage by fulfilling existing global and continental commitments which strengthen health systems and

[2] The poor, elderly persons, persons with disability, migrants, refugees and internally displaced persons as well as people living with stigmatizing health conditions and with special needs as defined within the national context and policies.

improve social determinants of health in Africa by implementing the following **strategic priorities**:-

- Promoting social protection mechanisms and ensuring access to quality-assured and affordable essential health services including medicines, vaccines, health commodities and technologies;

- Increasing health financing through innovative and sustainable funding mechanisms, public private partnerships, increased allocation of domestic resources, including previous commitments and global solidarity;

- Creating adequate national human resource management frameworks to substantially increase health worker training, recruitment, deployment, regulation, support and retention. It is crucial to address health worker education in Africa as well as to addressing the challenges of health worker education, mobility and migration as a key emerging issue.

- Improving governance, accountability and stewardship of the health sector. This entails strengthening community health systems; information systems, decentralizing service delivery focused on integrated comprehensive primary health care and efficient use of resources;

- Strengthening health research, innovation, ICTs for health, technological capabilities and developing sustainable evidence informed solutions for Africa's health challenges;

- Enhancing emergency health preparedness and response systems and capabilities at national, regional and continental levels;

- Strengthening multi-sectoral collaboration, partnerships and rights based programming to comprehensively address the social determinants of health.

- Strengthening the capacity of ministries of health to regulate and monitor activities of non-state health providers to ensure complementarity with government efforts.

Strategic Objective 2: Reduce morbidity and end preventable mortality from communicable and non-communicable diseases and other health conditions in Africa by implementing the following **strategic priorities**:

- Ending preventable maternal, new born and child deaths and ensure equitable access to comprehensive, integrated sexual, reproductive, maternal, neonatal, child and adolescent services, including voluntary family planning;

- Ending AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases, neglected tropical diseases and other emerging and reemerging communicable diseases;

- Sustaining and scaling up expanded programs on immunization;

- Reducing all forms of malnutrition including stunting among young children and related nutrition objectives as specified in the Africa Regional Nutrition Strategy (2016-2025);

- Prioritizing programs to address risk factors and premature mortality from diabetes, cancer, cardio-vascular diseases, respiratory infections, mental health, injuries and other non-communicable diseases with a particular focus on combatting tobacco use, substance abuse and other risk factors.

4. Strategic Approaches

To achieve the objectives of this strategy, due attention should be given to the following priority strategic approaches:

a. Sustainable improvement in health system performance

Cost-effectively addressing avoidable disease, disability and death in Africa will require a heavy investment to strengthen all health system components, while taking into account important equity considerations to address the most vulnerable and marginalized segments of society. It is also important to incorporate new opportunities offered by advances in technology and to develop and retain human resources.

b. Leadership and good governance

AHS 2016-2030 will only achieve its objectives if there is top level commitment, stewardship, accountability and transparency in the leadership and governance of the health sector. Improved harmonization and alignment is a key element of good governance and establishment of one national plan, one governing framework and one monitoring and evaluation system should be prioritized by Member States. Member States should consider instituting effective decentralization of functions, authority and resources to improve health sector performance. Drawing from the lessons learnt through the NEPAD initiative of monitoring government wide governance, similar approaches will be explored to assess improvements in health sector governance within the framework of this strategy and involve parliaments to ensure action informed by the findings.

c. Health Financing

While it is not the sole requirement for achieving results, sustainable and predictable health sector financing is one of the most crucial pillars of building viable health systems

and an important measure for improving equitable access to health services and reducing poverty. Member States should develop options for sustainable domestic financing of the health sector and increase per capita government health expenditure in line with the Abuja call and WHO commitments. Additionally, risk-pooling (e.g. national health insurance and other pre-paid forms of financing for health services), cross-subsidies, "sin" taxes on tobacco and alcohol and other measures to increase the financial envelope for the health sector should be considered. As health financing is a shared responsibility requiring global solidarity and collective effort, development partners should increase and align their financial and technical assistance with national health priorities. In addition, countries should put in place accountability mechanisms for efficient use of domestic and international resources. Countries should be encouraged to strengthen and operationalize their National health accounts, to ensure that allocations and health expenditures are well monitored.

d. Expanding social protection to address equity

Social protection is an important instrument to achieve universal access to key health and social services, including basic primary health care, education, nutrition and environmental health.

