A Decade of Transformation 2015–2024:

Improving the Health of the People of Africa

World Health Organization
African Region

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Contents

Foreword

It is an honour to write the foreword for this book, which chronicles the transformation journey of the WHO African Region, under the leadership of Dr Matshidiso Moeti. As her decade-long tenure as Regional Director comes to an end, this publication is a fitting reflection of her extraordinary legacy.

Dr Moeti's appointment in 2015 came at a time of immense challenges and opportunities. The devastating 2014 Ebola outbreak exposed critical gaps in health systems and emergency preparedness across the Region. At the same time, there was growing momentum among Member States and partners to strengthen health systems and accelerate progress towards universal health coverage.

She showed that change is possible, even in the face of immense challenges, and inspired a generation of health leaders to dream bigger and aim higher.

With her characteristic focus, determination and collaborative spirit, Dr Moeti charted a bold course forward. The Transformation Agenda, which she launched at the beginning of her tenure, provided the roadmap for transformative change rooted in accountability, results and values, positioning WHO in the African Region as a credible, trusted partner.

A key pillar of her vision was a more responsive and resilient emergencies programme. This redesign has proven its value, as evidenced by the Region's improved capacity to respond rapidly and efficiently to outbreaks of Ebola, COVID-19, mpox, cholera and other emergencies.

Dr Moeti understood that sustainable change starts with people. Through initiatives like the Pathways to Leadership Programme, she strengthened the leadership capabilities of not only WHO staff, but also leaders in Ministries of Health across the African Region.

Dr Moeti's experience and insights were also invaluable in shaping the Organization's global transformation journey, which foregrounds the principles of accountability, results-driven action and cultural change.

As Dr Moeti concludes her tenure, we celebrate her achievements and recognize her profound impact on public health in Africa and beyond. She showed that change is possible, even in the face of immense challenges, and inspired a generation of health leaders to dream bigger and aim higher.

On behalf of the entire WHO family, I extend my deepest gratitude to Dr Moeti. Her legacy will endure, shaping the future of WHO and the health of people across the African Region.

Dr Tedros Adhanom Ghebreyesus
WHO Director-General

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Abbreviations

AACHRD	African Advisory Committee on Health Research and Development
AAS	African Academy of Sciences
ACT	artemisinin-based combination therapy
ADI	Addis Declaration on Immunization
AfDB	African Development Bank
AFP	acute flaccid paralysis
AFR EDPLN	African Region Emerging Dangerous Pathogens Laboratory Network
Africa CDC	Africa Centres for Disease Control and Prevention
AHFP	Adolescent Health Flagship Programme
AHO	African Health Observatory
AHOP	African Health Observatory – Platform on Health Systems and Policies
AHSBA	Adolescent Health Services Barriers Assessment
AHTP	Africa Health Transformation Programme
AI	artificial intelligence
AMA	African Medicines Agency
AMR	antimicrobial resistance
AMS	antimicrobial surveillance
AMVIRA	Accelerated Malaria Vaccine Initiative Roll-out in Africa
ART	antiretroviral therapy
ARVs	antiretrovirals
ATACH	Alliance for Transformative Action on Climate and Health
AVAREF	African Vaccine Regulatory Forum
AVoHC	African Health Volunteers Corps
AWHC	Africa Women Health Champions
BCPs	business continuity plans
BMGF	Bill & Melinda Gates Foundation
BMS	Breast milk substitutes
CBM	Christian Blind Mission
CFC	Country-focused Coordination
CHE	Current health expenditure
CM NTDs	case management neglected tropical diseases
COP	Conferences of the Parties
CPEA	Cross-programmatic efficiency assessment
CPI	Country Health Emergency Preparedness & IHR
CRB	community-based rehabilitation
CRVS	Civil Registration and Vital Statistics
cVDPV2	circulating variant poliovirus type 2
DHIS2	District Health Information Software, version 2
DR-TB	drug-resistant TB
DTP3	diphtheria–tetanus-pertussis–vaccine third dose
eCHIS	electronic Community Health Information System
EDCTP	European and Developing Countries Clinical Trials Partnership
EIOS	Epidemic Intelligence from Open Sources
EML	Essential Medicines List
EMO	emergency operations
EMP	emergency preparedness
EMR	emergency response
EPG	External Relations, Partnerships and Governing Bodies [Unit]
EPR	Emergency Preparedness and Response [Cluster]
EPR-TAG	Emergency Preparedness & Response Technical Advisory Group
ERF	Emergency Response Framework
ES	environmental surveillance
ESA	East and Southern Africa
ESPEN	Expanded Special Project for Elimination of Neglected Tropical Diseases
EVIPNet	Evidence Informed Policy Network
FENSA	Framework of Engagement with Non-State Actors
FGM	female genital mutilation
Gavi	Gavi, the Vaccine Alliance
GATS	Global Adult Tobacco Survey
GBV/SEA	gender-based violence and sexual exploitation and abuse

GGA	Global Goal on Adaptation
GGHE-D	Domestic general government health expenditure
GIS	Geographic Information System
GISP	Global Initiative to Support Parents
GLASS	Global Antimicrobial Resistance and Use Surveillance System
GLLP	Global Laboratory Leadership Programme
GMC	General Management and Coordination [Cluster]
GROWE	Guidance for Rehabilitation Workforce Evaluation
GPW 12	Twelfth General Programme of Work
GPW 13	Thirteenth General Programme of Work
GS	General Service
GTS	Geospatial tracking systems
HALE	healthy life expectancy
HBHI	High Burden to High Impact
HDC	Health data collaboratives
HiAP	Health in All Policies
HIR	Health Emergency Information and Risk Assessment
HMIS	Health management information system
HNAPs	Health national adaptation plans
HPV	human papillomavirus
HSE	health security and emergencies
iAHO	Integrated African Health Observatory
ICOPE	Integrated care for older people
IDSR	Integrated Disease Surveillance and Response
IHM	infectious hazard management
IHR	International Health Regulations
IMCI	Integrated Management of Childhood Illnesses
IMS	incident management system
INB	Intergovernmental Negotiating Body
INFOSAN	International Food Safety Authorities Network
IPU	Inter-Parliamentary Union
ISTs	Intercountry Support Teams
ITM	Information and Technology Management [Unit]
ITN	Insecticide-treated net
ITU	International Telecommunication Union
JEAP	Joint Emergency Action Plan
JMP	Joint Monitoring Programme
KPIs	key performance indicators
MCATs	Multicountry Assignment Teams
MCV2	measles-containing-vaccine second dose
MDGs	Millennium Development Goals
MDR-TB	Multidrug-resistant TB
mhGAP	Mental Health Gap Action Programme
MHPSS	mental health and psychosocial support
MMR	maternal mortality ratio
MNH	maternal and newborn health
mOPV2	monovalent oral polio vaccine type 2
MOU	memorandum of understanding
mRNA	messenger ribonucleic acid
MTCT	mother-to-child HIV transmission
NAPHS	National Action Plan for Health Security
NAPTC	National Action Plan for Tobacco Control
NCDs	noncommunicable diseases
NHOs	National Health Observatories
NHRS	National Health Research System
NITAGs	National Immunization Technical Advisory Groups
nOPV2	Novel oral polio vaccine type 2
NPO	National Professional Officer
NQPS	National Quality Policies and Strategies
NSA	non-State actor
NTDs	neglected tropical diseases
OBRA	Outbreak Response Assessment Team
OOPS	out-of-pocket spending
ORS	oral rehydration solution
OSL	Operations Support and Logistics
PC-NTDs	neglected tropical diseases amenable to preventive chemotherapy
PFM	public financial management
PHC	primary health care

PHEIC	public health emergency of international concern
PHEOC	public health emergency operations centre
PHIOs	Public Health Intelligence Officer
PLWHIV	People Living with HIV
PrEP	pre-exposure prophylaxis
PRET	Preparedness and Resilience for Emerging Threats
PROSE	Promoting Resilience of Systems for Emergencies
PRSEAH	prevention of sexual exploitation, abuse and harassment
PSE	private sector engagement
RCV	rubella-containing vaccine
RECs	regional economic communities
RDHub	Regional Health Data Hub
R4H	research for health
RGA	Rehabilitation Guide for Action
RIFA	International Francophone Network of Elders
RMNCAH	reproductive, maternal, newborn, child and adolescent health
SDGs	Sustainable Development Goals
SEA	sexual exploitation and abuse
SHF	Sanitation and Hygiene Fund
SIAs	supplementary immunization activities
SIDA	Swedish International Development Agency
SIDS	Small Island Developing States
SLIPTA	Stepwise Laboratory Quality Improvement Process Towards Accreditation
SPAR	State Party Self-Assessment Annual Report
SRHR	sexual and reproductive health and rights
STAR	Strategic Toolkit for Assessing Risks
STEPS	STEPwise approach to surveillance
STIs	sexually-transmitted infections
SURGE	Strengthening and Utilizing Response Groups for Emergencies
TA	Transformation Agenda
TAI	Transformation Agenda Initiatives [Unit]
TASS	Transforming African Surveillance Systems
TB	tuberculosis
TM	traditional medicine
TIBA	Tackling Infections to Benefit Africa
TrACSS	Tracking AMR Country Self-Assessment Survey
UHC	universal health coverage
UNAIDS	Joint United Nations Programme on AIDS
UNECA	UN Economic Commission for Africa
UNFCCC	United Nations Framework Convention on Climate Change
UNFPA	United Nations Population Fund
UNHRD	United Nations Humanitarian Response Depot
UNICEF	United Nations Children's Fund
UNV	United Nations Volunteers
VHF	viral haemorrhagic fever
VPDs	vaccine-preventable diseases
WARN-TB	West and Central African Regional Network for TB control
WASH	water, sanitation and hygiene
WCA	West and Central Africa
WHA	World Health Assembly
WHE	WHO Health Emergencies Programme
WHO FCTC	WHO Framework Convention on Tobacco Control
WHO PEN	WHO Package of Essential Noncommunicable disease interventions for primary health care in low-resource settings
WHO TDR	WHO Special Programme for Research and Training in Tropical Diseases
WHO	World Health Organization
WPV1	Wild poliovirus type 1

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Executive summary

This Legacy Book, reflecting a decade of achievements by the WHO Regional Director, Dr Matshidiso Moeti, and her team at the WHO Secretariat in the African Region between 2015 and 2025, pays tribute to the bold leadership style of the first-ever woman to hold this position on the continent. Unafraid to make decisions and exercise the authority demanded by her position, while willing to consult broadly, Dr Moeti guided the WHO African Region through a barrage of public health crises, not least the Ebola outbreak in West Africa and the COVID-19 pandemic, when the need for a more resilient, responsive and effective WHO in Africa had never been greater.

Transforming the Secretariat

The Transformation Agenda provided the road map for the creative solutions and partnerships that marked the reform strategy, the primary aim of which was to optimally meet the health needs of Member States. From improved technical support through the novel Multicountry Assignment Teams (MCATs), to important strides towards gender parity and concomitant leadership development, the Transformation Agenda put the people of Africa at the centre of change. It has also been a key influence on global WHO transformation efforts, succeeding in repositioning WHO in the African Region as a credible, responsive institution.

During her first 100 days in office, Dr Moeti initiated restructuring efforts and undertook critical actions, including official visits to Ebola-affected countries and mobilizing resources to combat epidemics such as cholera and meningitis. She also promoted stronger partnerships, establishing an Independent Advisory Group to offer strategic policy advice. Furthermore, she improved internal processes related to finance, human resources and procurement, improving WHO's operational efficiency.

Transformation Agenda focus areas:

Pro-results values: Emphasizing accountability, equity and integrity within the Organization.

Smart technical focus: Aligning WHO's efforts with regional priorities and accelerating progress toward epidemic control, the SDGs and UHC.

Responsive strategic operations: Enhancing transparency, efficiency and management capacity, particularly in financial and resource management.

Effective communications and partnerships: Strengthening internal communications and external collaborations with stakeholders.

Notable public health outcomes:

WHO African Region certified free of indigenous wild polio in August 2020.

Improved disease outbreak responses.

Progress towards reducing maternal mortality rates.

Enhanced operational efficiency and cost management, ensuring the effective channelling of resources to country-level operations.

50–50

equal number of men and women in leadership positions in 2016, for the first time in the history of WHO in the African Region

29.9%–36.7%

increase in the percentage of women in professional and higher categories, 2017–2023

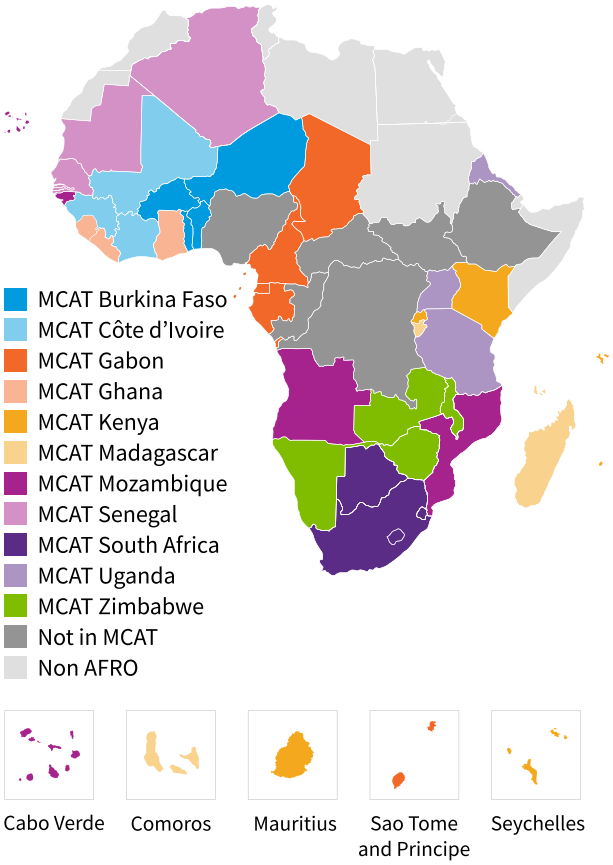
The Africa Health Transformation Programme (2015–2020) was specifically developed to institutionalize the Transformation Agenda. With universal health coverage at its core to ensure access to essential health services for all Africans, this strategic framework also foregrounded the urgency of strengthening health security, through enhanced preparedness for emerging threats, and capacity-building to sustain WHO's role in promoting health outcomes.

The comprehensive transformation of the WHO Secretariat in the African Region focused on building a culture of excellence through organizational reforms, leadership development, improving operational efficiencies, and aligning human resources with national health priorities.

A shift in the internal culture of WHO in the African Region was key, and was achieved by enhancing leadership capabilities and confronting sensitive issues, such as gender equity and harassment. Dr Moeti and senior leaders played a pivotal role in championing this change, exemplifying transparency and teamwork, while empowering staff to embrace new ways of working.

Along with the implementation of the innovative MCATs, which addressed resource constraints through a model that saw technical experts dedicate their skills to a small number of countries simultaneously, interventions to achieve gender parity notably increased the number of women in senior leadership and professional categories. Re-

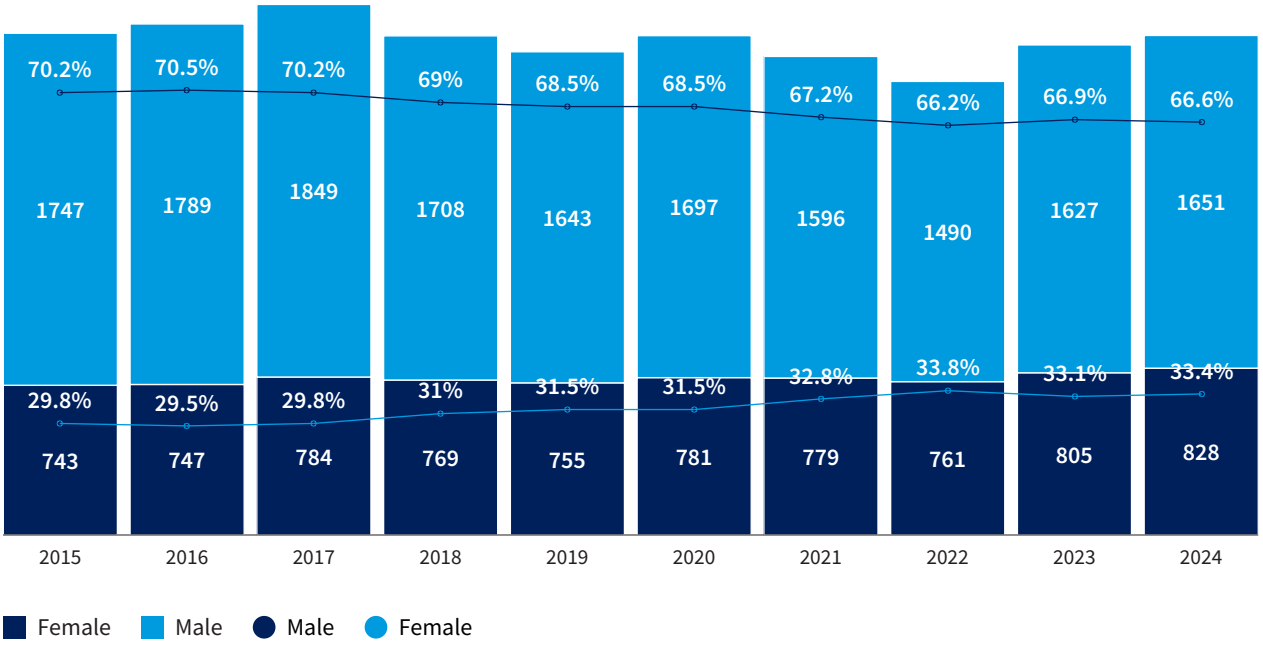
Figure 1: MCAT coverage of country offices in the WHO African Region



MCATS Scope / WCO Coverage

Location	Portfolio	Language
Burkina Faso	Burkina Faso, Niger, Togo, Benin	French
Côte d'Ivoire	Côte d'Ivoire, Guinea, Mali	French
Gabon	Gabon, Chad, Cameroon, Equatorial Guinea	French
Ghana	Ghana, Sierra Leone, Liberia, Gambia	English
Kenya	Kenya, Seychelles, Mauritius, Rwanda	English
Madagascar	Madagascar, Comoros, Burundi	French
Mozambique	Angola, Mozambique, Cabo Verde, Sao Tome and Principe, Guinea-Bissau	Portuguese
Senegal	Senegal, Mauritania, Algeria	French
South Africa	South Africa, Eswatini, Botswana, Lesotho	English
Uganda	Uganda, UR Tanzania, Eritrea	English
Zimbabwe	Zimbabwe, Zambia, Malawi, Namibia	English

Figure 2: Trends in gender balance (women representation) in the WHO African Region, since 2015



90%+

of audit recommendations implemented

45–65

number of recommendations closed, 2016–2021

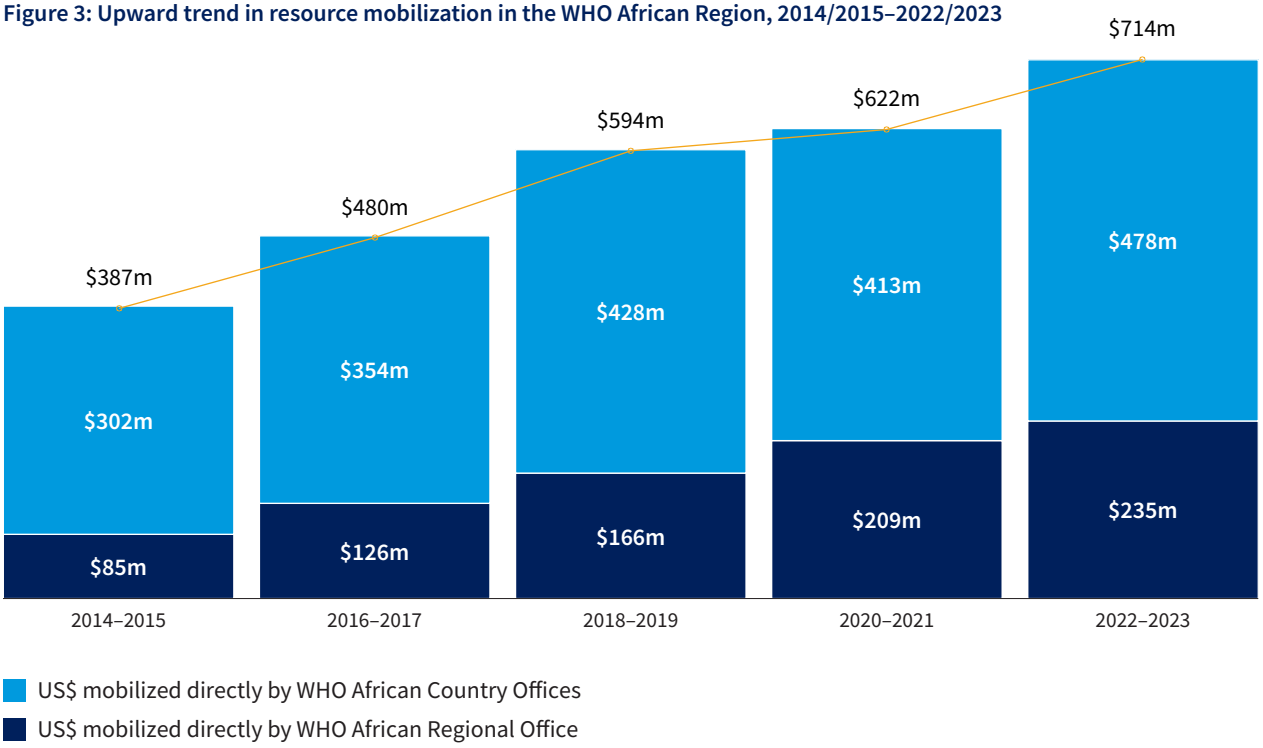
cruitment reforms and programmes like the Women in Leadership Speaker Series created a pathway for women to rise within the Organization.

To enhance operational efficiency, developments such as mobile money transactions revolutionized the way in which public health initiatives were funded, reducing delays and increasing transparency. WHO also embraced digital health platforms to collect real-time data, improving outbreak response, and strengthening national health systems. The COVID-19 pandemic, which cast a long shadow over Dr Moeti's second term, accelerated this shift, with the introduction of virtual meetings, telemedicine and online training programmes to ensure continuity of essential health services.

Governance reforms were aimed at boosting financial oversight and improving compliance, to increase trust with donors and stakeholders. Key measures included implementing new financial management systems and closing a significant number of audit recommendations. Notably, between 2016 and 2021, the number of recommendations closed soared, from 45 to 65. In effect, this meant that over 90% of the recommendations were implemented, signalling a substantial improvement in the Organization's governance structures.

The Transformation Agenda also significantly enhanced health outcomes across Africa through the strengthening of strategic partnerships. Strategies included decentralizing external relations, engaging non-State actors (NSAs), and hosting the Africa Health Forum in Rwanda in 2017 and in Cabo Verde in 2019. These boosted WHO's capacity to mobilize resources and support Member States. In practical terms, the success on this front is evident not only in increased funding, but also improved stakeholder engagement and more resilient health systems, especially during the COVID-19 pandemic.