Social protection programs tackle multiple dimensions of poverty and deprivation (decent work, education, health care, food security, income security) and can therefore be powerful tools in the battle against poverty and inequality, vulnerability and poverty.
In the absence of social protection, people, especially the most vulnerable, are subjected to increased risks of sinking below the poverty line or remaining trapped in poverty for generations. All social protection mechanisms should be mobilized, including social health insurance. Fiscally-sustainable social protection schemes based on strong legal and regulatory frameworks should be an integral component of national development strategies to achieve inclusive, equitable sustainable development. Measures for identifying people who may be left behind need to be put in place in a participatory manner. There should be a review of user fees with a view to abolishing them, while ensuring continued quality services, as this is important in social protection.

e. Prioritizing human resources for health

Health sector reforms must ensure there is a human resource management plan and capacity that: promote all aspects of human resources for health development and retention, addressing policies, strategic plans, information, training, recruitment, deployment and retention, administration, working and living conditions and the health of staff. Good performance of all health staff should be rewarded. Expertise in health management should be developed. The establishment of continental/sub regional norms and standards of training and licensing should be instituted. All countries should establish National Health Workforce Observatories. Mechanisms to enhance cooperation and sharing experience among countries should be encouraged. Additionally, a continental mechanism to regulate and better manage intra and extra-continental migration of health workers need to be established.

f. Essential medicines, Commodity Security and Supply Systems

Universal health coverage must be supported with adequate supply of commodities including essential medicines, contraceptives, condoms, vaccines and effective drugs and other supplies. They should be part of the Package of Essential Health Services. Essential medicines and supplies should be exempt from taxes and a special dispensation provided for landlocked countries. Integrated medical commodity procurement and supply systems need to be strengthened to ensure appropriate ordering, storage and distribution. The regulation of medical products and technologies at the continental level should be prioritized to support availability of quality products.

g. Surveillance, Emergency Preparedness and Response

A paradigm shift is needed to establish effective disaster preparedness and response management systems at continental, regional and Member State level. 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 be supported by a strong evidence base generated by country-led research and information systems. Member States and regional economic communities need to formulate, strengthen and periodically review their Surveillance and Emergency Preparedness plans for health disasters as well as natural disasters which have health consequences. Countries should implement fully the International Health Regulations (IHR 2005). The Africa CDC will play a major role in facilitating information sharing and building capacity for enhancing preparedness, alert and response to public health emergencies due to all hazards and threats.

h. Refocusing service delivery and empowering communities

It is crucial to strengthen and invest in disease prevention and in comprehensive, people-centered, integrated delivery of primary health care; while prioritizing equity, quality, cost-effectiveness and efficiency in health service delivery (including by strengthening district and community-based health systems).

i. Multi-sectoral partnerships addressing socio-economic and environmental determinants of health and enabling better health sector performance

Inter-sectoral action for health should engage other ministries, levels of government and non-state actors in a manner that demonstrates broad stewardship by ministries of health towards all actions conducive and necessary for health. (“Whole of Government” and “Health in All Policies” approaches).

j. Health research and innovation

There is need to institutionalize mechanisms for defining, producing and utilizing African research in ways that can transform the health sector as well as the African economy and society as a whole. Achieving health goals and targets requires matched investment in research and innovation in order to improve access to medical technologies and products. Furthermore, data from health research and innovation must be collected and

analyzed to inform policy and decision-making at all levels of the healthcare system. Member States should encourage locally driven and financed research through the empowerment of local research institutions, setting up of innovation hubs and allocation 1% of the national GDP for research and innovative as envisioned in the Science, Technology and Innovation Strategy for Africa 2014 - 2024. Building regional expertise in research should be supported where it offers more returns through strengthening regional research centres, building research networks and sharing results across countries.

In line with the WHO Global Strategy for Traditional & Complimentary Medicine 2014-2023, it is important to strengthen structures supporting and regulating traditional medicine. This could be through analysis of the prevailing systems, involvement of traditional health practitioners and communities and focusing on strengthening the best practices of traditional medicine.

k. Strategic information and evidence

Member States should increase investment in health management information systems including the CRVS systems, strengthened leadership and governance to optimize evidence informed decision making and leverage on the global data revolution initiatives. Data quality assurance mechanisms should also be put in place.

l. Investing in adolescents and youth

Investing in young people is not only more equitable and morally correct but a smart pragmatic economic intervention with a high return on investment. Healthy young people are in a better position to realize their potential and to seize opportunities as they mature and enter the labor force. 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 resulting in greater economic productivity, lower fertility rates, political stability and transmission of achievements to other generations. The “economic miracle” experienced by East Asian economies could become a reality for many countries in Africa if they create conditions for young people to make a safe and healthy transition from adolescence to adulthood, acquire the skills they need to find good jobs and succeed in a dynamic economy, enjoy their rights and realize their full potential. Strategic investments in adolescents and youth will therefore position Africa to reap the demographic dividend.

m. Enhanced multi-country collaboration

Several AHS 2016-2030 interventions can benefit from multi-country collaboration as a cross-cutting strategic approach for achieving higher economies of scale. Examples already exist, such as the EAC and ECOWAS successes in standardizing health worker matriculation and certification requirements, medical commodity regulatory frameworks among others. Illustrative areas that can further benefit most from multi-country collaboration in Africa may include the following:

- Designating existing AU organs as well as other regional health and social research institutions which can help standardize health and vital statistics, research and knowledge gaps which address specific health priorities;
- Harmonization of public health legislation, regulatory and standards setting mechanisms
- Social protection and inter-country reciprocity of health insurance.
- Standardization of health professionals' training, qualification and licensing
- Regulation of medicines and health products
- Mechanisms to gain economies of scale through joint procurement of medicines and medical devices, inspection and monitoring of sub-standard, spurious false, fake and counterfeit medicines.

Another dimension of multi-country collaboration is through the strengthening of **South-South as well as South-North-South** partnerships which support the health sector. Based on past experiences from the codes of conduct which seek to influence recruitment of African health workers by industrialized nations, such partnerships can also help bring the benefits of African diaspora to bear positively on the health sector. This includes utilizing African diaspora technological and financial assets that can be linked to key gaps in health financing, knowledge, technology or service capacity. While return of talent programs have not yet proven to be a panacea for leveraging diaspora skills in the development of their home countries in Africa, some innovative financial and technological advances among African diaspora have succeeded in adding value, including telemedicine, research and development of new drugs and health technologies among others.

n. Applying development effectiveness in implementation of AHS 2016-2030

Based on the conclusions of the Addis Ababa Action Agenda (2015) for development finance, a robust financial implementation tracking mechanisms of the AHS needs to be developed, with emphasis on technical and allocative efficiency, in order to provide Member States with guidance on the utilization of the allocated funds. The AUC financial tracking mechanism should be based on the indicators of financial health sector commitments by Member States and development partners, including the previous Abuja Declarations and the Paris Declaration of allocating 0.7% of GDP by developed countries to development assistance should be highlighted in the Strategy.

X. POLICY CONTEXT, MONITORING, REPORTING AND ACCOUNTABILITY FRAMEWORK

1. Policy Context:

It is important to note that AHS 2016-2030 is an advocacy tool for MS and RECs implementation of the continental frameworks, the AHS 2016-2030 thus serves as a consolidating framework that helps advocate for and monitor all health-relevant continental frameworks already adopted by RECs and Member States.

In light of this, the AHS 2016-2030 synergizes and mutually-reinforces the existing continental policy and strategy frameworks. These include the AU's "Agenda 2063: The Africa We Want", the SRHR Continental Policy Framework and its Maputo Plan of Action 2016-2030, Abuja Commitments and the Catalytic framework to control and end AIDS, TB and malaria in Africa by 2030, the Africa Regional Nutrition Strategy 2015-2025, Pharmaceutical Manufacturing Plan for Africa (PMPA) among others. The AHS 2016-2030 does not add to the management and oversight burden of these other continental instruments, rather, it augments the ability of the partners involved in these commitments to actually fulfill their objectives in enhancing the health sector.

2. Actions and Resources to Strengthen Accountability and Partnerships:

The ultimate accountability chain in achieving the objectives of the AHS 2016-2030 begins with the Member States approval in 2016, while the AUC and RECs provide the added value of coordination, support, facilitation, monitoring and evaluation. Successful implementation of the Africa Health Strategy will take more than defining the role and responsibilities of all stakeholders.

The AUC, RECs, Member States and CSOs in particular will require significant technical and financial assistance from development partners and other regional players in order to fulfill their respective roles in support of AHS 2016-2030

In order to avoid complicating the partnership landscape, it is important to build upon existing mechanisms that help harmonize and align the actions of all actors amongst themselves as well as align the actions of all partners involved in the health sector with the strategic directions contained in the AHS 2016-2030.