Figure 3: Upward trend in resource mobilization in the WHO African Region, 2014/2015–2022/2023



46 –55

increase in life expectancy in the WHO African Region, 2000 – 2019

Strengthening health systems towards universal health coverage

One of the continent's biggest success stories, and an especially proud moment for Dr Moeti, was WHO's official announcement in August 2022 that improvements in life expectancy in the African Region had outstripped other regions of the world, increasing by an average 10 years per person in the 19 years to 2019.

While still well below the global 64 years average, the increase provided statistical proof of the transformative progress in key areas of health, including essential health services and infrastructure, gains in reproductive, maternal, newborn and child health, and the fight against infectious and noncommunicable diseases (NCDs).

Expanding access to health services, improving health outcomes and addressing systematic challenges are all key to achieving UHC, and with WHO driving the evolution, the Region notched up a modest increase in the UHC service coverage index, from 23 to 44 out of 100 (2000–2021). To achieve a score of 60 by 2030, securing access to essential services for more than half of Africa's population, will require significant investment in health systems.

Recognizing that the health workforce is key to UHC, WHO supported the increase in capacity to train health workers, achieving a 70% improvement. Between 2018 and 2022, the number of graduates increased from 150 000 to over 255 000 across 39 countries – evidence of governments investing heavily in the establishment and maintenance of over 4000 health training facilities.

The African Region now boasts a record number of health workers, with a threefold increase between 2013 and 2022, from 1.6 million to 5.1 million, including 850 000 community health workers. This growth has directly impacted access to health care services for people on the continent,

1.6m–5.1m

increase in health worker numbers, 2013–2022

72%

of health workers are now women

28%–35%

increase in the proportion of female medical doctors, 2019–2022

11–27

increase in ratio of health professionals per 10 000 population, 2019–2022

with the ratio of health professionals per 10 000 individuals increasing from 11 to 27 (2013–2022).

Gender parity has also improved, with 72% of health workers now being women. The proportion of female medical doctors increased from 28% to 35% between 2019 and 2022. Efforts to address disparities in leadership roles remain a work in progress.

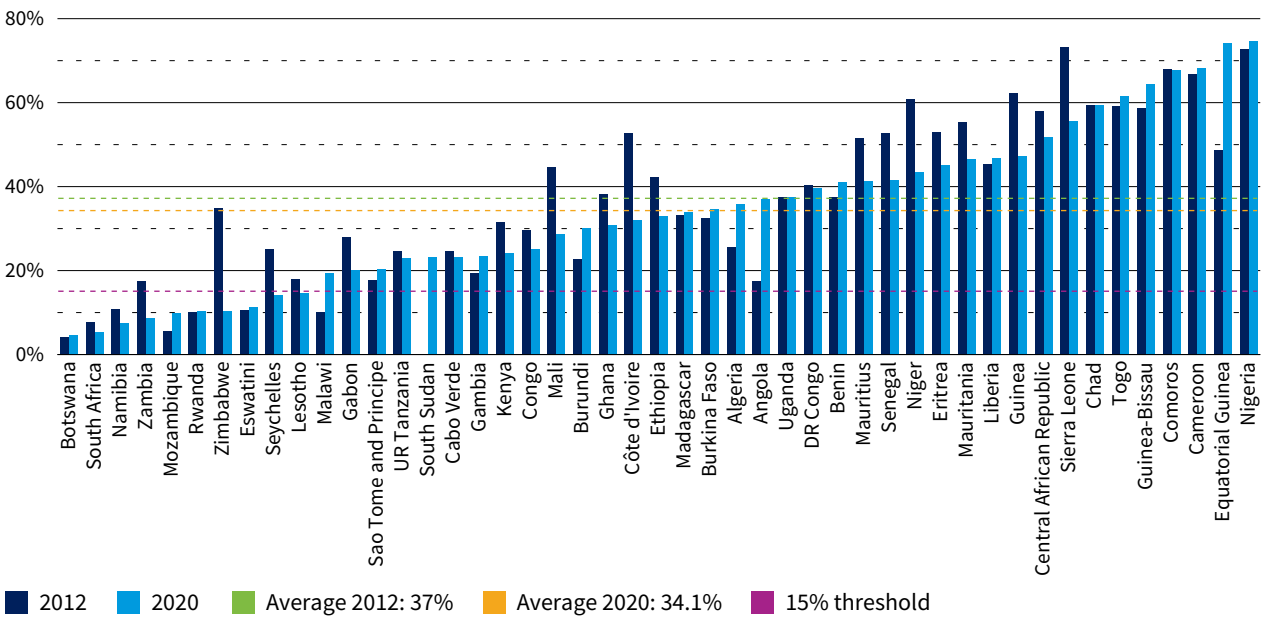
UHC demands that all people have access to the full range of quality health services they need, when and where they need them. Although this remains an ongoing struggle, exacerbated by COVID-19, WHO successfully supported the establishment of national essential medicines lists across all African countries, an important first step in the process. Initiatives such as the African Medicines Agency (AMA) and pooled procurement programmes also enhanced access to affordable health supplies.

Unified regulatory standards for medicines, vaccines and other health care products will be fundamental going forward, along with enhanced coordination among stakeholders, adequate financing, and resilient supply chains. Two gaps where WHO will have a particularly significant future role to play include local manufacturing of medical products and monitoring of regulatory systems to ensure compliance.

To address the threat to UHC posed by antimicrobial resistance (AMR), WHO supported a remarkable increase in the number of countries with related national action plans, from 4% to 100% between 2015 and 2024.

High out-of-pocket health expenditures are still a cause for concern, impoverishing millions of people across Africa. Although the share of this spending has decreased, disparities between countries persist. To help turn the tide, WHO interventions included assisting 32 Member States to enhance their health financing systems

Figure 4: Out-of-pocket expenditure in the WHO African Region



Source: Global health expenditure database

4–36

number of countries with an organized laboratory system, 2015–2023

88%

of countries have a national director/ head of laboratory services

68%

of countries have a national laboratory policy

80%

of countries have a national laboratory strategic plan

through evidence-based strategies, while also providing relevant training to all 47 Member States.

An area in which COVID-19 accelerated rather than impeded progress was diagnostic and laboratory services. Over the past decade, WHO in the African Region has devoted itself to supporting the establishment of laboratory directorates or units under ministries of health, to improve delivery of laboratory services at national level.

Diagnostic services are integral to strengthening disease surveillance and diagnostic capacity, and consequently optimal health care delivery. In 2022, WHO and Africa CDC launched a network of laboratories to reinforce genome sequencing of the COVID-19 virus, and a year later, WHO officially launched its mRNA vaccine technology hub in South Africa.

Between 2015 and 2023, the number of countries with an organized laboratory system increased from four to 36, while 41 of the African Region's 47 Member States (88%) now have a national director/head of laboratory services, with 32 (68%) having a national laboratory policy, and 38 (80%) a national laboratory strategic plan.

As health information systems mature, they become an increasingly valuable tool to advance countries towards UHC, providing a road map for better allocation of resources and expanding the reach of health services. As such, WHO has enhanced health information systems by promoting the use of tools such as the District Health Information Software, version 2 (DHIS2), a free and open-source software platform. Countries using DHIS to collect, report, analyse and disseminate health information doubled between 2015 and 2023, from 21 (45%) to 43 (91%). This notably improved availability and reliability of routine health data, with high-quality routine data now accessible for at least 80% of the crucial health indicators.

With good governance and strong leadership central to achieving UHC and the health-related SDGs, WHO in the African Region has concentrated on supporting Member States to update their national health policies and strategic plans. As of

44%–91%

number of countries collecting, reporting, analysing and disseminating data for crucial health indicators, 2015–2023

5%–40%

countries producing good quality mortality data

38%

decrease in maternal mortality ratio, 2000–2020

54%–74%

increase in skilled birth attendance, 2012–2022

2023, 34 countries had comprehensive and updated national health sector policies or strategic plans, outlining a clear vision, strategic objectives, and relevant actions and investments.

Strengthening health ministry leadership through training, mentorship, capacity-building and on-site support has also been front and centre of support efforts to countries, focused on establishing institutionalized, multistakeholder health sector coordination mechanisms. This combined work has enhanced alignment of national policies with global health priorities, while collaborations with the private sector and multistakeholder partnerships have boosted service delivery and resource mobilization.

To advance research capabilities and support African scientists, WHO partnered with the European and Developing Countries Clinical Trials Partnership (EDCTP), Tackling Infections to Benefit Africa (TIBA), the African Academy of Sciences (AAS) and Africa CDC, among others, to support countries to conduct clinical trials and genomic sequencing, as well as develop COVID-19 countermeasures during the pandemic. Partnerships were also established with academic institutions which, together with frameworks for evidence-based policy-making, have empowered African countries to address local health challenges.

By the end of 2023, WHO had supported the development of national eHealth strategies in 38 African countries, with 18 countries implementing interventions to improve digital health literacy. WHO, in collaboration with the International Telecommunication Union (ITU), had also developed a digital health curriculum, and trained over 200 participants across 47 countries on artificial intelligence.

Improving health and well-being along the life course

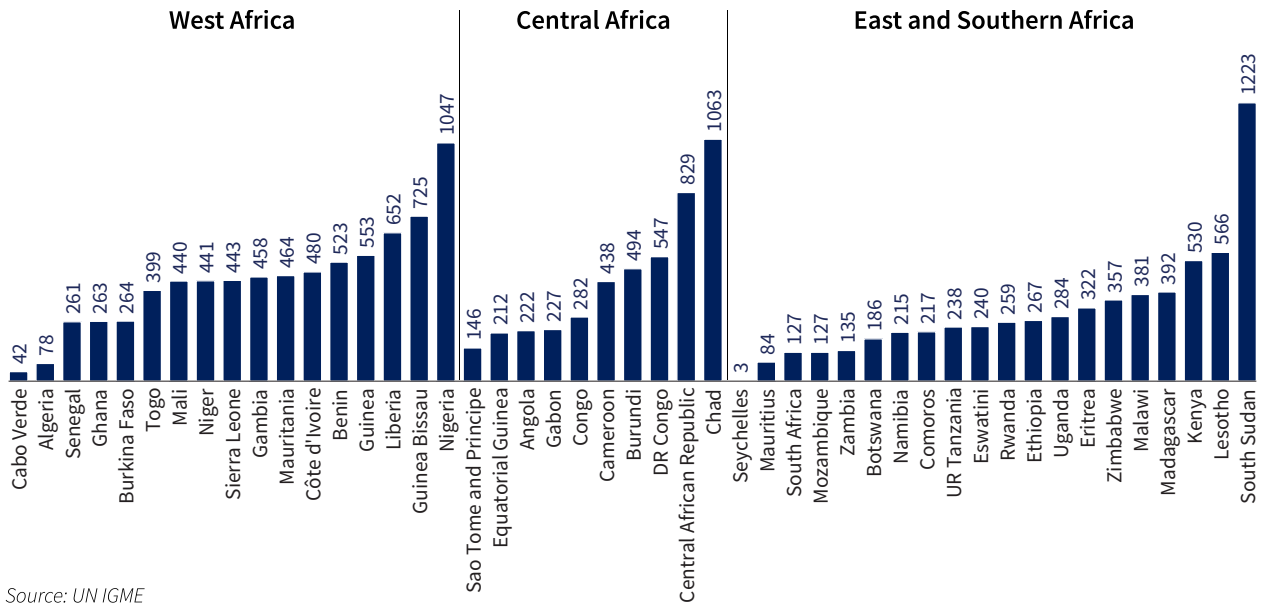
During the era of the MDGs, most countries in the WHO African Region were primarily focused on basic health packages, targeting specific diseases and health challenges through vertical interventions. WHO's life course approach marked a paradigm but essential shift to improve Africa's prospects of realizing the next-generation SDGs, which came into force in 2016.

Integrating health services across all stages of life – infancy, childhood, adolescence, adulthood and old age – the approach aims to ensure continuity, while also comprehensively addressing evolving health needs. Strengthening primary health care (PHC) underpinned the approach, accompanied by promotion of healthy behaviours and improved resilience during crises like the COVID-19 pandemic.

At the start of the Transformation Agenda in 2015, the African Region faced significant challenges in respect of both PHC and reproductive, maternal, newborn, child, and adolescent health (RMNCAH), two critical elements of the life course approach. In response, WHO conducted advocacy, developed policies and strategies, built capacity, disseminated guidelines and provided crucial technical assistance for the implementation of health sector strategic plans, while also mobilizing more than US$ 100 million for this area of work over the past decade.

This progress translated into a 38% decrease in the maternal mortality ratio between 2000 and 2020. Skilled birth attendance rose from 54% to 74% (2012–2022), along with enhanced access to family planning services and modern contraception methods. However, maternal mortality remains disproportionately high in West African countries, necessitating continued investments in the quality of care and health innovations.

Figure 5: Maternal mortality ratio (deaths / 100 000 live births) in the WHO African Region, 2020



Source: UN IGME

53%

reduction in under-five mortality since 2000

Advancing the health and development of every child was a priority for WHO, heightened by the potential of Africa's fast-growing youth population to drive considerable regional growth. With notable successes, including a 53% reduction in under-five mortality since 2000, countries like Malawi, Rwanda, and Sao Tome and Principe have realized reductions of over 75%.

WHO's efforts to revitalize child health strategies have also improved vaccination coverage and early diagnosis of diseases. Yet, countries need to accelerate progress to meet the SDG targets for under-five and neonatal mortality by 2030.

Towards improving the health and well-being of the 250 million adolescents in sub-Saharan Africa, WHO launched the Adolescent Health Flagship Programme, guiding governments to implement evidence-based interventions. Adolescents' access to health services has improved, with 40 countries now implementing strategic plans. However, more effort is required to tackle adolescent pregnancies and early marriages, and improve access to sexual health services.

The rapid growth of the elderly population, with the population of people aged 60 years and older in sub-Saharan Africa expected to triple by 2050, presents new health challenges. WHO has been an important advocate of programmes to enhance the health and well-being of older people, in line with the tenets of the United Nations Decade of Healthy Ageing (2021–2030). Under the Decade of Healthy Ageing programme, WHO assisted countries to combat age-based discrimination, create age-friendly environments, and provide Integrated care for older people (ICOPE).

Through its strategic leadership, multisector collaboration and community engagement, WHO has driven transformative changes in all areas of the life course. However, achieving sustainable progress will require countries to address persistent challenges, ensure gender equity, and embrace digital innovations for tracking health outcomes and improving care delivery.

Advancing efforts to control and eliminate communicable diseases

COVID-19 interrupted much of the real progress made in the African Region towards disease prevention and control, including reductions in the incidence of malaria, tuberculosis, polio, HIV, measles and hepatitis B, as well as the introduction of new vaccines and efforts to increase access to clean water and sanitation.

The adoption of UHC provided the opportunity to shift systems thinking, and WHO reorganized the African Region clusters to catalyse the restoration of services to pre-pandemic levels in the short term, but also to invest in stronger systems with the capacity to withstand future health emergencies.

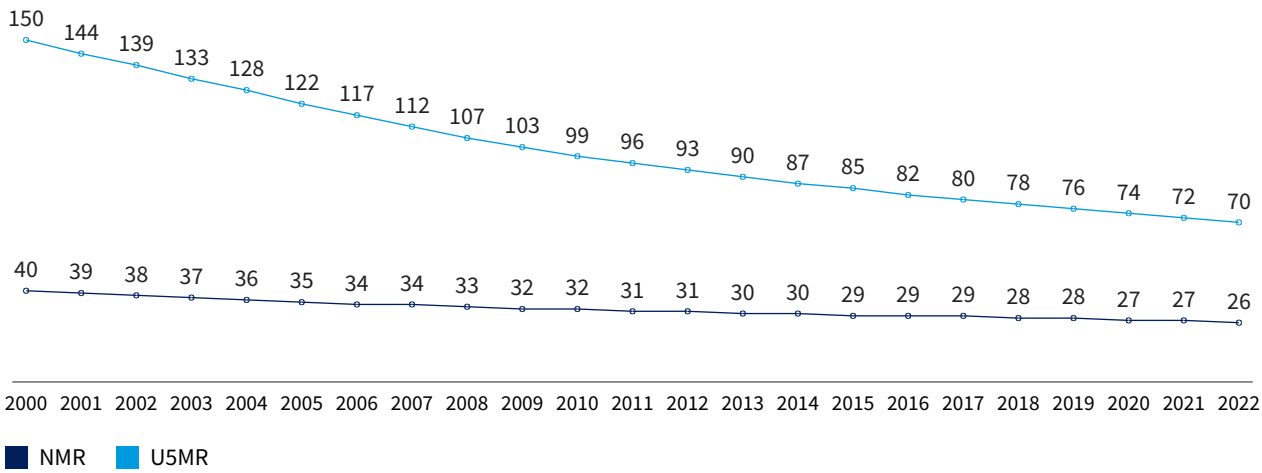
Significant progress was made in tackling communicable diseases through innovative strategies, partnerships and resilience-building efforts. New strategies and guidance to fast-track priority actions were published, encouraging countries to shift their approach from vertical disease control programmes to integrated and cross-cutting approaches.

Malaria control saw significant breakthroughs with the introduction of vaccines like RTS,S and R21, reducing severe malaria by 30% and child deaths by 13% in Ghana, Kenya and Malawi (2019–2024). Countries such as Cabo Verde achieved malaria elimination, demonstrating the impact of vector control programmes and targeted interventions. Yet, malaria remains a challenge in high-burden countries, requiring sustained efforts.

In the fight against neglected tropical diseases (NTDs), Togo became the first country globally to eliminate four NTDs, reflecting the success of WHO's Expanded Special Project for Elimination of NTDs (ESPEN). In addition, 13 countries were officially validated or certified for elimination of at least one NTD as a public health problem (2015–2024). Financing commitments such as the US$ 1.5 billion mobilized at the Kigali Summit in 2022, have reinvigorated efforts towards the 2030 elimination targets, although funding gaps remain.

The African Region has made strides toward HIV control, with seven countries achieving the 95-95-95 targets set by UN-

Figure 6: Trends in under-five and neonatal mortality rates (per 1000 live births) in the WHO African Region



Source: UN IGME

7.3m–6.7m

decrease in zero-dose children, 2022–2023

74%

DTP3 coverage regionally

50m

children vaccinated against polio in five countries

AIDS. The East and Southern African (ESA) subregion has reduced by more than half the number of new HIV infections and AIDS-related deaths (57% and 58% respectively) since 2010. The West and Central African (WCA) subregion has also made notable progress, reducing new HIV infections by 49%, and AIDS-related deaths by 52%. Botswana and Namibia were both recognized for curbing mother-to-child HIV transmission rates, while access to antiretroviral therapy (ART) expanded, raising life expectancy among people living with HIV. However, gaps persist, requiring further investments and policy reforms.

TB control efforts, meanwhile, benefited from increased diagnostic tools and shorter treatment regimens, with TB incidence reduced by 23% between 2015 and 2022. Going forward, persistent challenges include the rise of drug-resistant strains. WHO has promoted integrated TB and HIV services to improve outcomes and ensure holistic care.

For hepatitis, progress remains uneven, with only 18% of newborns receiving the hepatitis B birth dose vaccine. WHO supported the development of national strategic plans (NSPs) for hepatitis, but the regional programme faces significant underfunding, necessitating greater domestic investment and innovative financing mechanisms.

Immunization programmes achieved key milestones, in spite of the disruptions caused by COVID-19. African Vaccination Week in 2023 was marked by the Big Catch-Up campaign, a global push by WHO and partners to reach under-immunized and zero-dose children, and strengthen routine immunization programmes. By the end of that year, for example, DTP3 coverage had increased to 74% regionally, while the number of zero-dose children decreased from 7.3 million to 6.7 million (2022–2023).

Improvements in domestic funding for immunization are supporting the uptick, with more countries covering vaccine costs through government resources. Between 2018 and 2022, the government share of expenditure on vaccines used for routine immunization increased from 35% to 59%, marking a positive trend towards sustainable financing.

The gains have been sustained by WHO's comprehensive approach towards enhancing immunization programmes, strengthening disease surveillance, promoting research and innovation, and collaborating with partners. Assistance to countries took the form of strategic planning and guidance; disease surveillance and monitoring; roll-out of new vaccines; disease-specific interventions; monitoring of immunization coverage; and the establishment and capacitation of laboratory networks.

The importation of wild poliovirus (WPV) from Pakistan into Malawi, notified in January 2022, required a swift response, with over 50 million children vaccinated in five countries, leading to the interruption of transmission in 2024. Vaccine innovation such as the introduction of the novel oral polio vaccine type 2 (nOPV2), the first vaccine to be authorized under the WHO Emergency Use Listing, reflects the Organization's commitment to sustainable immunization efforts.

Other new vaccines included the rubella-containing vaccine (RCV), introduced by 75% of African Region countries, and the measles-containing-vaccine second dose (MCV2), introduced by 91% of countries. Yet, vaccine equity and accessibility remain critical concerns, especially in remote areas.

Despite the persistent challenges, WHO's integrated approach, combined with increased domestic investment and strategic partnerships, provides a pathway for notable progress towards disease elimination and public health security by 2030.

13.5%–9.5%

decrease in tobacco use, 2015–2023

70.6–52.2

per 100 000 population – decline in alcohol-attributable deaths, 2016–2019

22.1%–16%

reduction in physical inactivity, 2016–2022

Tackling noncommunicable diseases and mental health

The rising burden of NCDs and mental health challenges in the African Region, where WHO predicts that NCDs will become the leading cause of death by 2030, required key strategies for prevention, treatment and policy reform, underpinned by integrated health systems.

In 2019, NCDs were responsible for 37% of deaths, driven by risk factors such as tobacco use, harmful alcohol consumption, poor diets and physical inactivity. Despite improvements – there was a modest decline in age-standardized NCD mortality, from 616 to 587 deaths per 100 000 population (2013–2019) – inequities persist. Health systems in many countries remain ill-equipped, while limited access to diagnostic services, medications and preventive care disproportionately affects vulnerable populations.

WHO has actively supported countries to implement public health interventions targeting modifiable risk factors. The adoption of the WHO Framework Convention on Tobacco Control (WHO FCTC) and the MPOWER policy package has driven down tobacco use from 13.5% to 9.5% (2015–2023).

Efforts to reduce the harmful use of alcohol, including the SAFER initiative, are showing progress, with alcohol-attributable deaths declining steadily from 70.6 to 52.2 per 100 000 people (2016–2019). WHO's SHAKE salt reduction strategy and sugar-sweetened beverage taxes have also been implemented across several countries, while the Region has recorded a reduction in physical inactivity from 22.1% to 16% (2016–2022), making it the only region on track to meet the global inactivity reduction target by 2030.

To address limited health care capacity, WHO supported implementation of the Package of Essential Noncommunicable (PEN) Disease Interventions at primary care level, adopted by 34 African countries. Building on that success, the PEN-Plus initiative, launched in 2022, addressed the

growing need for more comprehensive care. Through the initiative, WHO supported countries to reinforce capacity at district hospitals and other first-level referral facilities.

Mental health services, historically underfunded and stigmatized, are gaining momentum. National mental health policies have expanded, with 70% of countries aligning policies with international human rights standards. The Mental Health Gap Action Programme (mhGAP), along with the Quality Rights Initiative, promote integration of mental health into primary care and empower non-specialist health care workers.