3. Monitoring, Reporting and Accountability of AHS 2016-2030:

Monitoring and evaluation of performance of the health system depends on the generation and use of sound data on health system inputs, processes, outputs and outcomes. The health programs must be responding to health problems. Countries must ensure that the data collected is accurate and timely as it will indicate both the

performance of the system as well as the relevance of the programs to health problems. The adequacy of a monitoring and evaluation system may be assessed by the regularity, completeness and quality of reports. Data should be disaggregated by sex, age and geographic location to enable more focused action. Community participation in monitoring health programs should be encouraged. Both, a mid-term evaluation and a final evaluation of AHS 2016-2030 will be conducted to track progress, adjust the course of implementation and bring new insights towards achieving the objectives.

Given the implementation period of AHS 2016-2030 will be 15 years, it is important to have an effective system for its monitoring and evaluation (M&E). To this end, a full Results Monitoring and Evaluation Framework (RMEF) will be developed as an integral part of this strategy. The RMEF will be based on indicators, targets, information collection and reporting and accountability systems which are already in use at the AUC, RECS and MS, and in line with the metrics used by existing key continental and global policy instruments.

Periodic reviews shall be held at the national, regional and continental levels. This will help to share best practices, effectively address obstacles, strengthen partnership and accelerate progress in the implementation of this Health Strategy. Accordingly, evaluation of the AHS 2016-2030 will be undertaken every five years to ensure effective implementation of the strategy. Quality assurance and control mechanisms should be an integral part of the reporting and accountability mechanism. Efforts should be concentrated on the improvement of the vital statistics and civil registration systems, epidemiological surveillance and mortality audits.

The AUC working with NEPAD is putting in place an accountability mechanism at the health sector level, taking advantage of the existing mechanism such as the African Peer Review Mechanism. The mechanism comprises of the evidence generation from the online data base www.africahealthstats.org, independent review of the evidence through platforms such as the MNCH taskforce, AWA experts and the AU statutory meetings where action will be taken and African leaders held accountable for their commitments.

4. Dissemination, Advocacy and Communication Strategy for AHS 2016-2030:

To ensure ownership by Member States and RECs, it is of fundamental importance that this AHS 2016-2030 receive a deliberate effort by the AUC, RECs and Member States to mobilize support around its strategic directions. In light of the fact that it reflects the sum total of all continental and global commitments relevant to the health sector in Africa, a focused set of actions is needed to ensure that it is understood and supported by all Africa's citizens (including those living in the diaspora), media, society, private sector, opinion makers, civil society, international development partners and global development institutions.

The advocacy and communication strategy shall be developed by the AUC and should benefit from the massive momentum generated by CARMMA, Abuja Call and other successful commitments.

The dissemination and mobilization approaches for the Strategy should include, at a minimum, the following channels:

- Print, TV, radio and other media (particularly FM stations which are gaining popularity)

- Online media, including regular updates, key messages and monitoring metrics published and updated regularly on the websites of the AUC, RECs, Member States and partner organizations;

- Social media, including Facebook, Twitter, Flicker and others

- Interactive, online consultations to seek feedback from stakeholders (particularly adolescents and young adults);

- Regular, structured engagement of officials, parliamentarians, sport celebrity, other leading personalities at suitable events including sporting tournaments, town hall meetings, political rallies and informal platforms (traditional theater, music and other gatherings).

The average African citizen should be made aware of their rights, their path towards health-seeking behaviors, the availability of services, responsibility towards their community's health and their ability to contribute towards ideas and actions that advance the domestication of the AHS 2016-2030 in response to national, district/county and community needs..

In developing and implementing this advocacy and communication strategy, the AUC will draw upon its own successes and should be able to rely on the technical and financial support from partners to refine the messages to specific target groups, broadcasting/publicizing the messages, receiving and analyzing citizen feedback and regularly updating the metrics showing progress towards achieving the targets. Such partners would range from the continental advocacy groups, African media enterprises, information and communication technology (ICT) companies, African sports bodies, civil society groups and others operating in Africa.

XI. INSTITUTIONAL ROLES AND RESPONSIBILITIES

Given the nature of AHS 2016-30 - an aspirational continental commitment aimed at guiding Member States, the latter have the main responsibility for its implementation. Accordingly, the lead role for coordinating and overseeing the AHS 2016-2030 rests with the AUC with support from RECs and UN agencies.

The main obligation of development partners and the private sector investors who are keen to support the health sector in Africa is to ensure that their investments in Africa are consistent and harmonized with, both, the AHS 2016-2030 as well as the strategies and plans of Member State recipients of their investments. Civil Society Organizations are key partners in the AHS 2016-2030 expected to play a role in the implementation and review of AHS 2016-30 in collaboration with the AUC, NEPAD Agency, RECs, Member States, and the UN agencies.

The roles and responsibilities outlined below are consistent with those adopted in AHS 2007-2015 as well as the expected roles envisaged for various stakeholders in the SDGs and the “Agenda 2063: The Africa We Want”. The key principle of ownership requires Member States, RECs and the AUC to continue demonstrating strong leadership and commitment towards achieving the aims of AHS 2016-2030, while the principles of partnership reflected in the SDGs and reiterated in other continental policy instruments call on national and international partners to support the lead role of the Member States. The accountability principles also require the RECs and the AUC to hold Member States accountable for the implementation of AHS 2016-2030.

1. The African Union Commission (AUC):

The African Union Commission will disseminate this strategy and among other things, undertake advocacy, resource mobilization and dissemination of best practices at continental level in support of the implementation of this Strategy. The AU Commission shall also support the establishment of a continental accountability mechanism to track the implementation of continental commitments and carry out ongoing advocacy at political levels on strategic health issues jointly affecting member states. There shall also be advocacy for common policy principles across other health related sectors such as finance and economic planning, water and sanitation, social protection, trade, industry, education, environment, etc) to encourage investments to cover critical gaps for common health goods beneficial to social and economic wellbeing of member states. The AUC shall also moderate the analyses of political and economic data to help determine joint interests and positions for member states when participating in global health forums. Harmonization of regulatory and standards setting mechanisms shall also be an area of focus.

2. The NEPAD Agency

The NEPAD Agency shall support technical implementation of the strategy and resource mobilization. Its specific roles will include: (a) mobilizing and directing technical expertise and financial resources to implement agreed regional and national programs and projects; (b) supporting research and knowledge management; and (c) providing technical support to AU Commission's policy processes and activities.

3. Regional Economic Communities (RECs)

RECs will provide technical support to Member States, advocate for increased resources for health systems strengthening, harmonize the implementation of national Action Plans, monitor and report progress, identify and share best practices.

4. Member States

Member States are expected to, adapt and incorporate the key strategic priorities of AHS 2016-2030 into their national health and multi-sectoral policy instruments. They will also put in place strong leadership efforts to ensure that the required advocacy, governance, legislative frameworks and actions including resource mobilization and allocations, governance, including legislative frameworks and actions are implemented in order to demonstrate their ownership of AHS 2016-2030. Member States will undertake monitoring and reporting at country level to the RECs and AU Commission. Member States are also required to ensure good governance, participatory and inclusive approaches required to meaningfully and fully engage communities, CSOs and the private sector. They need to ensure that a conducive environment is in place to implement AHS 2016-2030, including harmonizing and streamlining their own policies, strategies, standards and plans to ensure coherence.

5. Partners

- **International Development Partners**

These include the UN agencies, bilateral and multi-lateral organizations, philanthropic foundations, international partnerships, international and regional financing institutions, and other international organizations. Their main role is to contribute their technical assistance and financial investments in support of AHS 2016-2030. In line with the development cooperation principles, multi-lateral and bi-lateral organizations, international and national civil society organizations and other development partners will align their financial and technical assistance and cooperation plans with national and regional needs and priorities for implementation of AHS 2016-2030.

- **Civil Society Organizations**

These include national and international NGOs, officially-recognized Faith Based Organizations (FBOs), CBOs, trade unions, professional associations, cultural and traditional institutions as well as auxiliary entities such as the National Societies of the Red Cross and Red Crescent Movement, media organizations etc. As key stakeholders,

they should be included and play an active role in the conceptualization, advocacy, mobilization, technical assistance, implementation and oversight in support of AHS 2016-2030.

- **Private Sector**

The private sector includes local and international pharmaceutical and medical equipment and commodities manufacturers and traders/agents, medical laboratory service providers, large companies (local, international or multinational; including insurance, banking/financial services, airlines, construction, agribusiness, utilities, extraction industries, consumer products, ICT technology, heavy industry, other non-health sector actors), small & medium enterprises (formal and informal), partnerships and groups involved in innovative financing for social impact, charitable foundations of companies or individuals, the private health service providers in medical practices, hospitals, clinics and pharmacies, the private health science educational institutions as well as the industrial/business coalitions, chambers of commerce, etc. The private sector will provide innovation, material and co-financing inputs which contribute to the expanded financial, human, infrastructural and technological resource base needed to improve health sector performance in Africa.