Addressing the social determinants of health

To address the critical role of social, economic and environmental determinants in shaping health outcomes in the African Region, WHO emphasized the need for multisectoral collaboration that takes account of factors such as poverty, inequality, education, urbanization and climate change to achieve sustainable health improvements.

While the African Region has seen improvements in living standards, profound social inequalities persist, with vulnerable populations such as people with disabilities facing disproportionate barriers to health care. For example, only 17% to 37% of those who need assistive devices like prosthetics receive them, while life expectancy for people with disabilities is 20 years below the average.

The COVID-19 pandemic, conflicts and natural disasters have uncovered and continue to foreground the fragility of health systems, exposing underlying inequities. To address these challenges, WHO promoted a whole-of-government, whole-of-society approach, aligning efforts across sectors to improve health outcomes and resilience to crises.

Countries like Botswana have implemented the Health in All Policies (HiAP) approach, promoting collaboration across sectors to integrate health considerations into areas like transport and law enforcement. WHO also initiated the Healthy Cities Network, where cities across the continent implemented interventions to prevent NCDs and injuries, including food policies, tobacco control, road safety, safe and active mobility or air quality monitoring. Abidjan and Dakar, for example, designed nutrition standards to reduce excessive salt consumption in public schools, while Freetown sensitized vendors to the dangers of excess salt consumption and trained them to communicate the message to their customers.

The Region faces a double burden of malnutrition, with both undernutrition and rising rates of obesity and diet-related diseases such as diabetes. Despite efforts, food insecurity continues to threaten vulnerable populations, exacerbated by climate change and conflicts. However, WHO-supported initiatives, such as Sierra Leone's exclusive breastfeeding programme, demonstrate the potential for change. Sierra Leone surpassed the 50% breastfeeding target, following sustained efforts driven by community campaigns and legal reforms. In addition, WHO promoted food safety by working with countries to improve hygiene in traditional markets and monitor food contamination risks.

Climate change poses a significant threat to public health in Africa, with extreme weather events, air pollution and water scarcity contributing to health crises across the continent. WHO supported countries to develop health adaptation plans and climate-resilient health systems, with 29 countries committing to build resilient health systems under the COP26 Health Initiative (as of December 2024).

To reduce road traffic accidents, the leading cause of injury-related deaths in Africa, WHO supported Member States

to implement robust, multisectoral and evidence-based road safety interventions that have led to decreases in one third of countries.

Prevention of violence against children is high on WHO's agenda, guided by evidence-based interventions contained in the INSPIRE framework, which was produced by WHO and partners in 2016. The United Republic of Tanzania is leading the Region with comprehensive violence prevention strategies within the health, education and social services systems, while Namibia has a robust policy and legislative framework on the protection of children against violence and abuse, along with a National Plan of Action 2022–2025 to prevent and respond to violence against children.

Gender-based violence and sexual exploitation and abuse (GBV/SEA), meanwhile, remain major threats to public health. WHO supported 20 countries in the Region to implement its guidelines to address these scourges through the RESPECT framework, launched in 2019, which provides guidance to policy-makers in strengthening and scaling up efforts to prevent violence against women.

Improving health security in Africa

Through strategic partnerships, innovative data systems and enhanced logistics, WHO has supported Member States to make significant progress in preparing for and responding to public health emergencies, while strengthening systems for resilience against future crises.

Shouldering the heaviest burden of pub-

50%

improvement in timeliness of outbreak detection

60%

reduction in time required to contain outbreaks

24 hours

to activate incident management teams

lic health crises globally, the Region reports more than 100 outbreaks and emergencies every year, sparked by disease, conflict and natural disasters. Along with Ebola and COVID-19, these include cholera, measles, yellow fever, polio, meningitis and mpox, with vulnerable populations worst impacted, and health care systems severely tested.

The visionary 2016 Framework for Collaboration between WHO and the African Union Commission on the Establishment and Operationalization of the Africa CDC to Improve Health Security in Africa, together with the various iterations of what became the Emergency Preparedness and Response (EPR) Cluster in 2019, which focuses on bolstering the Region's defences against health threats and humanitarian crises, has ultimately changed the way in which the Region responds to epidemics and outbreaks.

EPR's three flagship initiatives announced in 2022: Promoting Resilience of Systems for Emergencies (PROSE); Transforming African Surveillance Systems (TASS); and Strengthening and Utilizing Response Groups for Emergencies (SURGE), have entrenched support to countries to prepare for, detect and respond to public health emergencies.

Reliable data and surveillance systems are essential for tracking diseases and informing rapid responses. EPR's Health Emergency Information and Risk Assessment (HIR) Programme, combined with the new data analytics and innovation centre, The Data Sphere, launched in 2024, prompted significant reductions in the time required to detect outbreaks.

While the Ebola outbreak in 2014 saw over 28 000 cases and over 11 000 deaths, a similar outbreak in the Democratic Republic of the Congo in 2022 was detected in just 29 days. It was brought under control in a remarkably short 37 days, with only one case and one death. Between 2015 and 2023, 17 out of 18 Ebola and Marburg outbreaks were controlled without cross-border spread. Timeliness of outbreak detection saw a 50% improvement, translating into illnesses averted and lives saved, while the overall time to contain outbreaks has reduced by 60%, from 156 to 63 days (2017–2023).

Incident management teams are now activated within 24 hours in over 90% of all graded events, with over 1700 responders receiving emergency response training to help address skills gaps and mount a more robust response.

Major gains have also been made towards incorporating innovations and technology to enhance public health intelligence activities, with the launch of the Epidemic Intelligence from Open Sources (EIOS) platform. EIOS now contributes to the detection of over one third of all public health events in the Region.

Advancements in genomic surveillance were critical during the COVID-19 pandemic, with sequencing capacity expanding from 12 to 42 countries, bolstering the Region's preparedness for future outbreaks. WHO in the African Region and Africa CDC jointly established a genome-sequencing laboratory network for COVID-19 and other emerging pathogens in September 2020.

Beyond increasing national capacities for sequencing, WHO also trained laboratory personnel on using rapid antigen diagnostic tests (Ag-RDTs), supported the establishment of wastewater surveillance for pathogens with epidemic and pandemic potential, and conducted bioinformatics trainings.

Logistical challenges during emergencies, such as delays in delivering supplies during the 2014 Ebola crisis, highlighted the need for improved systems. In response, WHO launched regional emergency hubs in Kenya, Senegal and South Africa (in process), reducing delivery times from 67 to just three days. These hubs, with pre-positioned supplies and efficient stockpiles,

Figure 7: WHO African Region outbound delivery lead-time before and after operationalization of the temporary warehouse at the Kenya regional emergency hub

enable faster responses to crises while reducing dependency on external sources. The hubs also served as training centres for over 3000 emergency responders, enhancing the Region's preparedness and operational efficiency.

WHO also supported the development of risk assessment tools like the Strategic Toolkit for Assessing Risks (STAR), with 31 countries using it to establish comprehensive risk profiles and develop multihazard plans by 2023. Governance improvements, including new partnerships like the one with the Inter-Parliamentary Union, have strengthened legal frameworks for health security across the continent.

Challenges and lessons learnt

With over 100 emergencies occurring annually, including outbreaks of Ebola, COVID-19 and mpox, the Region has navigated numerous crises with limited funding and challenging health infrastructure. However, despite these hurdles, incremental progress in preparedness and response has been achieved, with improved core capacities aligned with the International Health Regulations (IHR, (2005)).

Climate change has exacerbated public health challenges, triggering more natural disasters like floods and droughts, and driving the rise of zoonotic diseases. Countries are adopting digital technologies to anticipate, track and respond to climate-induced health risks, demonstrating how innovation can bridge resource gaps and build resilience.

Chronic underfunding and a shortage of 6.1 million health workers have hampered health outcomes. However, investments in local talent and expanded training programmes have begun to address workforce challenges. Efforts to curb the "brain drain" by creating opportunities for health professionals within their home countries are steadily helping to build more self-reliant health systems.

The COVID-19 pandemic revealed very clearly the Region's dependence on imported medical products and vaccines. However, countries like Ghana, Senegal and South Africa are advancing local vaccine production to strengthen self-sufficiency. In addition, regulatory bodies are receiving support to ensure that locally-produced products meet international standards, reducing vulnerability to global supply disruptions.

While maternal health remains a chal-

lenge, with high mortality rates, innovative digital tools are helping to track pregnancies and prevent complications. The Region is also grappling with the growing burden of NCDs, and countries are promoting public awareness campaigns and integrating NCD care into primary health care to reduce risk factors and improve access.

Collaborations with the African Union, Africa CDC, national governments and private stakeholders have transformed how the Region responds to crises. Regional emergency hubs have reduced response times, ensuring that life-saving supplies reach affected communities more rapidly. Moreover, community engagement has proven essential, fostering trust and cooperation during outbreaks.

Conclusions and future perspectives

While health systems remain fragile, with inequities and limited access to care continuing to pose significant barriers, the progress achieved by the WHO African Region reflects resilience, innovation and adaptability, as is evident from the detailed summary presented above. Through continued investments in the workforce, technology, partnerships and community engagement, progress is being made towards improved health security and equity, moving closer to the goal of UHC by 2030.

The Transformation Agenda drove improvements across key areas such as outbreak detection and response, polio eradication, maternal health and the elimination of NTDs, while organizational reforms fostered a culture of accountability, transparency and partnership. These resulted in increased resource mobilization and more effective donor collaboration.

The COVID-19 pandemic tested the Region's resilience, but lessons from past emergencies enabled WHO and partners to mount an effective response. Improved surveillance, emergency preparedness and collaboration with Member States were instrumental in managing the crisis, demonstrating the importance of investments in health security.

As a committed advocate of the primary health care (PHC) approach, WHO has promoted integrated care, governance, financing and workforce development to support the achievement of UHC. Strengthening health equity by increasing domestic health financing and reducing out-of-pocket payments has been an important focus area to ensure that no one is left behind.

The Transformation Agenda also prioritized the social determinants of health, by seeking multisectoral collaboration on factors such as poverty, education and the environment. Tackling malnutrition, food safety and NCDs has improved health outcomes. However, climate change remains a pressing challenge, disproportionately affecting vulnerable populations and exacerbating public health risks.

Digital technologies are transforming health care delivery in Africa. Artificial intelligence solutions and tools, geospatial surveillance and mobile health applications have enhanced service delivery and public engagement. WHO continues to support Member States to develop national digital health strategies to harness these innovations responsibly, while addressing emerging risks like cybersecurity threats.

Sustaining progress will require ongoing investments in resilient health systems, partnerships and community engagement. WHO must continue to align its efforts with country priorities and the SDGs, focusing on UHC and health equity. The journey towards health security and sustainable development is far from over, but the lessons learnt over the past decade provide a solid foundation for future success.

With strategic planning, innovation and collective action, the African Region is well-positioned to achieve meaningful, lasting improvements in health, ensuring that health becomes a reality for all.

“I wanted everyone to understand that they not only had a right, but also the responsibility to share their views. The danger otherwise is that you miss out on some very good ideas.”

Dr Matshidiso Moeti

My reflections on my decade as Regional Director

On her arrival at the WHO Regional Office for Africa, Dr Matshidiso Moeti was cautioned by a senior colleague that she should rather keep her own counsel, and not muddy the waters of authority. With her deep roots in the Tswana cultural tradition of equity, dialogue and the right to be heard, that simply was not an option. Indeed, Dr Moeti's leadership style, acknowledged as a key element of the success of her decade as Regional Director, reflects a bold leader, unafraid to make decisions and exercise the authority demanded by her position, but who is also willing to listen to everyone, regardless of their job status.

"I was determined to upend the notion that people needed to creep around. I wanted everyone to understand that they not only had a right, but also the responsibility to share their views. The danger otherwise is that you miss out on some very good ideas. So I've worked very hard, through town hall meetings and an open-door policy, to make all staff feel that they are valued, that they can and should contribute, and that they have rights and can speak freely."

As a woman who herself had faced difficult choices as she pursued her medical career, Dr Moeti is frank that gender equity concerns were among the main drivers of her decision to run for the post, and that giving women a voice in the WHO African Region followed naturally as a priority. Public health was, after all, not her first choice; the fact that she had become a mother, and that her home country Botswana had no medical school where she could pursue her first-choice paediatric studies, had set her on a new path.

She jokes now that with her family background of public health – her parents devoted themselves to health care and policy – she had thought: "Oh well, I'll go and do public health." This coincided, however, with the onset of the HIV epidemic, with Botswana the worst affected country

globally at the time. Renowned for leading WHO's "3 by 5" Initiative in Africa at the height of the epidemic, which significantly scaled up access to antiretroviral therapy among people living with HIV, Dr Moeti began collaborating with political leaders and global partners, building her expertise and accomplishments.

"I was very happy to be able to inspire, I hope, my colleagues working with me, and show that this is possible – even if it continues to be a challenge – to achieve gender equity at leadership levels in health, as in all other sectors of development."

"I've had the opportunity to work in the UN at country, regional and global levels. I worked with UNAIDS in Geneva HQ, with UNICEF in a regional office, and worked with WHO at country level as a WHO Representative. I learnt about public health, the politics of health, global health, working at different levels, and I thought it would be a privilege to offer my experience and my skills to lead WHO in the African Region." Frankly she adds; "I also thought it was about time for a woman to do this job".

Dr Moeti believed she could be a role model for other women colleagues, showing it was indeed possible for women professionals, despite the multiple roles they play in families and in societies, to reach such a position, and deliver in the role. "So I was very happy to be able to inspire, I hope, my colleagues working with me, and show that this is possible – even if it continues to be a challenge – to achieve gender equity at leadership levels in health, as in all other sectors of development."

The hard work was just beginning, she quickly found out. African countries had made some progress towards the Millennium Development Goals (MDGs), including increased child vaccination rates and concomitant reductions in child and maternal mortality. Importantly, she attributes the wins that were made to a collective approach, with countries, governments and partners working together towards the shared objective of ultimately

improving health in Africa. The threat of communicable diseases was also becoming increasingly evident, and much more progress was still needed in areas including malaria, HIV and tuberculosis.

She heard loud and clear, from Member States, partners and others, that they wanted a WHO that was more responsive, more accountable for its actions, and more results-focused in terms of how it invested in and did its work.

Nevertheless, it was to be a trial by fire as Dr Moeti took up the job during the Ebola outbreak in West Africa, not least at a time when WHO in the African Region was facing the harsh glare of public scrutiny on its response to that and other disease outbreaks, and public health emergencies. She heard loud and clear, from Member States, partners and others, that they wanted a WHO that was more responsive, more accountable for its actions, and more results-focused in terms of how it invested in and did its work.

"It was a greatly challenging time for us as an Organization, and for me coming in as the leader of WHO in the African Region. But it sparked, in the entire executive management team that I established, the determination to reform the way in which we work in the Region – which gave rise to our Transformation Agenda."

During her first term, the focus was on being more results-oriented and data-driven, planning with Member States and WHO headquarters to identify priorities for action, while also being more proactive, outcomes-focused, and cementing sustainable partnerships. Internally, Dr Moeti knew that the accountability of staff members in terms of resource allocation needed to be enhanced. Donors and partners needed to be able to see value from the money and other assets they entrusted to WHO, ultimately helping Member States to produce better results.

"We established a quite elaborate, intentional programme of monitoring how we manage resources, how we manage staff in WHO, how we deal with accountability. I remember we expanded the compliance team that I found here, introducing a reg-

ular monitoring mechanism to identify countries that were doing well in terms of managing WHO resources, reporting on time to donors. We knew that was an area that needed a huge amount of improvement, and we did manage to improve it. We had, I think as I was coming in, about 1000 or so donor reports that were delayed and late. And now, with the effort and investment that we made following this up at country level, it's only about 30 or 40. So that's been a huge change."

"We had, I think as I was coming in, about 1000 or so donor reports that were delayed and late. And now, with the effort and investment that we made following this up at country level, it's only about 30 or 40. So that's been a huge change."

Equity in access to health care was another major priority area, especially between urban and rural areas in Member States. Although primary health care was generally accepted as the solution, centralization of financing was creating imbalances in the distribution of resources, and by extension, capacity at peripheral levels. A flagship programme to promote decentralization during Dr Moeti's first term, which was consolidated during her second term, saw WHO work with countries to influence the alignment of investments in primary health care, and improve the efficiency of health systems. She says they knew that if they could get medical staff, supplies and equipment to that first level of care, enabling the treatment of people near to their homes, it would significantly boost efficiency at hospitals.

"I think that some of the lessons we learnt during the first term included the fact that very focused vertical approaches are important in making an initial significant impact on a problem. But we have to find ways to combine that work. For example, in protracted humanitarian crises we also have the largest number of unvaccinated children and mothers who die in childbirth and from other health problems. There is an opportunity therefore to make overarching progress if we can continue delivering essential care in such crises."

Changing mindsets about the benefits of domestic investment in health, including health care staff, was another key focus, and WHO in the African Region introduced a programme to advise countries about the smartest, most efficient ways of financing health needs from national resources. An often misunderstood area, fighting entrenched beliefs that investment in health is a bottomless pit without returns, required education and advocacy for increased allocations to health. Human resources for health are a crucial element, and Dr Moeti is proud of the launch in May 2024 of the Health Workforce Investment Charter to counter outmigration from African countries, which sets out rules and principles for investment in human resources.

If Ebola marked the start of Dr Moeti's first term, it was the COVID-19 pandemic that kept her awake at night during her second. Never before had the need for investment in health systems that are resilient to emergencies and disease outbreaks been more evident.

If Ebola marked the start of Dr Moeti's first term, it was the COVID-19 pandemic that kept her awake at night during her second. Never before had the need for investment in health systems that are resilient to emergencies and disease outbreaks been more evident. The biggest fallout that remains is the crisis of unvaccinated children, prevented from accessing routine immunizations due to lockdowns, which is now manifesting itself in big outbreaks of measles across the continent, to cite just one example. Maternal death rates rose, while access to treatment for health problems like HIV, TB and malaria was also negatively impacted.

"The recovery phase that has followed has highlighted the need for primary health care, and the imperative of connecting available resources which would otherwise be invested only in individual diseases. I'm very excited to see some of our countries taking on board and imple-

"A child younger than five who comes for vaccination should also be screened for other childhood illnesses and considered for other vaccinations, with relevant health information shared with parents and caregivers. This will help us to be more efficient in the way that we invest both resources from governments and partners."

menting what is called a people-centred approach to health. This will help ensure we don't miss opportunities when certain people, at whatever stage of life, come into contact with the health system. For example, a child younger than five who comes for vaccination should also be screened for other childhood illnesses and considered for other vaccinations, with relevant health information shared with parents and caregivers. This will help us to be more efficient in the way that we invest both resources from governments and partners."

Dr Moeti describes her second term as one of consolidation, one of the most painful parts of which was the occurrence of incidents of sexual exploitation and abuse during the response to the 10th Ebola outbreak in the Democratic Republic of the Congo. She takes responsibility that they occurred in a Member State of the African Region, and the exploitation of the people WHO was supposed to be serving – women from local communities – remains an unforgettable experience. "But it also left an absolute determination that every one of our staff members needs to be aware of this. We have created channels for staff who observe such behaviour by colleagues to safely report it, to safely indicate that something wrong is happening here, and I'm hoping very much that staff believe in that mechanism, in the safety of the anonymity of that mechanism, and are able to be part of the solution. We've been able to mount a strong response, as WHO, working across levels, sensitizing our staff members very widely about this, and at a certain point in time, there were more and more reports emerging from the African Region. I took that as a positive sign that people feel able, when they see wrongdoing, to use the system to say, 'hey, this needs attention here'."

As for the high points, Dr Moeti says these centre on her travels around the continent, seeing WHO country teams working with national authorities to translate into action some of the strategies the Organization is driving. She recalls one example where the health minister of a country investing at central level in good, specialized hospitals could not accept the fact that a poorer neighbouring country was recording lower maternal death rates, thanks to its primary health care approach. Through data, they were able to illustrate the need for investment not only in specialist care in capital cities, along with the value addition, but also in outcomes and impact from investment at the most local level.

The UNV programme is one she is very excited about, with about 200 UNVs appointed, about 80% of them women. However, Dr Moeti says a lot of work has also been done with leadership at Regional Office and country office levels, investing in seeking out women candidates for positions.

"Then women who are about to deliver will have access to care and follow up near to where they live, including in rural areas. If they are at higher risk, they can be moved nearer to a hospital with facilities to do a Caesarean section. This can be done in an intentional way and the number of maternal deaths will be reduced. What really pleases me is that the WHO Representative and the Minister worked to completely shift the way in which the government was investing in health, and influenced other partners to follow this example, with the data already showing the impact."

She is always also delighted to meet the smart, qualified, flexible, innovative women UN Volunteers, and hear the stories of the difference they are making. Taking


VOLONTAIRES
VOLONTAIRES

pictures with them is one of her biggest pleasures, illustrating that gender equity is not only happening in speeches but evolving in WHO's actions, in partnerships that open the way for volunteers to transition to professional positions. It is something Dr Moeti would like to see grow, with increased support from male leaders who understand that it is not a competition, but rather an example of really leveraging a resource that is desperately needed in WHO systems.

"So, in my view, what needs to change, and a role that I recognize WHO can play, and we have been working on playing progressively, is to be that connector between research, its outputs and rapid policy adoption of new, clever knowledge and tools at the country level."

To her successor, she says the work on gender equity should continue being a focus area, to build on the progress made. The UNV programme is one she is very excited about, with about 200 UNVs appointed, about 80% of them women. However, Dr Moeti says a lot of work has also been done with leadership at Regional Office and country office levels, investing in seeking out women candidates for positions. This required special sessions for women to boost their confidence with trainings, briefings and mentorship to ensure they applied for available posts at all levels.

Her next piece of advice is to focus on the very dramatic upsurge in noncommunicable diseases, which do not have global financing initiatives. "We really need to accelerate the implementation of primary health care and expand the essential package of health services, building on the investments already made and improving the overall capacities of our health systems. We need to understand that people don't only have TB or HIV, but also diabetes, cardiac diseases, hypertension and others. If we expand our essential medicines lists, train people and give them the necessary screening equipment and prevention knowledge, we can address the challenge with a person-centred approach, without the need for a global movement behind them."

The same connections apply equally for communicable diseases, she adds, as in the case of cervical cancer, which is primarily caused by transmission of the human papillomavirus (HPV). "When we are screening women for HIV, when women are coming to HIV clinics for treatment, let's take the opportunity to find out if they might also have HPV. If they do, let's take the opportunity to provide early treatment and cure them of this (completely treatable) cancer, so they don't go on to them die in the way that they are doing now. "Crucially, the risks to health and health systems posed by climate change must also be given the attention they demand, Dr Moeti cautions. "Our Region is home to six of the top 10 worst disaster-affected countries in the world, with heatwaves, floods, cyclones and wildfires affecting the health and livelihoods of millions of people. We have laid a strong foundation for concrete steps that countries can take to address these challenges, but we need to continue to support them to build resilient and sustainable health systems, and make health an integral part of negotiations on climate-change adaptation and mitigation."

Relationships are also key, and need to be built upon, with leaders of Member States and African political leaders, including the African Union. Dr Moeti spent a lot of her time travelling to countries, meeting Heads of State, advocating for investment in health and for priority health problems. "We see the AU investing in its own institutional capacity and several institutions emerging, and I think this is an excellent

thing. This is a way of African political leadership taking ownership, right down to political communities of key institutions that are going to make a change in the health of African people, in partnership with organizations like ourselves and other international partners. We need to continue to invest in those relationships, make sure that we adapt our ways of working, and support and enable these institutions to emerge and collaborate to address Africa's health problems."

Her final piece of advice is in respect of Africa's young population, which Dr Moeti describes as a "massive asset", especially in the fields of technology and innovation. Innovation is extremely important, including investment in research, she says, and young people are full of good ideas about how things could work differently, how technology could be used to expand reach. "I think we can leverage young people's skills with technology and innovation to find solutions for Africa. That requires us, as WHO, to strengthen our connection with young people, to strengthen our association and partnerships with the private sector, because that's where many young people are able to, with a clever idea and innovation, find investment and run that as a business to ultimately improve delivery of services in Africa."

Investment to translate innovation and research into actual services for health in African countries in a priority, she adds. "We are still in a phase where a lot of the research in Africa is funded from outside the continent, with academic institutions and donor organizations funding individual researchers in Africa. So while we very often see great ideas and innovations being developed with the involvement of African scientists, it take a long time for these to actually be adopted by African countries into their ways of working.

"So, in my view, what needs to change, and a role that I recognize WHO can play, and we have been working on playing progressively, is to be that connector between research, its outputs and rapid policy adoption of new, clever knowledge and tools at the country level."

As Dr Moeti takes her leave of WHO after a decade at the helm in Africa, she expresses her gratitude to her husband, children and broader family for their understanding and support. "I have to acknowledge (that work-life balance has) been one of my biggest challenges, really, and I acknowledge that. It just so happens that I came straight into the Ebola outbreak and I had to jump in. As I was coming into my second term, there was the COVID-19 pandemic. In my first term I did manage to exercise regularly, socialize adequately, but I must confess that post-COVID-19, I haven't recovered that. One of the unfortunate aspects of the COVID-19 pandemic is that it's taught us to work 24/7. But I recommend to my successor, for everybody that follows, and for the leadership, that we must pay attention to setting boundaries. It's not an easy thing to learn, I confess."

But she says she will never forget the human connections made with colleagues at all levels within the Organization, and with health actors in Africa and across the globe more broadly. She also acknowledges the opportunities she has had to travel across the African continent, interacting with and learning about its different cultures, improving her French, witnessing countries improve as a result of the support provided, and feeling pride in having a hand in that.

And of course, Dr Moeti loves food "a lot", and her experiences of the rich offerings around the continent have been an unexpected treat.

"I think we can leverage young people's skills with technology and innovation to find solutions for Africa. That requires us, as WHO, to strengthen our connection with young people, to strengthen our association and partnerships with the private sector, because that's where many young people are able to, with a clever idea and innovation, find investment and run that as a business to ultimately improve delivery of services in Africa."

Dr Matshidiso Moeti

Introduction

1

1.1

Brief history of the creation of WHO and health conditions in Africa

It was in 1892, more than a century before the COVID-19 pandemic delivered an indelible reminder that diseases have no respect for physical borders, that fatal cholera outbreaks in Europe precipitated, after several fruitless attempts, the adoption of the International Sanitary Convention for international cooperation in disease prevention and control.[1] The Constitution of the World Health Organization (WHO) would be approved only 54 years later in 1946, after the end of World War ll. Nonetheless, these global attempts to create mechanisms for international cooperation to prevent and control outbreaks of communicable diseases, heralded the recognition of the value of a collaborative global response to preserve health and save lives.

With its headquarters well established in Geneva, six Regional Offices[2] and at least 150 country and other offices around the globe, WHO is mandated to connect nations, partners and people to promote health, keep the world safe, and especially, to serve the vulnerable. Africa, with its especially challenging disease environment due to a combination of virulent tropical diseases and commercial trade from Eurasia through Egypt that introduced pandemic diseases such as the plague, presented a challenge from the start.[3]

When WHO divided its Member States into regions, a central tenet of the Organization's governance and practice, it was

1 https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(02)11244-X.pdf
2 The Regional Office for Africa (AFRO) for the African Region; the Regional Office for the Eastern Mediterranean (EMRO) for the Eastern Mediterranean Region; the Regional Office for South-East Asia (SEARO) for the South-East Asia Region; the Regional Office for the Americas (AMRO) for the Region of the Americas; the Regional Office for the Western Pacific (WPRO) for the Western Pacific Region; and the Regional Office for Europe for the European Region.
3 https://www.aehnetwork.org/wp-content/uploads/2022/04/Health-in-Africa-for-AEHN-Handbook-FINAL-3-May-2022.pdf

within a complicated political landscape, with all but four[4] African countries still having the status of colonies. Rampant malaria and other communicable diseases added a further layer of complexity, driving comparatively high levels of illness and death in Africa. People relied mainly on traditional medicine, although modern health services were being developed in emerging urban areas.

By 2015, life expectancy in Africa increased to 52.3 years, with notable reductions in maternal and under-five mortality rates.

The Regional Office for Africa was the last to be established, holding its maiden Regional Committee session in Geneva in late 1951.[5] In a reflection of the attitudes of the time towards the continent, the first Regional Director for Africa, François Daubenton, is reported to have urged WHO to "promote the participation of 'enlightened Africans' capable of winning the understanding and cooperation of the people".[6] It would be another two years before the WHO Regional Office for Africa was moved to African soil, established in Brazzaville, in what was then French Equatorial Africa (now the Republic of the Congo).

Although the new Regional Office initiated surveys, training programmes for health workers, sanitation projects and studies of infectious diseases such as yellow fever, experts have since suggested that the apparent lack of urgency to address the continent's myriad health challenges set an unfortunate precedent. For example, in 1955 the World Health Assembly decided to exclude Africa from a planned malaria eradication programme, citing bad roads, large rural populations and precarious health systems as impediments to achieving the programme's goals on the continent.

Continuing today, the African continent bears a disproportionate burden of disease globally, exacerbated by severely constrained resources and a complex context for collective decision-making. Together with geographical factors including recurring natural disasters, and poor economic performance, it is a combination that is driving suboptimal health indicators, despite a proud record of achievement, with serious challenges for overall development.

This highlights the importance of the African Union and its emerging health agencies, as well as the Regional Economic Communities (RECs).

By 2006, then Regional Director for Africa, Dr Luis Sambo, was still voicing concern that millions of Africans were dying unnecessarily every year from preventable and treatable diseases, including malaria, HIV and tuberculosis, along with pregnancy-related conditions. Chronic diseases such as hypertension and diabetes were also emerging. The vast majority, he said at the time, had yet to benefit from medical research and public health advances.[7]

Fast forward to 2015, when Dr Matshidiso Moeti took the reins from Dr Sambo, Africa still faced more serious health concerns than other regions of the world, despite many of its countries making significant if highly variable progress towards the achievement of the United Nations Millennium Development Goals (MDGs), designed to boost development efforts.

Notable progress at the time included an

4 Egypt, Ethiopia, Liberia, South Africa.
5 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5055806/
6 World Health Organization. Regional Committee for Africa, Summary of Statement made by Brock Chisholm, 31 July 1952, p 21, Second Session, Monrovia, Regional Committee & Report of the Regional Director 4 August 1952, Third Session, Kampala, Regional Committee, 13 August 1953, p. 24
7 https://www.afro.who.int/sites/default/files/2017-06/african_regional_health_report2006_0.pdf

increase in healthy life expectancy to 52.3 years in 2015, up from 46 years in 2000, a decreased maternal mortality ratio from 830 to 542 per 100 000 live births during the same period, and a marked reduction in the under-five mortality rate.

Ultimately, however, the goals went unrealized, a situation attributed to, among other things, unkept promises of official development assistance by developed countries.[8] The WHO African Region met only a single target – halting and initiating the reverse of the spread of HIV. Even the impressive 49% reduction in maternal mortality by 2013 failed to deliver the 75% MDG target by 2015.[9] Later that year, the MDGs were replaced by the broader and more comprehensive Sustainable Development Goals (SDGs), providing a new framework for health action not only in the African Region, but globally.

To enhance global health and well-being, WHO sets out its strategic priorities every five years. During Dr Moeti's first term, she was guided by the 2014–2019 Twelfth General Programme of Work (GPW 12), aimed at strengthening health systems, promoting universal health coverage (UHC), ensuring global health security, addressing the rising burden of noncommunicable diseases, reducing health disparities, and fostering the development and adoption of innovative health technologies and approaches to enhance health outcomes.

Her subsequent term, meanwhile, coincided with the Thirteenth General Programme of Work, 2019–2025 (GPW 13), focused on achieving the triple billion targets: increasing UHC for one billion more people, enhancing protection from health emergencies for one billion more people, and improving health and well-being for one billion more people.

8 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7122698/

9 The work of WHO in the African Region 2014–2015. Biennial report of the regional director. Brazzaville: World Health Organization Regional Office for Africa; 2015 https://www.afro.who.int/sites/default/files/2018-03/9789290232926.pdf

1.2

Conceptualizing the Transformation Agenda

Dr Moeti knew that if the Region was to have any chance of achieving the SDG health development targets, significant, swift and effective reforms were needed. With weak health systems in Member States and poor health outcomes, evidenced by countries' inability to attain the health-related MDGs, the challenges were, in Dr Moeti's own words, extremely daunting.

The WHO African Region was also responding to the biggest Ebola outbreak in history[10], and struggling to contain outbreaks of wild poliovirus type 1 (WPV1). Increasing negative sentiments related to the Region's overall management, and lack of accountability and compliance with WHO rules, added a further layer to the long list of obstacles.

Dr Moeti's response came in the form of the Transformation Agenda, developed to translate her commitments into concrete action. Its ambitious goal was to accelerate the reform of the WHO Secretariat in the African Region to deliver a more effective, responsive Organization, better prepared to meet the needs of Member States and support the delivery of optimal health care to all Africans, regardless of where they live.

Extensive consultations followed, including with some of the harshest critics of the African Region who were invited by Dr Moeti to participate as she sought to design a road map for reform and set new priorities. The goal was to reignite trust and pride in the Organization. Dr Moeti was adamant that she and her colleagues would never again have to explain poor audit results to WHO regional and global governing bodies.

Restructuring the Secretariat was arguably one of the biggest achievements, but

10 https://www.who.int/emergencies/situations/ebola-outbreak-2014-2016-West-Africa#:~:text=2016%20%2D%20West%20Africa-,Overview,outbreak%20than%20all%20others%20combined

equally critical were improved monitoring, audit performance and resource accountability, and recruitment processes. Achieving buy-in from WHO headquarters, Member States and partners alike was critical, and not without its challenges, but the goal was clear: to transform the WHO Secretariat in the African Region into a forward-looking, proactive, responsive, results-driven, transparent, accountable and appropriately-resourced organization.

"The Transformation Agenda is a vision and a strategy for change aimed at facilitating the emergence of the WHO that the staff and stakeholders want."

Dr Matshidiso Moeti, WHO Regional Director for Africa

Primarily, the road map focused on setting up a robust system for improving the efficiency and accountability of the Secretariat, supported by consistent monitoring of administrative, financial and human resource management. Another critical priority was to provide quality support to Member States in key technical areas, and ultimately, support their progress towards improved health outcomes, with the overarching goal of ensuring universal access to a package of essential health services in all Member States.

This necessitated a significant investment in improving management structures, including the development and introduction of managerial key performance indicators, linked to corrective action to address identified gaps, across the Regional Office and in all country offices. Regional and country office teams had to be strategically repositioned to better respond to, and deliver impactful results for Member States, supported by Multicountry Assignment Teams (MCATs) with the capacity to deliver quality, expert technical support where it was most needed at country level.

Improving gender parity, especially among senior and mid-level staff, was one of the priorities of the Transformation Agenda, underpinned by initiatives such as the United Nations Volunteers Programme (UNV)[11] and the WHO AFRO Pathway to Leadership Programme[12].

"The COVID-19 pandemic has presented a unique opportunity to take stock, adapt and consolidate the Transformation Agenda for sustainable and impactful change. We have arrived at a turning point in our transformation journey in the African Region and are now looking ahead to the Consolidation Phase of the AFRO Transformation Agenda."

Dr Matshidiso Moeti, WHO Regional Director for Africa

Implementation of the Transformation Agenda began in 2015, and was divided into two distinct phases, with Phase 1 (2015–2017) focusing on a change management strategy aimed at, among other things, delivering results at county level and changing the organizational culture. Phase 2 (2018–2020) emphasized the need for a healthy, respectful and fair workplace, while holding people and teams accountable for essential change initiatives. Its value was quickly recognized at headquarters, and two years following its implementation, the WHO Global Transformation Programme was launched, with WHO in the African Region widely regarded as having influenced a number of the initiatives aimed at transforming WHO into a modern international organization.[13]

From 2021, the Transformation Agenda entered its Consolidation Phase, designed to build on the solid foundation of the preceding six years, but notably impacted by the COVID-19 pandemic, which quickly exposed the fragility of health systems on the continent. Its objectives, which included a renewed focus on prioritizing country-level impact, aligned with WHO's global commitment to fortify country offices with essential resources and staff. This strategic approach was to enable WHO to deliver tangible results where they matter most – at country level.

11 https://www.unv.org/
12 https://www.afro.who.int/news/transformation-begins-pathway-leadership
13 https://www.afro.who.int/regional-director/transformation-agenda/journey-map/2021-and-beyond#:~:text=The%20AFRO%20Transformation%20Agenda%20consolidation,a%20reality%20on%20the%20continent

1.3

Scope of the report and target audiences

This legacy document is a collective effort to reflect on the achievements during Dr Moeti's tenure as Regional Director for Africa over the 10 years from 2015 to 2025, in the face of hurdles including high staff turnover, especially in key posts. It is intended to showcase the resourceful and innovative solutions deployed to work with countries and partners to circumvent the challenges and, even when targets were not fully realized, to support African Member States to achieve often astounding health results.

Without the often unsung groundwork that marked the initial phases of the Transformation Agenda, many of the headline-grabbing advances might never have been possible.

This resource is intended to be accessible to a broad range of readers, from government officials and health experts, to WHO staff, students in health-related fields and even members of the general public. It is designed to serve as a record of the changes that were effected, the significant financial and human investment required to do so, and how they contributed to improved overall health in the African Region.

While elements such as regulatory compliance, value for money and technical guidelines for improvements may not be as exciting to readers as breakthroughs like the introduction of the first malaria vaccine or ending the outbreak of wild poliovirus, they represent a significant level of investment in the building blocks that paved the way for critical health outcomes. Without the often unsung groundwork that marked the initial phases of the Transformation Agenda, many of the headline-grabbing advances might never have been possible.

In the next 10 chapters of this book, readers will be treated to unique insights into how WHO in the African Region, under the

leadership of Dr Moeti, initiated the groundbreaking Transformation Agenda, then worked closely with Member States and partners to guide the continent through the challenges posed by the biggest pandemic in modern history, emerging with a proud record of progress towards the attainment of the ultimate goal of UHC. It also details the extent of the work that still lies ahead, and includes some of Dr Moeti's advice to her successor, and current and future WHO staff, about the continent's health priorities going forward.

Chapter 2: Understanding the Transformation Agenda – provides a deep dive into the Transformation Agenda journey from 2015, examining its objectives, focus areas and anticipated results. It highlights key strategic actions taken during Dr Moeti's first 100 days to set the Transformation Agenda in motion, and the subsequent phases, detailing efforts to institutionalize the programme, while also covering various evaluation processes to monitor progress.

Chapter 3: Transforming the Secretariat – examines the steps taken by the Secretariat to operationalize the Transformation Agenda, including restructuring the Organization in the Region, enhancing leadership capabilities, especially at country level, while confronting head-on the challenges of gender equity and a healthier workplace environment free of abuse and harassment.

Chapter 4: Strengthening health systems towards universal health coverage – highlights progress and the way forward in respect of efforts to accelerate progress in countries of the African Region towards UHC. It examines measures of progress through the lens of challenges including workforce shortages; accessibility to essential medicines and other products; high out-of-pocket spending on health; and diagnostic, laboratory, data generation and research constraints, all complicated by the prevailing threat of antimicrobial resistance.

Chapter 5: Improving health across the life course – explores the paradigm shift of the Organization away from a siloed approach to health care, in recognition of the fact that all stages of life are intrinsically connected and so necessitate a collaborative response. It also highlights the focus on advancing women's health in the Region.

Chapter 6: Advancing efforts to control and eliminate communicable diseases – presents details of the response to communicable diseases, to advance the Region towards the achievement of SDG target 3.3. These include initiatives to accelerate technical support to countries to boost pandemic preparedness, as well as disease prevention and control. It also provides a synopsis of the challenges and achievements in respect of diseases including malaria, neglected tropical diseases (NTDs), HIV, TB and hepatitis.

Chapter 7: Tackling noncommunicable diseases and mental health – takes stock of the growing burden of NCDs and the strategies deployed by WHO in the African Region to stem the tide. It includes details of the top four NCD killers impacting African Member States: cardiovascular diseases, cancers, diabetes and chronic respiratory diseases, and discusses the urgent need for improved prevention measures to target their modifiable risk factors. Mental health challenges are all addressed here, especially the urgent need for all countries to have standalone mental health policies or plans to guide mental health activities and tackle this key area of health.

Chapter 8: Addressing the social determinants of health – investigates the non-medical factors that influence health outcomes, such as the conditions into which people are born, and in which they grow, work, live and age. These contribute significantly to health inequities, and the state of people's well-being. This chapter therefore details the focus that WHO has given to empowering communities, addressing the double burden of malnutrition and ensuring food safety, and tackling the related environmental risk factors, while helping countries to proactively adapt to climate change.

Chapter 9: Improving health security in Africa – focuses on the crucial imperatives of managing health emergencies, while concurrently supporting countries to create more resilient health care systems with the capacity to withstand and mitigate future crises. It examines the major gains over the past decade, achieved through interventions including enhanced public health intelligence, genomic sequencing capacity, addressing bottlenecks in supply chains, and developing a skilled emergency health workforce.

The final two chapters, **Chapter 10** and **Chapter 11**, address the challenges and lessons learnt, and provide the conclusion and the way forward, respectively.

Understanding the Transformation Agenda

2

2.1

The Transformation Agenda

"I have carefully examined our deliberations in this assembly, examined the scientific literature and information coming through our Country Cooperation Strategies. I have identified five interrelated and overlapping priorities. They are: (i) improving health security; (ii) strengthening national health systems; (iii) sustaining focus on the health-related MDGs/SDGs; (iv) addressing the social determinants of health; and (v) transforming the African Region into a responsive and results-driven Organization. These are the priorities I commit myself to and would like to be held accountable for throughout my tenure as the WHO Regional Director for Africa."

Dr Matshidiso Moeti, WHO Regional Director for Africa

It was with these powerful commitments that Dr Moeti, of the Republic of Botswana, accepted her appointment as WHO Regional Director for Africa, before the WHO Regional Committee for Africa, the Organization's decision-making body in the African Region, at its Sixty-fourth session in November 2014 in Cotonou, Benin. She reiterated that pledge during her induction speech at the 136th session of the WHO Executive Board in Geneva, Switzerland, in January 2015[14], laying the foundation for her groundbreaking Transformation Agenda.

With the imperative to speed up the WHO reform programme in the African Region, given the international community's disquiet with the Organization's response to the 2014 Ebola virus disease epidemic in West Africa, the burden on Dr Moeti when she officially took office on 1 February 2015 was an onerous one.

Member States and regional and global stakeholders expected her to deliver a new and better way of doing business for the Organization in the African Region, implementing the WHO global reforms[15] initiated in 2012 to make the Organization fit for purpose and better equipped to address the increasingly complex health challenges of the 21st century. The three components of the reforms were programmatic (to improve people's health), governance-related (to increase coherence in global health) and managerial (in pursuit of organizational excellence). Member States and stakeholders

14 Acceptance speech by Dr Matshidiso Rebecca Moeti, WHO Regional Director for Africa, at the 136th Session of the WHO Executive Board Geneva – January 2015; URL: https://www.afro.who.int/regional-director/speeches-messages/acceptance-speech-dr-matshidiso-rebecca-moeti-who-regional

15 World Health Assembly Resolution on WHO Reform (WHA65/9); URL: http://apps.who.int/gb/ebwha/pdf_files/WHA65-REC1/A65_REC1-en.pdf#page=25

wanted to see an appropriately resourced and equipped WHO that could strengthen national health systems, effectively manage and control disease prevention and outbreak preparedness and response, while launching supranational actions in support of global health security.

Dr Moeti's response was the Transformation Agenda of the WHO Secretariat in the African Region 2015–2020[16], the product of an inclusive process comprising wide-ranging consultations, driven by a Transition Team and other stakeholders,[17] tasked with bringing to life her vision for positive change. As a programme for accelerating implementation of WHO reform in the African Region, it was the first step towards "the WHO that the staff and stakeholders want"[18] – foresighted, proactive, responsive, results-driven, transparent, accountable, appropriately-resourced, equipped to deliver on its mandate, and an organization that meets the needs and expectations of its stakeholders.

16 The Transformation Agenda of the World Health Secretariat in the African Region; 2015-2020; ISBN: 978-929023282-7 (NLM Classification: WA 541.1) URL: https://www.afro.who.int/sites/default/files/pdf/generic/Transformation_agenda_english.pdf

17 The Transition Team: WHO staff members in the African Region; members of the diplomatic corps accredited to the Republic of Congo; ministers of health and senior health policy-makers from Member States.

18 The Transition Team had defined "The WHO/AFRO We Want" as a WHO Secretariat in the African Region, where staff members are fully qualified, technically competent, supported and responsive to the needs of Member States; one that is proactive in identifying the needs of Member States and guiding countries and partners on the right things to do; one that is less bureaucratic, more open and transparent and responds to country and stakeholder needs in a timely manner; one that is innovative – an organization that encourages new ideas and supports their validation and adoption; and one that embraces an entrepreneurial culture characterized by responsiveness, opportunism, proactivity, and excellence.

2.2

Objective, focus areas and expected results

With its four focus areas – pro-results values, smart technical focus, responsive strategic operations and effective communications and partnerships – and clear objectives and expected results (Table 1), the Transformation Agenda for the period 1 February 2015 to 31 January 2020 was a road map to guide the evolution of the WHO Secretariat in the African Region during Dr Moeti's first term as Regional Director. The objective was to see the Organization fulfil its potential as Africa's principal health development leader, and assume its role as the reliable and effective protector of health in Africa.

To achieve the expected results, strategic actions were defined for three separate timeframes – actions to commence within the first 100 days; strategic actions for the first two years (deadline, January 2017); and actions that would continue into the latter years of Dr Moeti's term, up to January 2020. Given that accountability was the core thrust of the Transformation Agenda, a Performance Monitoring and Evaluation Framework was also developed.

Table 1: Focus areas and objectives of the Transformation Agenda

Focus area	Objectives	Expected results
Pro-results values	Foster the emergence of an organizational culture that is defined by the values of excellence, teamwork, accountability, integrity, equity, innovation and openness.	• Enhanced accountability by individuals and teams. • Improved fairness in rewards. • Recognition and sanctions for staff members. • Responsive, supportive and inclusive teams. • Enhanced ethical standards for staff.
Smart technical focus	Ensure that the technical areas of WHO's work in the African Region are aligned with regional priorities and commitments, and that interventions are based on evidence, innovations and lessons learnt from experience.	• Ebola virus disease epidemic controlled. • Strengthened regional capacity for health security, including effective preparedness and timely response to disease outbreaks and emergencies, and polio eradication. • Accelerated progress on Millennium Development Goals (MDGs) and implementation of Sustainable Development Goals (SDGs). • Functional cross-cutting systems approach within the WHO African Region, facilitating progress towards universal health coverage (UHC). • Enhanced knowledge management.
Responsive strategic operations	Evolve into an organization with enabling functions that efficiently support the delivery of programmes, goods and services.	• Human, financial and material resources aligned with the identified priorities. • Strengthened WHO human resource capacity. • Enhanced transparency in recruitment, placement and performance management. • Improved efficiency and accountability in the areas of finance, procurement and general management. • Improved leveraging and use of available technologies and tools, especially the Global Management System (GSM) and Business Intelligence dashboards.
Effective communications and partnerships	Foster a more responsive and interactive organization, internally among staff members and externally with stakeholders.	• Enhanced internal communication between and across all the three levels of the Organization. • Reinforced external communication. • Strengthened strategic partnerships.


Safety Box
BIOHAZARD

2.3

Key strategic actions initiated by the Regional Director during the first 100 days

"I am confident that the changes we have initiated and our commitment to working in a more responsive, results-focused and accountable manner with Member States and partners will go a long way in improving our effectiveness. We are determined to help accelerate the building of resilient health systems that prevent and manage disease, assure health security and improve the health and well-being of the people in the WHO African Region."

Dr Matshidiso Moeti, WHO Regional Director for Africa

The Regional Director hit the ground running, with a focus on five priority areas that set the course for her first five-year term. These were: improving health security; strengthening national health systems; sustaining focus on the health-related MDGs; addressing the social determinants of health; and transforming the Regional Office for Africa into a responsive and results-driven organization.

To strengthen partnerships, Dr Moeti reached out to several key partners to share her vision for health development, successfully reaching agreements with them on clear collaborative mechanisms. She also constituted an Independent Advisory Group of high-profile experts, selected for their personal experience, professional backgrounds, gender, geographical origins, and international standing and affiliations. This was to ensure that she was receiving the best possible strategic and policy advice to address the African Region's health priorities.

In addition, she initiated a project to improve existing business processes, including financial and human resource management, as well as procurement and definition of the staff complement necessary to optimally conduct WHO's work in the Region, particularly the implementation of various models of service delivery to increase efficiency and cost-effectiveness.

Some of the key achievements during this period included:

Restructuring of the Regional Office* to better address the prevailing health priorities, and to set a clear future direction and course.

Lobbying for and mobilizing international support to:

- Build resilient health systems in the wake of Ebola.
- Help halt cholera epidemics in countries such as Malawi, Mozambique and the United Republic of Tanzania.
- Help end a meningitis epidemic in Niger, including mobilizing, with key partners, 880 000 doses of meningitis tetravalent vaccine, leading to a significant decrease in related fatalities.

Spearheading efforts towards the establishment of a new entity for neglected tropical diseases (NTDs), which later became known as the Expanded Special Project for Elimination of Neglected Tropical Diseases (ESPEN), and which came into effect in January 2016.

* The Health Security and Emergencies Cluster was set up to merge with the then existing Outbreak Response, International Health Regulations, and Disaster and Emergency Response programmes; The Noncommunicable Diseases Cluster was set up to address the emerging threat of NCDs and their risk factors, as well as mental health, violence and injuries; The Communicable Diseases (CDS) Cluster was set up to focus on key priorities in the African Region such as HIV, TB, malaria, NTDs, and public health and the environment; the Family and Reproductive Health (FRH) Cluster was put in place to focus on health throughout the life course, nutrition and immunization; the General Management and Coordination (GMC) Cluster was established to help the Region ensure better compliance and financial accountability in all its work; the Health Systems and Services (HSS) Cluster was to focus on health policy development, financing and access, integrated service delivery, and health information and knowledge management. Essentially, HSS was to contribute to the realization of UHC in the Region. A new Polio Eradication Programme was established in the Office of the Regional Director, while a new Unit for Health Promotion and Social and Economic Determinants was set up in the office of the Director for Programme Management, given the cross-cutting nature of this function.

2.4

Institutionalizing the Transformation Agenda – The Africa Health Transformation Programme

The year 2015 was a busy one, with the first year of implementation of the Transformation Agenda coinciding with planning and preparation for the WHO Programme budget 2016–2017.[19] It was also the year of the adoption of the 17 Sustainable Development Goals (SDGs)[20] and the 169 targets to guide global development over the 15 years to 2030, notably Goal 3 to "ensure healthy lives and promote well-being for all at all ages". These, together with the lessons learnt during the first 100 days[21], set the stage for the next step in the Transformation Agenda process; development of the Africa Health Transformation Programme.

The Africa Health Transformation Programme 2015–2020: a vision for universal health coverage[22], anchored on the Transformation Agenda priorities, was a strategic framework to guide WHO's contribution to sustainable development in Africa. Established to operationalize the Transformation Agenda, its overarching goal was to ensure universal access to a package of essential health services for all in the African Region, accelerating progress towards UHC, with minimal financial, geographical and social impediments to health services.

Its three strategic priority focus areas included improving health security by tackling epidemic-prone diseases, emergencies and new health threats; driving progress towards equity and UHC; and strengthening the capacity of WHO in the African Region.

19 Twelfth General Programme of Work (2014–2019): https://www.int/about/resources_planning/twelth-gpw/en
20 https://sdgs.un.org/goals
21 The need to strengthen health security in the Region; for countries to build robust national health systems that are adequately financed, staffed, resilient to health threats and accessible to all; to rethink and pursue fundraising for the African Public Health Emergency Fund to urgently generate investment; and to deepen community dialogue.
22 The Africa Health Transformation Programme 2015–2020: A Vision for Universal Health Coverage: ISBN: 978-929 023 302.2 (NLM Classification: WA 541 HA1); (https://www.afro.who.int/sites/default/files/2017-06/full%20repoty.pdf)

These were, in turn, linked to the six categories of work of the WHO Twelfth General Programme of Work (GPW 12) – communicable diseases; NCDs; promoting health through the life course; health systems; preparedness, surveillance and response; and corporate services and enabling functions. The Programme also articulated key deliverables for Dr Moeti's five-year term to January 2020.

2.5

Evaluation of Phase 1 of the Transformation Agenda

Within only two years of its implementation, an independent mid-term evaluation[23] (2015 to February 2017) of the Transformation Agenda revealed that a list of key deliverables had already been achieved.

The evaluation also acknowledged progress in the human resource component of the Transformation Agenda, specifically the restructuring of the Regional Office, with four of the six clusters completed, and the introduction of a mandatory induction programme for new staff and an internship programme. It also recognized the initiation of efforts to strengthen country offices, and Dr Moeti's critical senior level appointments in the Regional Office and country offices.

Overall, the evaluation concluded that reasonable progress had been made by the Regional Office towards more effective, timely and efficient support to Member States, and highlighted emerging change in behaviours and mindsets. Critically, there was broad recognition, including from partners, that the work of the Transformation Agenda was beginning to turn the tide on the reputational difficulties experienced in the aftermath of the Ebola crisis. Through its alignment with WHO global reform, it was also providing a renewed focus for reform in the African Region.

23 Report of the mid-term evaluation of the Transformation Agenda of the WHO Secretariat in the African Region, WHO Evaluation Office, May 2017 https://www.afro.who.int/sites/default/files/2017-08/Report%20of%20the%20midterm%20evaluation%20of%20the%20Transformation%20Agenda%20of%20the%20WHO%20Secretariat%20in%20the%20African%20Region.pdf?ua=1

Along with contributing to bringing the Ebola epidemic under control and maintaining the momentum towards polio eradication in the African Region, key deliverables included:

- Establishing the Expanded Special Project for Elimination of NTDs.
- Supporting the African Union to establish the Africa Centres for Disease Control and Prevention.
- Launching the Accountability and Internal Control Strengthening Project.
- Establishing the Compliance and Risk Management Committee.
- Introducing managerial and administrative key performance indicators (KPIs).
- Creating a full-time Ombudsperson position at the Regional Office.

On the downside, the evaluation raised questions about delays in planned activities which it said had slowed progress. Weaknesses in communication and change-management support, for example, had impeded staff understanding and engagement with the Transformation Agenda. Acknowledging that reform required both behaviour change and time to take root, however, the evaluation recommended the enhancement of internal communication, complemented by a change management support system.

2.6

Key achievements during Phase 2 of implementation of the Transformation Agenda

Dr Moeti launched Phase 2 of the Transformation Agenda[24] (2018–2020), focused on "putting people at the centre of change", in April 2018. Informed by the results of the independent evaluation, it was aligned with the WHO Director-General's ambitious triple billion targets – one billion more people benefiting from UHC, one billion more people better protected from health emergencies, and one billion more people enjoying better health and well-being.

Phase 2, guided by six strategic workstreams (Table 2), shifted the emphasis to promoting a healthy, respectful and fair workplace; continuously engaging staff members and enhancing their commitment to change; identifying and encouraging the desired attitudes and behaviours; striving individually and collectively towards effective delivery of quality results; and holding people and teams accountable. It reinforced WHO's commitment to improved health outcomes in the African Region, through enhanced technical focus and performance, more effective partnerships, and optimized management of resources.

Phase 2 saw the transition of the Secretariat's work in 2019 to the WHO Thirteenth General Programme of Work[25], which elaborated WHO's strategy for achieving SDG 3 – "Ensuring healthy lives and promoting well-being for all at all ages". Centred on a country-led approach, the GPW 13 strategic shifts included moving from the six "categories of work" specified in GPW 12, to the 10 "outcomes" of GPW 13.

24 Transformation Agenda Phase II: Putting People at the Centre of Change https://www.afro.who.int/sites/default/files/2018-05/Transformation%20Agenda%20Phase%202%20-%20Putting%20people%20at%20the%20center%20of%20change.pdf

25 WHO Thirteenth General Programme of Work http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf?ua=

Table 2: Strategic workstreams of Phase 2

Strategic workstreams	Strategic actions
Strengthening change management processes and enhancing a values-based culture.	• Strengthening change management. • Developing a core group of health leaders. • Ensuring greater and more meaningful engagement of staff in the activities of the Transformation Agenda. • Promoting a healthy and respectful workplace, including prevention of bullying and sexual harassment. • Enhancing the work of the Transformation Agenda governance structures.
Enhancing the country focus approach for greater impact.	• Consolidating implementation of the recommendations of the functional reviews of country offices, and continued engagement with country office staff.
Stronger focus on the delivery of quality results.	• Reinforcing the utilization of the KPIs to manage for results. • Continued implementation of the African Region Flagship Programmes. • Promoting country innovations and best practices. • Enhancing knowledge management.
Promoting efficiency, accountability, quality and value for money.	• Enhancing human resource capacity at all levels. • Improving transparency, efficiency, quality and accountability in WHO processes, including procurement and delivery of services.
Broadening engagement with Member States and partners.	• Maximizing the Regional Director's interactions with Member States. • Consolidating the Regional Director's engagements with partners, donors and other key stakeholders.
Ensuring improved communication of the work of the Secretariat towards improving health outcomes in the Region.	• Strengthening external communications. • Strengthening internal communications, specifically intra- and inter-cluster communication.

2.7

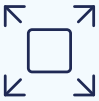
Consolidating the Transformation Agenda – The Regional Director's second term

African Region Member States elected Dr Moeti to serve a second five-year term as Regional Director from February 2020 to January 2025, with the year marked by the best and worst of times. The African Region was declared free of wild polio virus, but the onset of COVID-19, and its declaration by WHO as a public health emergency of international concern (PHEIC) and a global pandemic, changed everything.

Despite the unprecedented threat to the gains made under the Transformation Agenda, WHO in the African Region worked closely with Member States and partners to mount a robust response, leveraging the lessons delivered to adapt and implement a "consolidation phase". Focused on impactful and sustainable change as countries went into recovery mode, the Secretariat and country offices concentrated on empowering and supporting Member States, while continuing the work to build a sustainable, adaptable organization.

Evidence of these successes are detailed in subsequent chapters.

Some of the key achievements of Phase 2 included:



Repositioning WHO:
The Transformation Agenda repositioned the Organization to better serve Member States, seize new opportunities, and meet new challenges. It also helped to better align activities with the institution's long-term goals and strategic objectives, to enhance global performance and effectiveness. Importantly, these efforts have helped maintain WHO's relevance and credibility with key stakeholders, including staff, Member States and national governments, as well as with partners.

Organizational culture changes:
Staff recruitment processes were strengthened, alongside the introduction of leadership development, staff engagement and prevention of sexual exploitation, abuse and harassment (PRSEAH) initiatives, and the strengthening of ethical standards through a Compliance and Risk Management Committee and a full-time Ombudsperson. The 2021 Global WHO Transformation evaluation* validated positive change in organizational culture in the Regional Office for Africa, while the United Nations Joint Inspection Unit recognized the Transformation Agenda as a model for workplace culture reform.

Stronger focus on results at country level:
Adaptation to the cultural, political, economic and partnership environments of different Member States has optimized WHO's capacity to effectively serve Member States and achieve the stated objectives. In addition, by focusing on country-level operations, WHO has enhanced support for the Transformation Agenda from local stakeholders, including staff, partners, nongovernmental organizations and government officials. This lays a solid foundation for successful, sustainable transformation.

Public health achievements:
These include improved outbreak detection and response times, containment of acute outbreaks, and progress towards polio eradication, reduced maternal mortality rates and the elimination of NTDs.

Rational use of resources:
The Transformation Agenda has prioritized "value for money", reducing operational costs and improving financial performance. Through transparent financial management and optimal use of available resources, the Organization has been able to save funds and significantly increase resource allocation to country offices and support to Member States. Other achievements include improved donor reporting and compliance.

* Evaluation of the WHO Transformation, WHO Evaluation Office, May 2021
https://cdn.who.int/media/docs/default-source/evaluation-office/who-transformation-final-report.pdf?sfvrsn=c20b7baa_5

Transforming the Secretariat

3

3.1

Building a culture of excellence in health

The transformative journey of the WHO Secretariat in Africa was not only about restructuring, but also achieving a cultural shift driven by empowered staff, engaged stakeholders and actions guided by a shared vision for health. Cognizant that the human resources of any organization constitute its most important asset, and that the calibre of its personnel is pivotal to its success, the realignment of human resources to national health priorities and needs was identified as a critical component of the Transformation Agenda. The functional reviews of the 47 WHO country offices was introduced to serve this purpose.

Enhancing leadership capabilities was crucial to underpin the change, as was the need for new-look administrative and support systems with a more agile approach to managing finances, resources and technologies. The addition by Dr Moeti of the Assistant Regional Director (ARD) Cluster in 2019 was an ambitious initiative, designed to specifically tackle fragmentation within the Organization, reduce duplication and foster synergy between different technical departments to enhance support to Member States.

An offshore office was also opened in Pretoria, South Africa, as a means of reinforcing the responsiveness of support operations to country offices. Pretoria was selected due to its optimal flight connections to destinations in the Region, its available communications infrastructure essential for remote support and virtual meetings, and cost benefits.

This transformation also meant confronting some of the most challenging and sensitive issues head-on, especially gender equity and a healthier workplace environment free of abuse and harassment. Addressing the latter became a cornerstone of this cultural change, especially in the wake of crises that exposed vulnerabilities within the Organization. The Secretariat

committed to not only addressing these threats, but eradicating them, and thereby building a safer and more inclusive work environment.

The Transformation Agenda was never intended as a static process, but rather one that emphasized continuous learning and improvement.

The Transformation Agenda was never intended as a static process, but rather one that emphasized continuous learning and improvement. As WHO in the African Region progressed through the different phases over the past decade, strategies were refined in accordance with constant feedback gathered from staff, partners and stakeholders. This ensured that the Organization remained responsive to the dynamic health landscape of the African continent, with the lessons learnt ultimately providing a model for organizational transformation that was adopted as a corporate strategy by the Director-General in 2018, and replicated in other regions.

One of the most crucial factors behind its success was the strong, visionary leadership, particularly from Dr Moeti and the senior management team. They played a pivotal role in championing change initiatives, setting a clear vision, and consistently communicating the importance of the transformation to the entire Organization. Dr Moeti's active engagement sent a strong message to all staff that the transformation was not a temporary initiative, but a fundamental reorientation of how the Organization operated, foregrounding accountability, transparency and innovation.

By demonstrating their own commitment to these principles, they encouraged the entire Organization to embrace the changes, which proved especially important in overcoming initial resistance thereto. This visionary leadership helped to build trust, which was critical to maintaining staff morale and engagement.

At the core of this transformation were four critical pillars: the General Management and Coordination (GMC) Cluster, the Transformation Agenda Initiatives Unit (TAI), the Country Focus and Coordination (CFC) Unit, and the External Relations, Part-

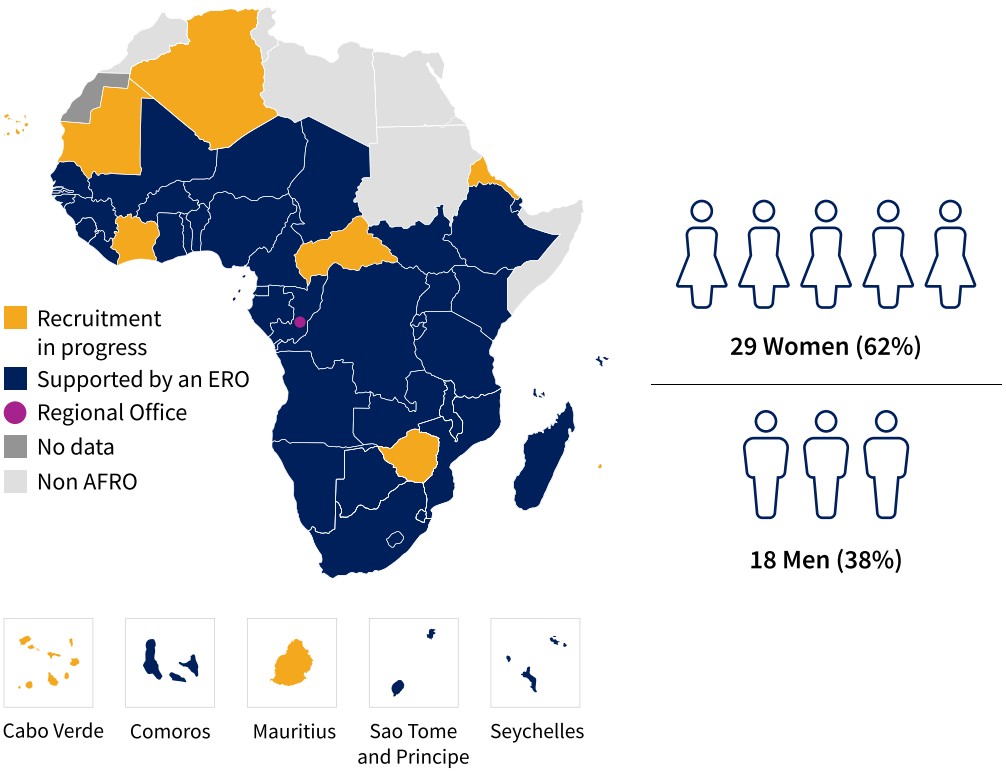
nerships and Governing Bodies (EPG) team, with each of the programmes making its own unique contribution.

The GMC Cluster, which was tasked with effectively managing and coordinating service delivery support across finance, operations, general administration and human resource management in the regional and country offices, also took responsibility for enhancing governance, operational efficiency and compliance. Its core functions relating to provision of support to country offices were relocated to the Pretoria Office, to reinforce the responsiveness of support operations. By streamlining management processes, strengthening financial oversight and fostering a culture of accountability, GMC has laid a solid foundation for a more transparent, efficient and effective WHO in the African Region.

The TAI Unit, meanwhile, has spearheaded efforts to drive culture change, foster leadership development, and promote a more inclusive and ethical workplace. Its initiatives targeted a shift in the organizational culture to one that prioritizes excellence, teamwork, equity and integrity. By empowering staff through mentorship, leadership programmes and gender equity through women's empowerment initiatives, TAI ensured that day-to-day operations were consistently aligned with WHO values.

The CFC played a pivotal role in aligning WHO country offices with the specific health needs and priorities of each of the Member States they serve. Through robust, comprehensive functional reviews and restructuring, the Unit ensured that country offices were staffed with the right mix of technical expertise and resources to deliver impact. In 2021, the Multicountry Assignment Teams (MCATs) initiative was launched as an innovative solution to maximize limited resources, by positioning

Figure 8: Map of External Relations and Partnerships Officers in the WHO African Region



Advancing Health Care Integration: The Transformation Agenda's Four Objectives

Improving workforce alignment:
This required revisiting staff structures to ensure that country offices were staffed with the right expertise based on national health priorities and needs. The Agenda also sought to address the longstanding issue of staff shortages, and to deploy health professionals more strategically across the Region.

Enhancing operational efficiency:
Fragmented operations and slow service delivery had been consistent challenges. The Transformation Agenda aimed to streamline these operations, by promoting better coordination between the regional and country offices, reducing bureaucratic delays, and introducing digital innovations to enhance service delivery.

Improving governance and accountability:
The absence of strong governance structures was a significant barrier to WHO's effectiveness. The Transformation Agenda sought to address this by embedding robust governance frameworks that promoted accountability, transparency and risk management.

Strengthening partnerships:
The Ebola crisis had highlighted the need for WHO in the African Region to foster stronger partnerships with governments, international organizations, civil society and other health stakeholders. As part of the transformation, the Organization worked to build more strategic and collaborative relationships.

technical experts in a single location to serve multiple countries simultaneously.

Finally, EPG has proven crucial in successfully mobilizing resources to operationalize WHO's mandate through the Thirteenth General Programme of Work, 2019–2025. The expectations of donors and partners have been realized, and efforts to diversify strategic partnerships and enhance partner engagement amplified through various actions. These included reinforcing country offices with high-calibre internationally-recruited External Relations Officers (EROs) in the majority of Member States, showcasing greater return on investment and diversifying the partner base, demonstrating greater accountability through quality and timely reporting, increasing participation in UN joint programmes and pooled funds, and strengthening relations with the private sector and non-State actors.

Working in tandem, these programmes fostered a more integrated and cohesive approach to health care delivery in Africa, providing the framework for the realization of the Transformation Agenda's four primary objectives.

The result, 10 years later, is an organization that is better equipped to meet the health needs of African populations, one that is more responsive to the evolving global health landscape, and more accountable to its stakeholders. Both the successes and the lessons from the past decade provide a strong foundation for continued growth and innovation.

3.2

Improving workforce capacity for sustained change

The CFC initiative, the purpose of which was to ensure that WHO's human resources were aligned with the unique health priorities of each Member State, was one of the most transformative elements in the transformation journey of WHO in the African Region. Many country offices had previously faced challenges with misaligned staff, inadequate technical expertise and gaps in leadership, which hampered their ability to respond to local health needs.

An extensive functional review process took place across all 47 country offices between 2017 and 2019, thoroughly assessing each office's staffing, technical capabilities and operational needs. These comprehensive reviews proved crucial in identifying gaps in expertise and misallocations of resources, informing tailored recommendations for each country.

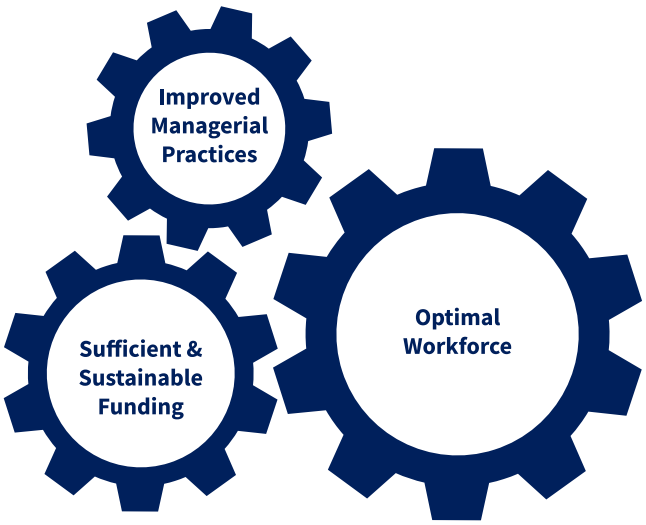
By aligning workforce capabilities with national health priorities, the Unit ensured that each office was better equipped to address the specific health challenges of its respective country. However, the Region required a total of US$ 314.5 million to fully implement the necessary competencies identified in these reviews. With only US$ 183.5 million available, this left a significant funding gap of US$ 131 million, highlighting the need for strategic resource mobilization to address the deficit and achieve the desired impact.

One of the most significant outcomes of the initiative was the dramatic increase in the number of technical staff across country offices. WHO in the African Region significantly expanded its workforce to help ensure that each office had not only the numbers, but also the necessary technical expertise to respond effectively to health challenges. This increase in capacity was especially important for countries dealing with complex health crises, such as infectious disease outbreaks and chronic health system challenges.

Figure 9: Methodology of the functional reviews

Objectives

Ensure better alignment of WHO's workforce and operations with host countries' health situation, needs & priorities



*Simultaneous delivery of **strategic priorities**, sustained **financial resources** and **proper office management** is critical to strengthening WHO country offices.*

Expected results

1. Optimal workforce capable of delivering the **strategic priorities**
2. **Revised structure** with appropriate number of **positions and competencies**
3. Improved managerial practices that **promote integration** for **optimal impact** and enable WHO to **influence health interventions**
4. A Country Office that **capture partners' attention and attracts their support to sustain country office interventions**

Table 3: Outcome of the functional reviews in 47 country offices: all positions by category

Category	Priority 1	Other priorities	Total no. of positions
General Service (GS)	745	358	1103
National Professional Officers (NPOs)	515	434	949
Professional and higher categories (IP)	323	146	469
UN Volunteers	28	42	70
Total	**1611**	**980**	**2591**

More than 2500 new positions were created across priority areas, with the GMC Cluster pivotal in ensuring that staffing was aligned with health demands, so enhancing the targeted delivery of health interventions, to ultimately bolster national health systems.

The introduction of Multicountry Assignment Teams (MCATs) in 2021 was an especially innovative outcome of the functional review initiative, in response to an identified need for WHO to regain its leadership role in providing high-level technical support in the Region. To meet the expectation, significant changes were needed at country office level, but in the absence of sufficient resources to fund the core and critical functions, a creative solu-

tion was needed. This came in the form of a shift away from the previous Intercountry Support Teams (ISTs) model, in which only three teams shared responsibility for the entire Region, to a much larger number of MCATs, each serving three to four countries.

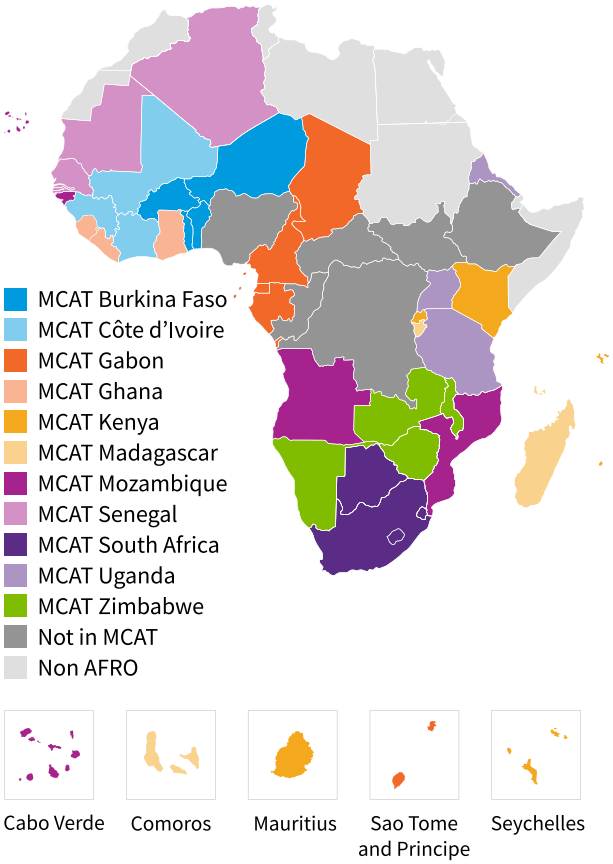
The MCATs represented a cost-effective solution for resource-constrained settings, as its experts only worked across their allotted countries, ensuring more dedicated, comprehensive access to WHO's technical expertise. Together with maximizing WHO resources, the approach also fostered greater regional collaboration and knowledge-sharing among neighbouring countries.

Currently, 38 MCAT staff are deployed in 11 locations, covering nine health areas (see Figures 10 and Table 4).

Although implementation of the MCATs remains ongoing, the majority of respondents to a 2021–2024 survey to assess their impact reported a significant improvement in the quality and delivery of WHO technical support. In areas where MCAT performance was rated the best, the success was largely attributed to the high calibre of its experts, bringing extensive international experience, in-depth knowledge of local public health contexts, as well as a thorough understanding of disease epidemiology.

The Burkina Faso MCAT, also encompassing Benin, Niger and Togo, has for example, made significant progress in addressing priority health challenges. Benin has trained over 400 health care workers to effectively combat emerging and re-emerging childhood diseases, while Burkina Faso has

Figure 10: MCAT coverage of country offices in the WHO African Region



MCATS Scope / WCO Coverage

Location	Portfolio	Language
Burkina Faso	Burkina Faso, Niger, Togo, Benin	French
Côte d'Ivoire	Côte d'Ivoire, Guinea, Mali	French
Gabon	Gabon, Chad, Cameroon, Equatorial Guinea	French
Ghana	Ghana, Sierra Leone, Liberia, Gambia	English
Kenya	Kenya, Seychelles, Mauritius, Rwanda	English
Madagascar	Madagascar, Comoros, Burundi	French
Mozambique	Angola, Mozambique, Cabo Verde, Sao Tome and Principe, Guinea-Bissau	Portuguese
Senegal	Senegal, Mauritania, Algeria	French
South Africa	South Africa, Eswatini, Botswana, Lesotho	English
Uganda	Uganda, UR Tanzania, Eritrea	English
Zimbabwe	Zimbabwe, Zambia, Malawi, Namibia	English

Table 4: Technical areas covered by MCATs

Area	MCAT staff #
HIV/TB/hepatitis	6
Health financing	5
Noncommunicable diseases	5
Nutrition	4
RMNCH	9
Tropical and vector-borne diseases	9
Diagnostic and laboratory services	0
Service delivery systems	0
Polio field environmental surveillance	0

improved monitoring of maternal deaths and developed a master plan to combat noncommunicable diseases, focusing on decentralizing screening and care.

In South Africa, the WHO Country Office and the MCAT, which also encompasses Botswana, Eswatini and Lesotho, has effectively advocated for neglected tropical diseases, notably schistosomiasis, to be listed as priority communicable diseases.

The flexibility, adaptability and rapid mobilization of MCATs have been standout strengths, enabling more effective response efforts across the Region. However, sustained success depends on continued support and collaboration at all levels, particularly with WHO Representatives and clusters. Strengthening these partnerships is essential to maintaining and accelerating the gains already made.

3.2.1 Gender parity

Gender equity was a central pillar of WHO's transformation efforts in the African Region, a reflection of the importance afforded to diversity in leadership and decision-making. WHO set ambitious targets to address workforce gender imbalances, thereby generating a steady increase in the percentage of women in professional and higher categories, from 29.9% to 36.7% (2017–2023). This, in turn, engendered a more inclusive work environment, not only for WHO staff, but also the broader health sector across the continent.

A significant milestone was achieved in 2016 in terms of gender parity, when the executive management of WHO in the African Region had an equal number of men and women in senior leadership positions for the first time in the Organization's history.

Dr Moeti took particular pride in programmes such as the Women in Leadership Speaker Series and the Women in Leadership Masterclass, aimed at helping create a pipeline of female leaders, empowering more women to aspire to senior positions. These initiatives were complemented by recruitment reforms that prioritized gender equity, ensuring that women had equal opportunities for leadership and professional growth within the Organization.

Attracting young talent was another focus area, with a partnership with the UN Volunteers (UNVs) Programme boosting the complement of UNVs in the Region, and by the same token, attracting a large number of skilled young professionals to Member States. The Africa Women Health Champions (AWHC) Initiative is especially celebrated for adding a large number of young talented women to the regional workforce (see Figure 11).

The TAI Unit also championed initiatives aimed at creating a work environment free of harassment, abuse and discrimination. The introduction of the zero-tolerance policy for sexual harassment, along with the creation of more robust reporting and support mechanisms for survivors of abuse, were critical steps in promoting a culture

Figure 11: Trends in gender balance (women representation) in the WHO African Region, since 2015

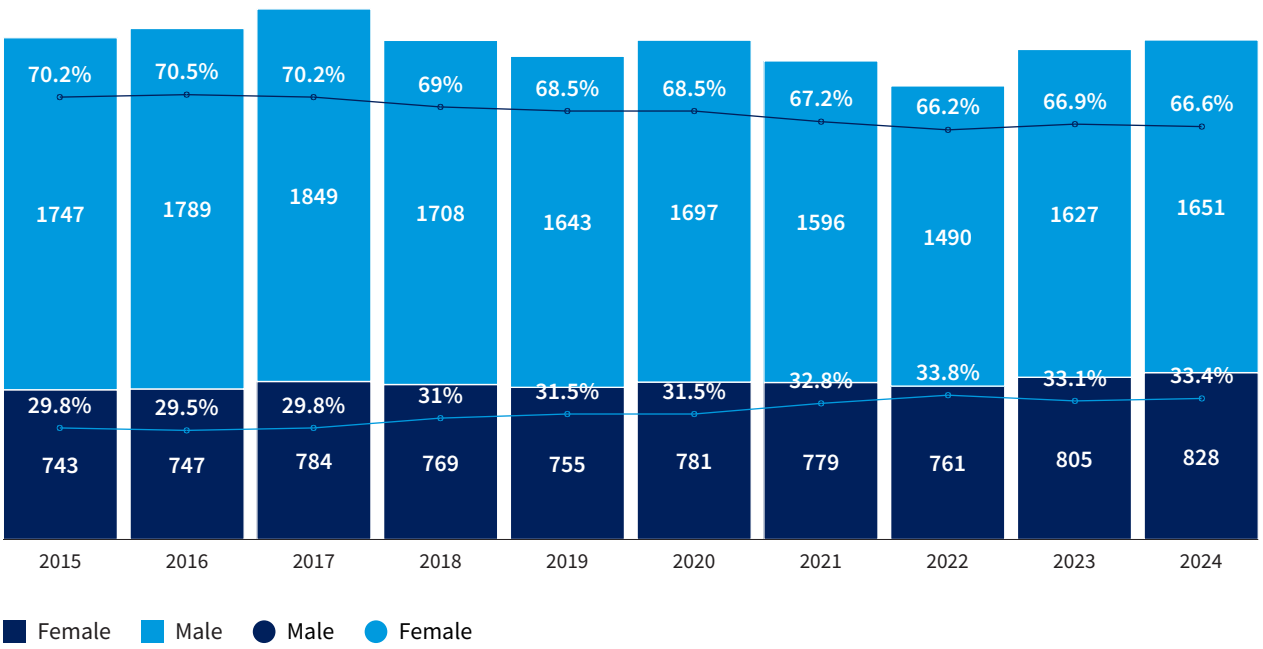
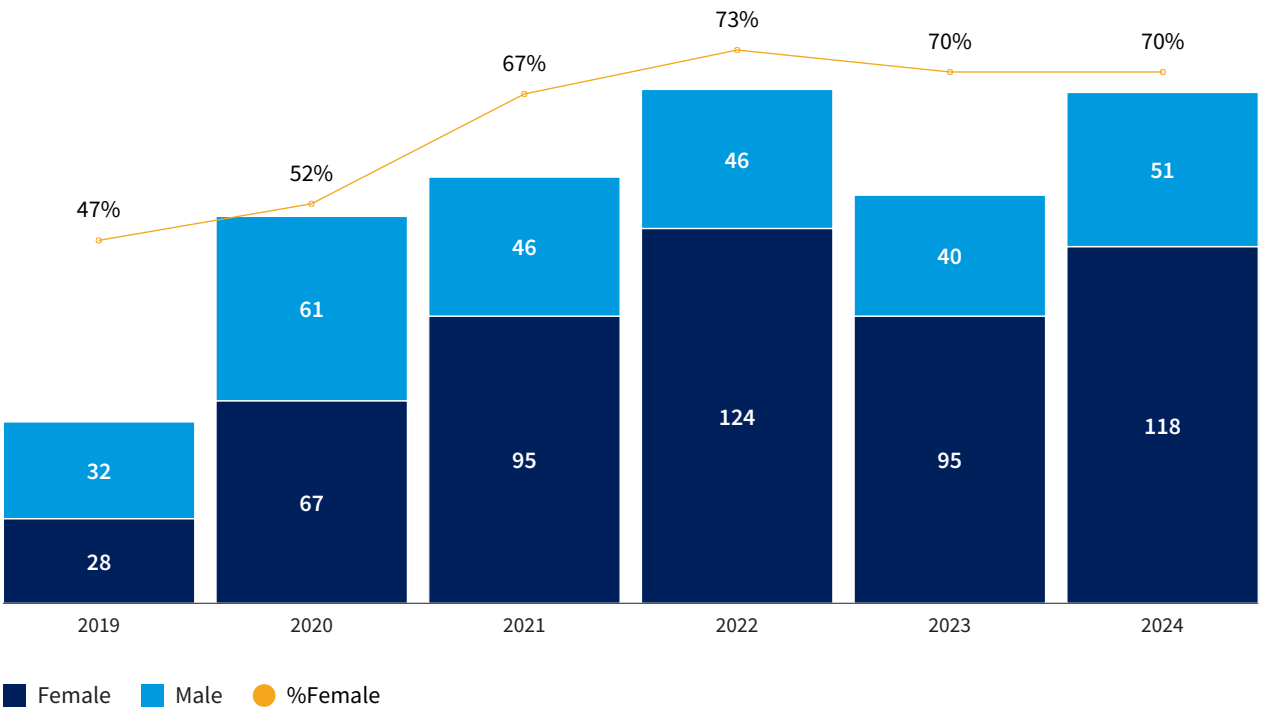


Figure 12: Trends in the use of United Nations Volunteers (UNVs) 2019–2024



of respect and inclusivity.

Botswana and South Sudan adapted WHO recommendations to update their national guidelines on the prevention and management of gender-based violence through the health sector, including the RESPECT[26] framework for front-line health workers. In addition, Ghana and South Africa now have national guidelines for operationalizing gender mainstreaming in health and a health sector gender policy, respectively, while Nigeria has six zonal core teams on gender-based violence care and support, following WHO-supported training.

3.2.2 Organizational culture change

One of the most profound and lasting outcomes of the transformation was the cultural shift within WHO in the African Region, with the TAI spearheading efforts to reshape its internal culture, putting an end to siloed departments, hierarchical structures and limited communication.

The range of initiatives implemented to help break down silos, encourage collaboration and promote ethical behaviour included the Change Agent Network of over 100 staff members, empowered to lead change initiatives across the Organization. Selected from different levels and departments to ensure the transformation was driven by a diverse group of people with a deep understanding of the Organization's internal dynamics, this ensured the transformation was not simply a top-down process, but rather one that was sustained through grassroots efforts.

Along with other TAI initiatives, the Network helped promote a culture in which

26 https://www.who.int/publications/i/item/WHO-RHR-18.19

Staff were empowered to propose new ideas, take risks, and experiment with new approaches to public health challenges, knowing that their contributions were valued and supported by leadership.

staff were held accountable for their performance, and encouraged to take ownership of their work. This shift in mindset not only improved individual performance but also fostered a more collaborative and innovative work environment. Staff were empowered to propose new ideas, take risks, and experiment with new approaches to public health challenges, knowing that their contributions were valued and supported by leadership.

The Pathways to Leadership Programme, which aimed to equip senior and mid-level staff with the skills and competencies needed to lead the Organization through the transformation, was also key to driving the change. A combination of workshops, coaching and hands-on projects saw hundreds of staff members benefit from this focus on developing key leadership qualities, such as strategic thinking, decision-making and team management.

The programme was also not limited to WHO staff. It targeted external health leaders in Member States too, equipping them with the leadership and management skills needed to lead their national health systems. This external focus helped build stronger partnerships between WHO and national governments, creating a more

collaborative approach to health system strengthening across the continent.

In addition to leadership development, the Region's Mentorship Programme was an acknowledgement of the importance of mentorship as a tool for fostering knowledge transfer and professional growth. The programme paired less experienced staff members with seasoned professionals, providing a platform for guidance, support and the sharing of institutional knowledge.

This external focus helped build stronger partnerships between WHO and national governments, creating a more collaborative approach to health system strengthening across the continent.

This initiative was particularly valuable in ensuring that younger staff members, or those new to the Organization, could learn from the experience of their more established colleagues. Mentorship relationships were carefully curated to match individuals with common interests or professional goals, creating a supportive environment that fostered both personal and organizational growth.

3.2.3 Effective communication

The transformation highlighted the critical role of regular and transparent communication in managing change, and WHO in the African Region prioritized open lines of communication from the outset, to ensure that staff were well-informed about the process, its goals, and the expected outcomes.

One of the most effective strategies was the consistent and clear communication of the vision and the progress being made, with the preparation and dissemination of regular updates, known as Change Highlights, to all staff across the three levels of WHO. The Transformation Agenda Initiatives also led the design and launch of the Transformation Agenda microsite on the website of the Regional Office for Africa, to facilitate external communications.

Additionally, regular contributions to the staff newsletter and town hall meetings, chaired by Dr Moeti, helped keep staff aware of the progress of, but also the reasons behind, the changes. This engagement with staff helped demystify the process, alleviating concerns and reducing anxiety. They were also empowered to provide feedback through surveys, focus groups and informal discussions, which contributed to a sense of ownership. This two-way communication allowed leadership to identify potential areas of resistance early on, and address concerns before they escalated.

Additionally, the focus on transparent communication contributed to the creation of a culture of open dialogue within the Organization. By fostering an environment in which employees felt comfortable voicing their ideas, concerns and suggestions, WHO was able to tap into the collective knowledge and creativity of its workforce. This collaborative approach not only improved the quality of decision-making, but also ensured that the transformation was inclusive and reflective of the Organization's diverse perspectives.

3.3

Enhancing operational efficiency

The African Region's vast and varied geography, coupled with limited infrastructure in many areas, presented unique challenges for health care delivery. Early on in Dr Moeti's tenure, there was broad agreement that digital innovation would be key to advancing public health interventions and strengthening operational capacity, with digital solutions providing opportunities to bridge the gaps.

To enable more efficient, transparent and timely health interventions for African countries, WHO worked proactively to integrate technology into multiple facets of its work, from financial operations to health data management, to streamline processes and maximize impact.

3.3.1 Digital payments: revolutionizing public health funding

One of the most groundbreaking innovations during Dr Moeti's tenure was the introduction of digital payments through mobile money or bank transfers in support of field implementation of activities funded by WHO. Traditional cash-based interventions had long been prone to delays and inefficiencies, along with a raised risk of mismanagement, particularly during large-scale health initiatives. Digital payments transformed these processes by offering a secure, transparent and swift method of transferring funds.

In the context of public health emergencies, such as mass vaccination drives for example, digital payment options became an invaluable tool. By enabling direct, real-time transfers of funds to health care workers and local teams, resources could reach the field quickly and safely. Particularly beneficial in remote or underserved areas where traditional banking infrastructure was either limited or non-existent, digital payments eliminated the need for physical cash transactions, reducing the risks of theft, fraud or logistical delays.

The transparency afforded by digital payments also marked a major leap forward. Every transaction could be tracked digitally, providing a clear audit trail for both WHO in the African Region and national governments. This level of accountability reassured donors and stakeholders, who could see exactly how and where funds were being used, while allowing for real-time monitoring of spending. This helped ensure that funds were distributed efficiently, and used in alignment with project goals.

One of the most groundbreaking innovations during Dr Moeti's tenure was the introduction of digital payments through mobile money or bank transfers in support of field implementation of activities funded by WHO.

During health crises such as the COVID-19 pandemic, WHO was able to scale up payments and resource disbursement to front-line workers in the Region, without the delays that typically accompany traditional financial methods. This agility was critical in managing the fast-paced demands of the pandemic response, where delays in funding could mean delays in delivering life-saving interventions.

3.3.2 Broader digital health strategies: enhancing data-driven public health

With digital platforms crucial for data collection, monitoring and dissemination to enhance the efficiency and effectiveness of health interventions, especially during large-scale health crises, WHO also embraced a host of broader digital health strategies to bolster their impact.

The launch of a series of eHealth platforms designed to collect and manage health data in real time is a case in point. Essential for the surveillance and monitoring of diseases, particularly during outbreaks, they collect data at the local level, then

aggregate them into centralized systems. In practice, these platforms enable health authorities to respond quickly to emerging threats.

This was especially important during the COVID-19 pandemic, when timely data were crucial for tracking the spread of the virus, monitoring health system capacity, and managing resources such as hospital beds and medical supplies.

The accuracy and timeliness of public health data benefited enormously as a result. Vaccine campaigns are a good example, with digital platforms allowing for real-time reporting of the numbers of people vaccinated, the location of vaccination sites, and the availability of vaccines. This level of detail helped ensure that resources were deployed where they were most needed, averting wastage, and ensuring equitable access to health services.

In the longer term, these platforms provided a foundation for more data-driven decision-making, allowing the Organization and national health authorities to better plan and allocate resources for future health interventions.

One of the important successes of these digital platforms lay with their integration into national health systems. By aligning WHO's digital health tools with existing national frameworks, the Organization was able to enhance the capacity of local health authorities, improve coordination, and foster stronger partnerships. This integration ensured that the benefits of digital health strategies were not confined to short-term projects, but instead sustained as part of broader health system strengthening efforts in the Region.

3.3.3 Enhancing collaboration through coordination workstreams

The ARD Cluster's coordination workstream approach, integral to supporting its core priorities of integration, coordination and coherence to provide enhanced support to Member States, effectively showcased the power of collaboration, despite facing significant funding and staffing challenges.

The Regional Health Data Hub (RDHub), a cloud-based system that consolidates various forms of data and connects data at country level, was one of the ARD Cluster's significant interventions.

Its primary health care workstream, one of a total of eight focused on key areas including digital health and data and analytics, facilitated joint support to Sierra Leone, resulting in a range of positive impacts. The provision of tools and guidelines contributed to reduced maternal and newborn mortality, for example, while data and analytics expertise boosted health data monitoring.

In terms of data integration, two especially significant interventions initiated by the ARD Cluster included the Regional Health Data Hub (RDHub), a cloud-based system that consolidates various forms of data and existing data systems across different disease programmes, and connects data at country level. Then, recognizing that data integration relies on both technology and people, the first draft of the Regional Data Governance Framework was published to guide the Regional Office and Member States on key elements of data security.

The adoption by the WHO Regional Committee for Africa in August 2024 of the Framework for integrating country and regional health data in the African Region: Regional Health Data Hub 2024–2030, marked a crucial step that promises to propel the project forward over the next five years. The Hub has the capacity to revolutionize the Region's data management, establishing robust governance protocols to protect Member States' data.

3.3.4 Sustainable transition to a paperless environment

The commitment of the WHO Secretariat in the African Region to sustainability and operational efficiency was exemplified by its shift towards a paperless environment, an initiative that was part of a broader effort to modernize workflow processes, reduce costs, and minimize environmental impact.

The implementation of electronic workflows enabled the Organization to move away from traditional paper-based processes that were often slow, cumbersome, and prone to human error. Key administrative tasks, such as document approval, financial reporting and resource allocation, were all digitized, allowing for faster processing times and greater efficiency. With online approval systems, staff members could also submit and track documents in real time, dramatically reducing the time spent on bureaucratic procedures.

The transition notably curtailed spending. By reducing the need for paper, printing and physical storage, operational costs associated with these resources were cut by as much as 80%. Additionally, the environmental benefits of this shift were considerable. With fewer trees being cut for paper production, and reduced energy consumption for printing and transporting documents, the Organization's digital initiative supported global sustainability goals, while contributing to a more eco-friendly organizational footprint.

The paperless initiative extended beyond internal workflows to include major meetings and conferences. Digital meeting applications provided document libraries and agenda management systems, allow-

ing participants to access materials digitally rather than relying on printed copies. This not only streamlined the management of large-scale events, but also contributed to a more sustainable and cost-effective approach to governance.

3.3.5 COVID-19 pandemic-related innovations

The COVID-19 pandemic limited physical interaction due to social distancing measures, further underscoring the importance of digital transformation as the reliance on digital solutions became even more pronounced. Digital platforms facilitated remote communication, virtual training sessions and telemedicine, all crucial to help ensure the uninterrupted delivery of health care and interventions in the face of massive disruptions.

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WHO in the African Region supported the roll-out of telemedicine services in collaboration with national governments, enabling patients in remote areas to consult with health care providers without having to travel to health facilities. This not only reduced the strain on health care systems, but also protected vulnerable populations from potential exposure to the virus.

The Organization also rapidly transitioned its training and capacity-building programmes to virtual platforms. This ensured that health care workers and public health officials across Member States continued to receive critical training on managing the pandemic, despite travel restrictions and lockdowns. The capacity to conduct hybrid Regional Committee sessions since 2022 was a major COVID-19 related innovation, ensuring continuity during the pandemic, and broader attendance afterwards.

The Information and Technology Management (ITM) Unit played a key role in driving digital transformation in Member States, by developing and monitoring the implementation of business continuity plans (BCPs) across the Region. As a preventive measure against risks that could disrupt WHO operations, all WHO country offices in the Region now have active BCPs in place, which have been used effectively during crises such as the COVID-19 pandemic to ensure continuity of operations.

3.4

Improving governance and accountability

Driven by the GMC Cluster, improvements in governance and accountability were fundamental to WHO's transformation from an organization grappling with numerous challenges related to financial management, service delivery quality, and compliance with its internal rules and procedures.

One of the GMC's central goals was to enhance financial oversight and compliance, with the subsequent reforms leading to notable strides towards enhancing internal audit and compliance mechanisms, both of which are crucial for maintaining the trust of Member States, donors and other stakeholders.

The Cluster introduced new financial management systems that streamlined budgeting, procurement and reporting processes. By strengthening financial controls and accountability mechanisms, GMC ensured that resources were used more effectively and transparently, while also working to standardize operational procedures across country offices to boost adherence to best practices in service delivery. This standardization led to more consistent and reliable health interventions, especially during public health emergencies.

A major indicator of this progress was the dramatic increase in the number of audit recommendations that were closed. Between 2016 and 2021, for example, the number of recommendations that had been addressed soared, from only 45 to 65. In effect, this meant that over 90% of the recommendations were implemented, signalling a substantial improvement in the Organization's governance structures.

The reduction in the number of unsatisfactory audit reports, a key commitment from Dr Moeti at the start of her first term, along with the closure of outstanding audit recommendations, improved WHO's transparency and bolstered donor confidence, opening the way to increased funding for

health programmes.

Another important advancement was the pooled procurement initiative, which has become a best practice for resource-limited settings, aiming for sustainability and cost-effectiveness in health care delivery. Particularly effective for Small Islands Developing States (SIDS), it enabled them to streamline procurement processes, procuring and supplying medical products and equipment at reduced prices, thanks to joint or pooled requests.

The impact was profound, with Member States benefiting from a 40% reduction in the price of medical products across the SIDS, clearly demonstrating the power of collective bargaining. Along with reducing costs, the model promoted sustainable use of resources by reducing duplication and wastage in the supply chain. By streamlining procurement processes and centralizing orders, logistical inefficiencies were effectively minimized, ensuring that medical supplies were distributed more effectively across the Region.

Furthermore, the adoption of digital tools, including a new Translation Management System, streamlined processes and improved cost-effectiveness. There was a sustained focus on improving cost-effectiveness in translation, interpretation and printing services specifically, with the most recent interventions including the recruitment of more local interpreters, the pairing of senior and junior interpreters, and recovering the cost of coordinating interpretation services. These yielded significant cost savings between July 2023 and June 2024 alone to the tune of over US$ 632 590.

Meanwhile, the introduction of state-of-the-art computer-assisted translation and terminology management tools, including neural machine translation, boosted productivity by 32%. As part of the cost containment drive, the rates for externally sourced translations were streamlined, leading to significant translation cost savings for the entire Region, and contributing significantly to overall organizational efficiency.

3.5

Strengthening partnerships

Strengthening partnerships was a strategic priority from the outset. Dr Moeti actively shared her vision for health development with key partners and concluded agreements on collaborative mechanisms. An independent advisory group of high-profile experts was constituted to provide strategic and policy advice to address the Region's health priorities.

During her time in office, Dr Moeti engaged in more than 300 high-level meetings with political leaders, participated in strategic partner dialogues and meetings, and undertook country visits.

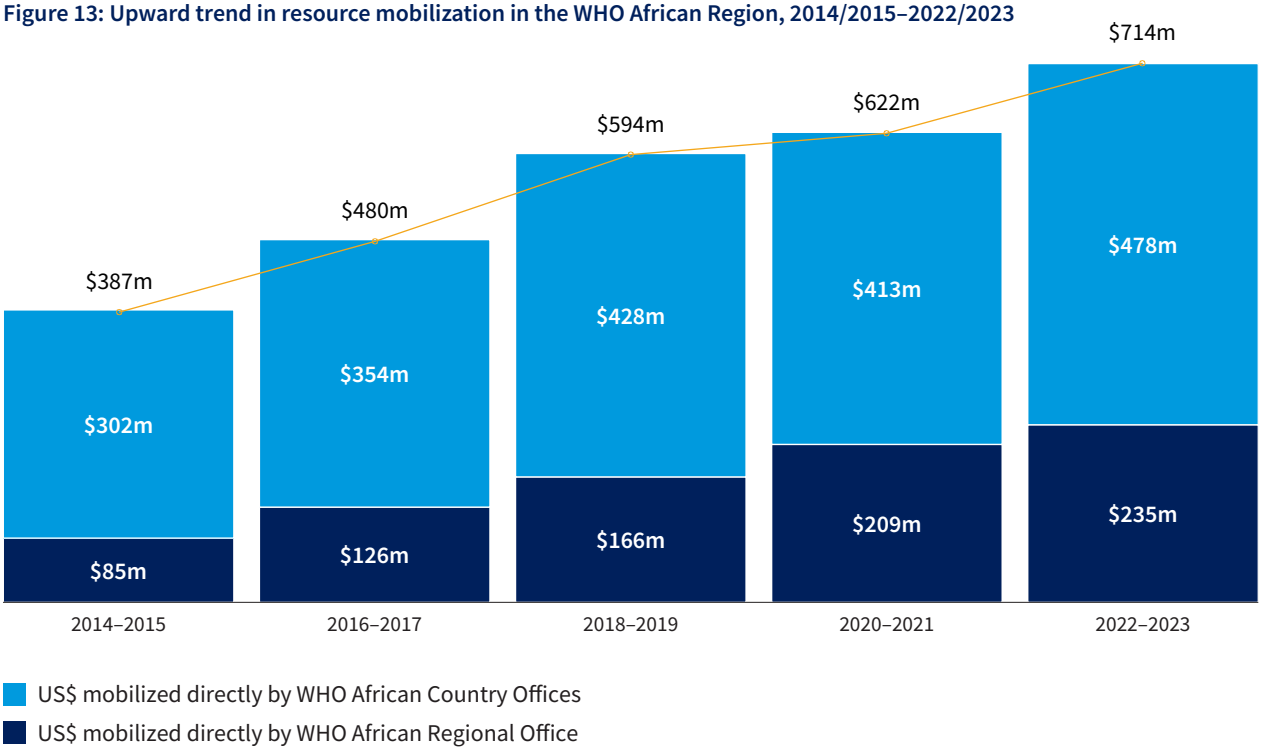
3.5.1 Shifting from mobilization to partnerships

Historically, resource mobilization was viewed as a one-directional process, with "donors" to WHO in the African Region providing financial resources, while WHO oversaw implementation. Through the Transformation Agenda, this model was transformed into collaborative relationships in which WHO and its "partners" played an active role in co-creating and contributing to improved health outcomes in the Region. This resulted in increased funding from both its legacy and new partners.

The Organization developed comprehensive engagement plans at regional and country levels to develop and maintain these critical relationships, leveraging digital tools such as the Contributor Engagement Management (CEM) system to obtain analytics and business intelligence on financing sources, thus diversifying its funding base.

In total, all these investments delivered an 84% increase in resources mobilized between 2015/2016 and 2022/2023, from US$ 387 million to US$ 714 million (see Figure 13). This increase in funding has been crucial in strengthening technical assistance to Member States in critical areas such as

Figure 13: Upward trend in resource mobilization in the WHO African Region, 2014/2015–2022/2023



immunization, NTDs, NCDs, health emergencies, health systems strengthening, sexual and reproductive health, maternal and child health and nutrition, among others.

3.5.2 Engaging non-State actors (NSAs)

The Framework of Engagement with Non-State Actors (FENSA), adopted by the World Health Assembly in 2016, was also a key enabler of strengthened partnerships with non-State actors (NSAs). FENSA's goal is to anchor and streamline WHO's relationships with NSAs, including nongovernment organizations, foundations and private sector partners. These actors are uniquely positioned to financially and technically complement WHO's work, especially at community level. Since 2020, WHO in the African Region has significantly improved its engagement with NSAs, recording a 193% increase.

Additionally, WHO diversified its portfolio of strategic partners through concerted efforts at country and regional levels, to include philanthropists, international financial institutions, multilateral development banks, corporate foundations, civil society organizations, academia and NGOs. This strengthened WHO's capacity to deliver on its mandate, while improving funding sustainability.

3.5.3 Ensuring sustainability of change

The Transformation Agenda also emphasized the importance of monitoring and evaluation, and capacity development at country level, as a tool for ensuring sustainability. Key performance indicators were consequently developed to track the progress of work on external relations and partnerships, allowing for continuous improvement and adaptation. The use of an interactive live data dashboard to monitor reporting in real time further enhanced compliance, accountability and

transparency, all of which are critical to the sustainability of partnerships. This resulted in the reduction of overdue technical and financial reports to partners, from over 12% of the total due in 2020, down to only 3% in 2024.

Additionally, a Masterclass programme in External Relations, Partnerships and Resource Mobilization for Health was established to strengthen the capacities of all WHO's external relations and partnerships staff. This programme was rolled out to over 500 technical and administrative staff, significantly boosting external relations and partnerships skills in the Region.

3.5.4 Strong political, leadership and strategic partnerships

The critical importance of strong political, leadership and strategic partnerships was a key lesson learnt. The Transformation Agenda underscored the value of engaging political leaders at the highest levels to advocate for health priorities, and secure improved domestic financing for the implementation of health programmes. Collaborative efforts with Member States, the African Union, regional economic communities and other stakeholders were essential in driving progress and ensuring alignment with national priorities.

The Transformation Agenda underscored the value of engaging political leaders at the highest levels to advocate for health priorities, and secure improved domestic financing for the implementation of health programmes.

Strengthening the partnership and collaboration between WHO and the AU was a specific priority of the Transformation Agenda, to accelerate progress towards the targets contained in the AU Agenda 2063 and the 2030 Agenda for Sustainable Development. Over the last decade, as the AU has expanded its focus on health and promoted the creation of several health agencies, WHO in the African Region has worked collaboratively with the AU and its various organs. In 2016, for example, the WHO Regional Office for Africa supported the establishment of the Africa Centres for Disease Control and Prevention (Africa CDC). This is discussed in more detail in Chapter 9.

To further enhance coordination beyond WHO for achieving the SDGs, the Regional Office created a framework to strengthen and support health sector partnerships at country level. The Africa Health Forum facilitated broader engagement with all stakeholders, while regular interactions with the African Union Commission (AUC) boosted synergy in the roles and functions of both organizations.

Further, the Regional Office actively supported the establishment of the African Medicines Agency by raising awareness of the treaty, and conducting high-level advocacy to encourage Member States to ratify it. The Organization also seconded staff to the AUC to support the operationalization of the Agency.

To amplify the collective voice of African Member States on the global stage, the Secretariat conducted regular briefings for Member States to enhance their participation in high-level global meetings and WHO governing body sessions. During the COVID-19 pandemic specifically, joint briefings were convened with Africa CDC and the UN Economic Commission for Africa, with this proactive engagement proving especially important during post-pandemic negotiations, including discussions on a new pandemic agreement, negotiations to amend the IHR (2005) and on sustainable financing of WHO.

The collaborative efforts of WHO, the AUC, Africa CDC and the African Union Development Agency (AUDA-NEPAD) have been instrumental in helping Member

States translate commitments into concrete actions. These efforts have enhanced the effectiveness of responses to public health emergencies such as COVID-19, Ebola, cholera and the latest mpox outbreaks. This joint work is also helping Member States to strengthen their national health systems, by bolstering the health workforce, enhancing local capacity to manufacture medical products locally, and reducing maternal mortality on the continent.

As WHO in the African Region looks towards the future, the challenge is to ensure that the significant progress made under the Transformation Agenda is sustained and accelerated. This requires a focus on institutionalizing key practices, maintaining a strong commitment to staff development, and fostering a culture of innovation and adaptability.

Meanwhile, enhanced partnerships between WHO, African regional economic communities and the Organization of African First Ladies for Development have all contributed to progress in numerous priority health areas. These include health security, disease control programmes such as HIV/AIDS, and health workforce development, among others. WHO has also strengthened its partnerships with the African Development Bank (AfDB) and other development banks, including the World Bank, the Islamic Development Bank and the European Investment Bank. These collaborations have been pivotal in advancing health initiatives across the Region.

To help monitor progress towards SDG implementation in the Region, WHO signed a memorandum of understanding in 2018 with the UN Economic Commission for Africa (UNECA). Through this collaboration, WHO has helped build the capacity of Member States to monitor progress towards the SDG targets at country level.

This proactive engagement and leadership have been pivotal in strengthening partnerships and building trust among partners on the African continent and globally, while garnering support from key traditional and non-traditional donors. These include new partners such as the Rockefeller Foundation, the Helmsley Charitable Trust, the Susan Thompson Buffett Foundation, the Qatar Fund for Development, and the OPEC Fund for International Development. Partnerships were further solidified through the development of multiyear action frameworks with key partners such as the United Kingdom, the Gates Foundation, and the US Department of Health and Human Services. This robust network of alliances enabled WHO to provide critical support to Member States.

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Strengthening health systems towards universal health coverage

4

4.1

Measuring progress towards UHC

When Cabo Verde gained its independence in 1975, there were only 13 doctors across the entire small nation of 10 Atlantic Ocean islands. Average life expectancy was 55 years and infant mortality was high, at 108 deaths per 1000 births. By 2019, the country had successfully reduced infant mortality to just more than 15 deaths per 1000 births; there were six hospitals, and life expectancy was up to 79 years for women and 71 years for men[27].

In August 2022, WHO officially announced that improvements in life expectancy in the African Region had outstripped other regions of the world, increasing on average by 10 years per person in the 19 years to 2019.

It was improvements like these, attributed to the Cabo Verde Government's prioritization of access to universal health care (UHC) and provision of primary health care services, that contributed to one of the continent's biggest success stories, and an especially proud moment for Dr Moeti. In August 2022, WHO officially announced that improvements in life expectancy in the African Region had outstripped other regions of the world, increasing on average by 10 years per person in the 19 years to 2019. She said at the time:

"The sharp rise in healthy life expectancy during the past two decades is a testament to the Region's drive for improved health and well-being of the population. At its core, it means that more people are living healthier, longer lives, with fewer threats of infectious diseases and with better access to care and disease prevention services."

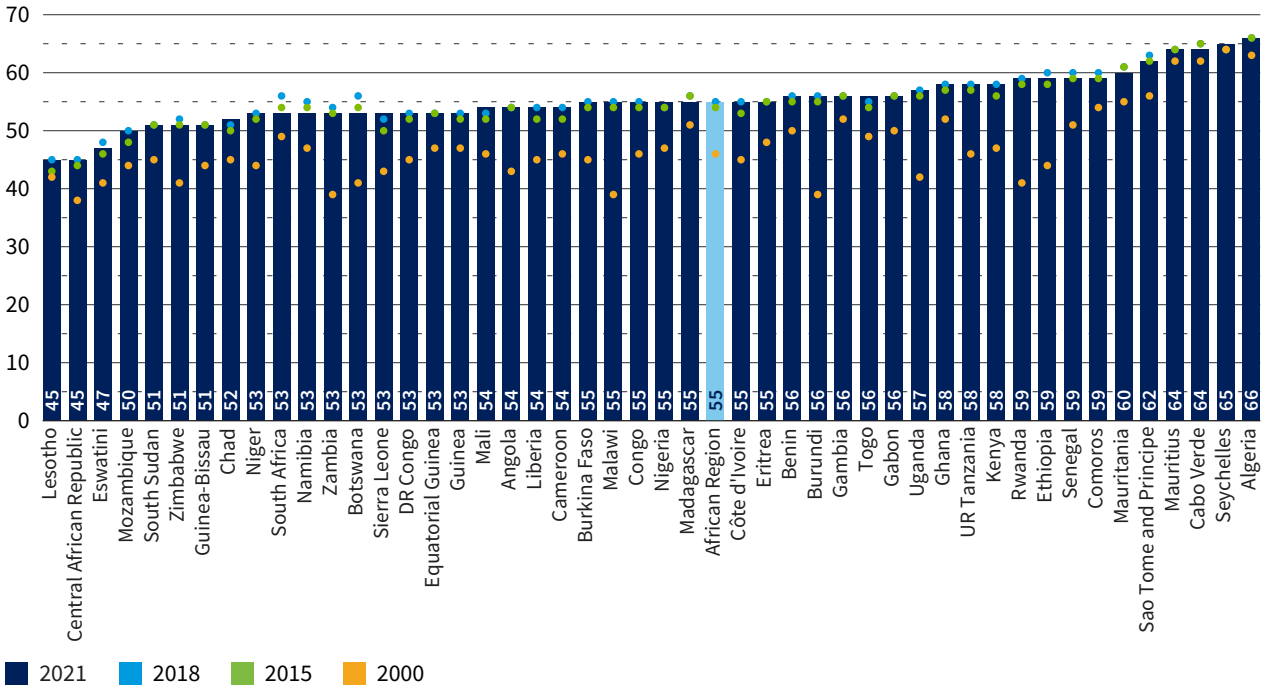
27 https://www.afro.who.int/news/cabo-verde-shows-us-health-care-progress-we-want-see-across-africa

While the regional average was still well below the global average of 62 years, the increase in healthy life expectancy, from 46 (2000) to 55 years, provided statistical proof of the impacts of health care improvements in the following key areas: provision of essential health services; gains in reproductive, maternal, newborn and child health; as well as progress in the fight against infectious and noncommunicable diseases (see Figure 14).[28]

The incontrovertible evidence of these improvements lay in the UHC Service Coverage Index (SCI) rating.[29] Introduced in 2015 as a composite measure to assess the extent and quality of health services provided to populations, the SCI evaluates the availability and utilization of essential health services in order to measure the effectiveness of health systems in delivering care. As it tracks countries' progress towards UHC, it also identifies gaps and areas for improvement.

28 WHO (2020). Global Health Estimates: Life expectancy and leading causes of death and disability. (https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates, accessed on 12 July 2024)
29 https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

Figure 14: Healthy life expectancy at birth in the WHO African Region



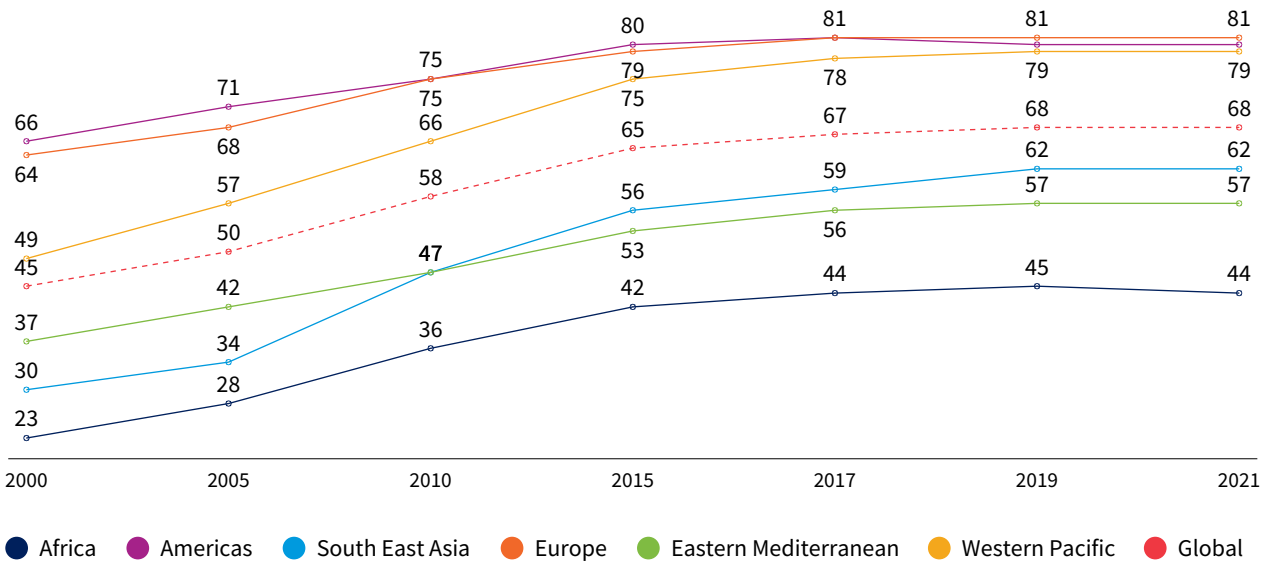
Source: WHO 2023

On the upside, the African Region was rated as having a UHC SCI rating of 44 in 2021 (see Figure 15), marking an almost twofold increase from 23 in 2000.[30] Improvements in preventing or treating infectious diseases have played a major role in driving this development in UHC service coverage.

In fact, however, the 44 statistic indicates that fewer than half of all people in the Region are able to access the health services they need, highlighting the amount of work still necessary to create a truly inclusive health service framework for the continent. To attain even the minimum 60 score by 2030, the African Region must double down on its efforts to achieve and maintain a growth rate of at least 2.5% annually. Additionally, at least 60% of Member States – or 30 countries – will need to put in place interventions targeted at increasing coverage of services and addressing inequalities. Health systems capacity also needs a significant boost, from the current 29%, to at least 40%.

30 WHO (2023). Universal health coverage index. (https://www.who.int/data/gho/data/indicators/indicator-details/GHO/uhc-index-of-service-coverage, accessed on 12 July 2024)

Figure 15: Trends in the universal health service coverage index, by WHO Region



Source: WHP 2023

4.2

Strengthening Africa's health workforce for delivery of quality health services

"By investing in the health workforce, we not only address the challenges within the sector but also generate dividends in education, employment and gender equality."

Dr Matshidiso Moeti, WHO Regional Director for Africa

In May 2024, the WHO Regional Office for Africa, together with partners, launched the Region's first-ever health workforce investment charter in Windhoek, the latest in a long list of interventions aimed at addressing health worker shortages on the continent.[31]

Optimal health worker capacity is recognized as key to the achievement of UHC, and WHO's pivotal role in addressing this critical challenge has included supporting a whole-of-society approach to health workforce planning, development and management, while increasing the availability and implementation of national health workforce policies/strategies, and assisting countries to adopt national health workforce accounts to improve tracking and reporting capabilities. Through WHO initiatives, countries have enhanced their capacity to track health workforce data and conduct health labour market analyses, which have been invaluable in informing policy reforms and stimulating job creation.

Increasing capacity for training health workers has been another focus area, with the 70% improvement rate a significant result. Between 2018 and 2022, for example, the number of graduates increased from 150 000 to over 255 000 across 39 countries – evidence of governments investing heavily in the establishment and maintenance of over 4000 health training facilities to graduate a wide variety of health care professionals, tailored to meet their populations' health needs. Interestingly, at least 40% of this capacity development has come from the private sector.

Despite the challenges that remain, the African Region now boasts a record number of health workers, with numbers increasing threefold between 2013 and 2022,

31 https://www.afro.who.int/news/african-regions-first-ever-health-workforce-investment-charter-launched

from 1.6 million to 5.1 million, including 850 000 community health workers. Gender disparities persist, but here too notable strides have been made, with women now comprising 72% of the health workforce. In addition, the proportion of female medical doctors increased from 28% to 35% between 2019 and 2022.

This growth in health workforce training has directly impacted access to health care services for people on the continent, with the ratio of health professionals, including doctors, nurses, midwives, dentists and pharmacists increasing from 11 to 27 per 10 000 individuals between 2013 and 2022[32].

Not all countries are progressing at the same pace, however, which impacts overall progress towards UHC on the continent. Some have successfully transitioned from the bottom 25% to the top 25% in health workforce development, but 12 countries[33] are still struggling and will need systematic and intensified support going forward.

As countries chase the bold target of halving the African Region's critical 6.1-million health workforce shortage by 2030[34], maximizing training outcomes will be crucial, particularly among those who work at primary care level where the impact is most significant.

32 World Health Organization Regional Office for Africa, A Decade Review of the Health Workforce in the WHO African Region, 2013–2022.

33 Central African Republic, Chad, Gambia, Guinea, Madagascar, Malawi, Mali, Niger, Senegal, South Sudan, Togo and United Republic of Tanzania.

34 https://www.afro.who.int/news/african-regions-first-ever-health-workforce-investment-charter-launched

4.3

Expanding access to essential medicines, vaccines and health products

UHC demands that all people have access to the full range of quality health services, when and wherever they are needed. Yet, WHO has struggled to improve access to medicines throughout its 76-year history, not least in Africa where the continent's position at the back of the COVID-19 vaccine queue highlighted the depth of the challenge.

The fact that all 47 countries in the African Region now have a national essential medicines list (EML) is a notable step forward. It reflects the WHO African Region's unstinting efforts to support Member States evaluate, revise and formulate evidence-based policies and strategies relating to essential medicines, vaccines and health products. The number of countries enforcing their national traditional medicine policy also surged, from 18 to 28[35] between 2010 and 2020, following WHO support to optimize and consolidate the role of traditional medicines (TM) in national health systems.

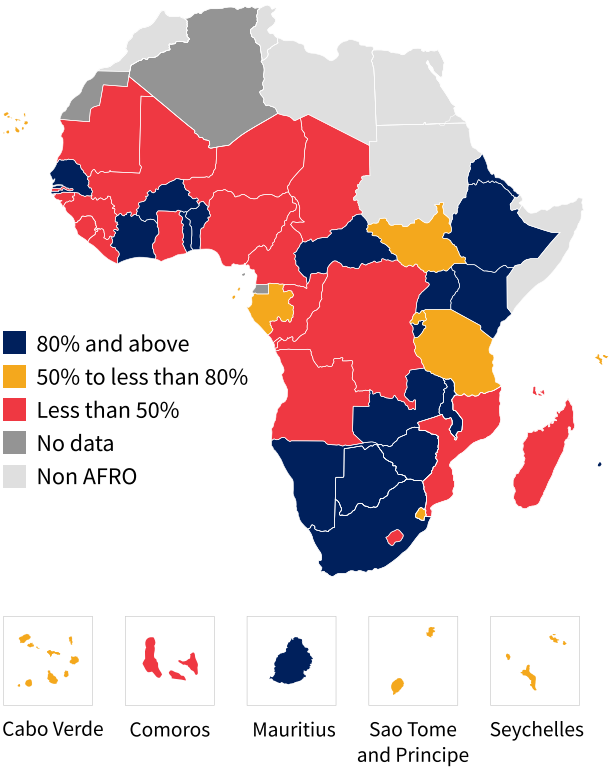
Blood safety and accessibility has also improved, with the number of African countries with a fully operational national blood policy increasing from 37 in 2015, to 43 in 2022. The average quantity of blood units obtained from both voluntary and involuntary donors, per 1000 individuals, saw a twofold rise between 2015 and 2022, from 5.2 to 10 units. The WHO Regional Office for Africa established a target for countries to acquire a minimum of 80% of their blood from voluntary, non-remunerated donors. As of 2022, 18 (38%) had achieved this target (see Figure 16), with further progress anticipated.

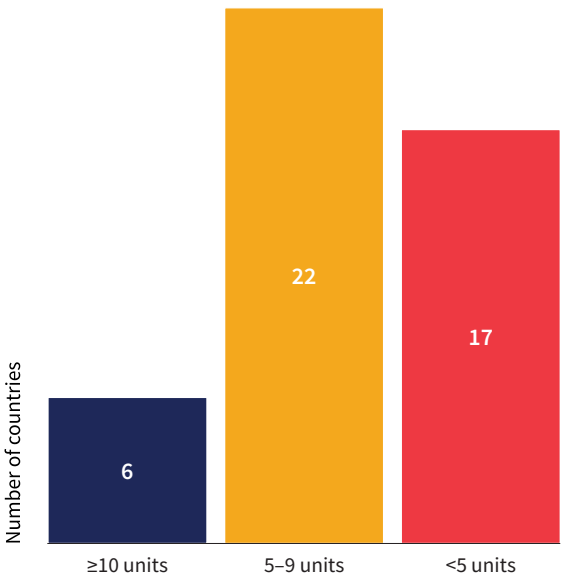
35 Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Madagascar, Malawi, Mali, Mauritania, Mozambique, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

In line with its mandate to offer reliable advice and establish benchmarks for the quality, safety and effectiveness of health products, WHO supported the establishment of the African Medicines Agency (AMA), by advocating for ratification of the AMA treaty, and providing technical support for its implementation. WHO in the African Region also played a role in creating a pooled procurement programme for Small Island Developing States (SIDS), by serving as its secretariat. Both these initiatives have resulted in improved access to health items, with the SIDS signing long-term agreements with chosen suppliers.

Improving access to high-quality medical products to the levels that UHC demands will fundamentally require unified regulatory standards for medicines, vaccines and other health care products, along with enhanced coordination among stakeholders, adequate financing, and resilient supply chains. Two gaps where WHO will have to play a particularly significant future role are local manufacturing of medical products, and monitoring of regulatory systems to ensure compliance and curb the growing burden of counterfeit and substandard medicines and other medical products on the continent.

Figure 16: Blood donation rate per 1000 population in the WHO African Region, 2022





4.4

Tackling antimicrobial resistance

"Antimicrobial-resistant infections caused 1.27 million deaths globally in 2019, more than HIV/AIDS and malaria combined. Sub-Saharan African countries bear the highest burden of AMR-associated death rates, at 99 deaths per 100 000 people."

Dr Matshidiso Moeti, WHO Regional Director for Africa

The fight against AMR and efforts to achieve UHC cannot be separated, considering that the former poses a significant threat to achieving accessible health services for all. Given that its increasing incidence is certain to make the provision of health care more challenging, less effective and more expensive, AMR is a priority for WHO in the African Region.

Following a World Health Assembly resolution on AMR in May 2014, and the development of a global action plan (GAP) on AMR[36] the following year in recognition of the profound threat AMR poses to human health, and the need for a One Health response, the proactive approach by WHO has made noteworthy progress.

Interventions have included assisting countries to develop national action plans (NAPs) and strengthening their capacity for effective implementation. Notably, the number of countries with NAPs on AMR under the One Health approach increased from two (4%) in 2015, to all 47 Member States (100%) in 2024. The number of countries with established AMR multisector coordination mechanisms increased from 13 (27%) in 2017 to 41 (87%)[37] in 2024. WHO also assisted 16 countries[38] to utilize its costing and budgeting tool to prioritize AMR interventions, and enhance advocacy, stakeholder engagement and resource

36 Global Action Plan on Antimicrobial Resistance, WHO 2015, (https://iris.who.int/bitstream/handle/10665/193736/9789241509763_eng.pdf?sequence=1)

37 Algeria, Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Mali, Malawi, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, South Sudan, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

38 Burundi, Central African Republic, Comoros, Equatorial Guinea, Gambia, Kenya, Mauritius, Nigeria, Rwanda, Sao Tome and Principe, Sierra Leone, South Sudan, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

mobilization. As a result, more than 220 costing coordinators across the Region are now better equipped and supporting other countries.

WHO introduced the Tracking AMR Country Self-Assessment Survey (TrACSS) in 2016 under a comprehensive One Health strategy, which has proved key in tracking countries' progress in addressing AMR concerns.

To boost monitoring of AMR trends, in 2016 WHO introduced the Tracking AMR Country Self-Assessment Survey (TrACSS), under a comprehensive One Health strategy, which has proved to be key in tracking countries' progress in addressing AMR concerns. The number of countries participating in the Global AMR and Use Surveillance System (GLASS), launched in 2015 to establish and boost surveillance systems, saw an appreciable increase between 2016 and 2024, from seven (15%) to 41 (87%).[39] GLASS standardizes data collection and analysis for decision-making.

The number of countries utilizing the monitoring tool, introduced in 2022 to track and report the progress of AMR NAPs, increased slightly, from 27 (57%) to 29 (61%)[40] between 2022 and 2024. This tool has enhanced efficiency and accountability of AMR NAP implementation in Ethiopia,

39 Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

40 Algeria, Benin, Burkina Faso, Burundi, Cabo Verde, Central African Republic, Cameroon, Congo, Côte d'Ivoire, Eritrea, Eswatini, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Mali, Malawi, Namibia, Nigeria, Seychelles, Sierra Leone, South Sudan, Uganda and United Republic of Tanzania.

Kenya and Zimbabwe, by improving reporting commitments and guiding resource mobilization efforts.

Going forward, access to early and high-quality laboratory diagnostics for AMR detection will be pivotal to identifying and monitoring AMR patterns.

The number of countries with national guidelines for the appropriate use of antimicrobials and the implementation of antimicrobial surveillance in selected health care facilities doubled between 2017 and 2024, from 10 (21%) to 20 (42%).[41] Additionally, national antibiotic consumption data from Burkina Faso, Burundi and Côte d'Ivoire showed that 75%, 90% and 82% of antibiotics consumed, respectively, belong to the Access group.[42] This approach aligns with WHO recommendations, which suggest that at least 60% of antibiotic consumption should come from this group for first- and second-line treatment for infections. The data was utilized to advocate for responsible antibiotic use.

To address the environmental impact of antibiotic production, WHO developed a technical guideline[43] that emphasizes stringent standards for waste management and cross-contamination, which regulatory inspectors must consider during routine inspections of pharmaceutical manufacturing facilities. Furthermore, through strategic directions and targeted interventions to address national priorities, coupled with the dissemination of success stories and best practices, WHO fostered advocacy and collaboration with diverse partners to enhance implementation of the AMR NAPs.

Other interventions included the preparation of regional products on the status of AMR resistance (2021),[44] awareness and education (2024),[45] and stewardship (2024),[46] which provided valuable insights for situational analysis and decision-making. The number of countries conducting nationwide AMR awareness campaigns to promote understanding and encourage behavioural change also increased exponentially between 2017 and 2024, from two (4%) to 16 (34%).[47]

Going forward, access to early and high-quality laboratory diagnostics for AMR detection will be pivotal to identifying and monitoring AMR patterns, as will evidence generation from regional programmes to identify gaps, and shape effective policy interventions.

To optimize proper use of antimicrobials, particularly in health care facilities, WHO will have a key role to play in assisting countries to enhance awareness, and develop and implement legislative and regulatory frameworks, along with other strategic interventions.

41 Algeria, Botswana, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Ethiopia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Malawi, Namibia, Nigeria, Rwanda, South Africa, Uganda, United Republic of Tanzania and Zimbabwe.

42 Access antibiotics have a narrow spectrum of activity, lower cost, a good safety profile and generally low resistance potential. They are often recommended as empiric first- or second-choice treatment options for common infections.

43 Technical guidance and aide-mémoire on good manufacturing practice inspection of pharmaceutical manufacturing facilities with focus on reducing the incidence of antimicrobial resistance, 2024, ISBN: 9789290313953.

44 Antimicrobial Resistance in the WHO African Region: A Systematic Literature Review, World Health Organization. Regional Office for Africa. (2021). License: CC BY-NC-SA 3.0 IGO.

45 Status of antimicrobial resistance education and awareness in the WHO African Region 2017–2021, WHO African Region 2024, ISBN: 9789290315063.

46 Status on national core elements for antimicrobial stewardship programmes in the WHO African Region, WHO African Region 2024, ISBN: 9789290313946.

47 Algeria, Benin, Burundi, Côte d'Ivoire, Eritrea, Ethiopia, Kenya, Lesotho, Liberia, Madagascar, Mauritius, Mozambique, Namibia, Nigeria, Rwanda and United Republic of Tanzania.

4.5

Protecting people from health spending-related impoverishment

From early in her first term, Dr Moeti was already voicing her concerns about high out-of-pocket (OOP) expenditure on health, which she said was impoverishing households and limiting access to health care services. An example was during the Health Systems Trust Conference in South Africa in 2016, when she expressed regret that some countries were dedicating less than US$ 60 per capita to health care, which she described as wholly insufficient investment to advance health systems strengthening.[48]

Studies indicate that to attain UHC, countries should allocate US$ 249–279 per capita towards health care (Stenberg et al., 2017). In 2020, five countries in the African Region (Botswana, Mauritius, Namibia, Seychelles and South Africa) invested a minimum of US$ 271 per capita in health. Conversely, the remaining countries spent less than US$ 249 per capita (see Figure 17).

48 https://www.afro.who.int/news/dr-matshidiso-moeti-who-regional-director-africa-calls-change-approach-health-systems

Figure 17: Current health expenditure per capita at country level in the WHO African Region

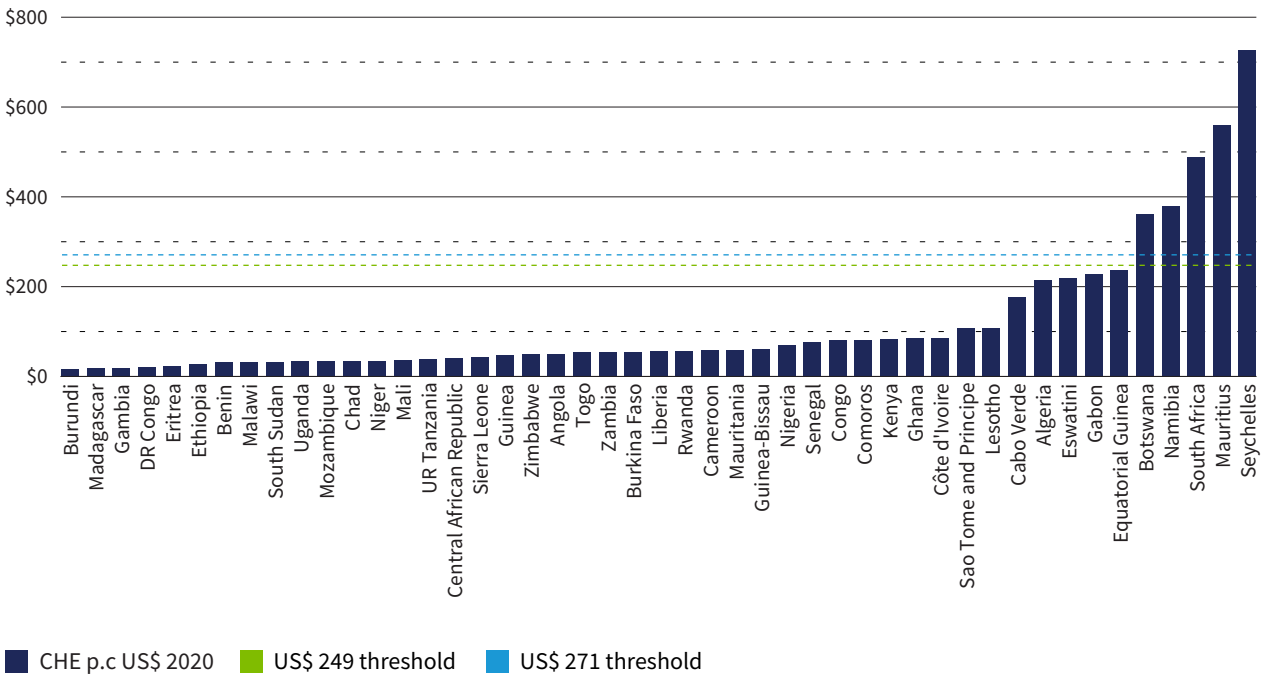
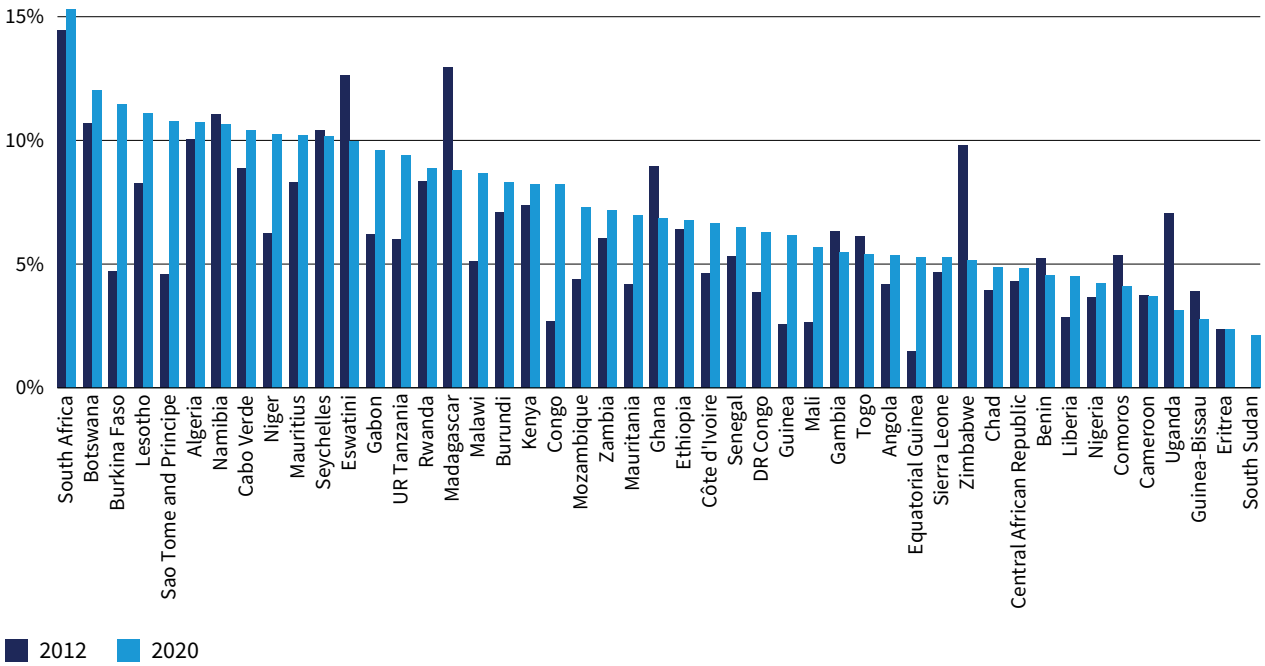


Figure 18: Domestic government spending as a share of total government spending in the WHO African Region



Source: GHED

Despite increased spending by 28 governments between 2012 and 2020, this trend varied from 6.3% on average in 2012 to 7.3% in 2020, falling way short of the 15% general government health expenditure from domestic resources target established by the African Union (AU) in the 2001 Abuja Declaration (see Figure 18