The following table indicates broadly the types of roles relevant to each entity in supporting the AHS 2016-2030:

AHS 2016-2030 Roles and Responsibilities

AHS level/ AU Stakeholder Tier	Goal	Objectives & Strategic Priorities	Cross-Cutting Functions
AUC	Maintain AHS relevance to Agenda 2063 & SDGs	Proactively promote AHS with RECs and MS and put in place an accountability mechanism for AHS	Strongly engage with AU organs, mechanisms & agencies to support AHS
RECs	Translate into region-specific goals and policies	Implement regional interventions (e.g. Africa CDC, PMPA	Ensure adequate resource mobilization, coordination and reporting by MS
Member States	Develop national plans which are responsive to country priorities and in support of AHS 2016-2030	Achieve AHS objectives and implement strategic priorities aligned with national ones	Commit domestic and secure externa resources, directly manage AHS implementation, M&E and reporting to AUC.
International Development Partners	Harmonize policies, strategies, plans and resource allocations and align them with AHS	Deliver technical assistance, monitor global trends, evidence, norms and global lessons learned	Assist MS, RECs and AUC in compiling M&E inputs, reporting and comparison with global progress in SDGs and related commitments
Civil Society & Private Sector	Assist AUC, RECs and MS to promote, disseminate and advocate for AHS	Assist in monitoring, reporting and supporting at MS & RECs level	Contribute innovation, implementation resources, technologies and financial resources in support of AHS at RECs and MS level

*(**MS** = Member States; **RECs** = Regional Economic Communities;*
***Africa CDC** = Africa Centers for Disease Control and Prevention*

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XIV. ANNEXES

1. AHS 2007-2015 Document
2. AHS 2007-2015 Assessment Report
3. Methodology
4. Hierarchy of Goals & Objectives

Annex 3: Methodology

The AHS 2007-2015 was due to expire in December 2015 and the 1st AU Specialized Technical Committee on Health, Population & Drug Control (STC-HPDC) recommended that a revised 2016-2030 Africa Health Strategy be developed based on an Assessment of AHS 2007-2015.

An AHS Technical Secretariat (TS) consisting of AUC, NEPAD, UN agencies and National Department of Health of the Republic of South Africa held 4 meetings between July 2015 and March 2016 to develop the assessment terms of reference, recruit an international consultant as well as to review and provide technical inputs into the six drafts of both the assessment and the new AHS 2016-2030 which were developed by the international consultant.

The specific 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.

An assessment of the AHS 2007-2015 was conducted by the AUC to determine the extent to which it influenced Member States and RECs. This was performed under the auspices of a Technical Secretariat led by the AUC's Department of Social Affairs and in collaboration with key partners. Based on the Assessment Report recommendations, policy direction of other continental and global health instruments and in consultation with various stakeholders and guided by the Technical Secretariat, this new Africa Health Strategy 2016 - 2030 was developed.

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).

The main analytical framework upon which the degree of utilization of AHS 2007-2015 was measured was the extent to which MS and RECs health policy frameworks, plans and strategies reflected any of the following seven Strategic Directions of the AHS 2007-2015:

1. Strengthening the **national health systems**; especially HTP, HRH, HIS
2. Creating **multi-sectorial policy linkages & integrated approaches**
3. Improving **national and sub-national governance systems**
4. R**esource mobilization towards more sustainable health financing options**
5. Aid effectiveness through enhanced **harmonization & alignment**
6. Prioritizing **health of women, children, others in need of social protection;**
7. Investing in **research** which strengthens health systems

The methodological constraints and considerations to be kept in mind in reviewing the assessment included the following factors:

a. Time & other constraints precluded the key informant interviews with MS, RECs, donors and other partners

b. Unavailability of specific benchmarks, indicators and targets of the AHS 2007-15

c. A desk review may not accurately determine the extent to which AHS was domesticated by MS nor adequately determine whether or not such domestication led to any changes in the health status of the people

d. The extent to which AHS 2007-2015 had guided MS & RECs in implementing their health policy frameworks is not meant to reflect MS success in tackling 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

Annex 4: Hierarchy of AHS 2016-2030 Goals & Objectives: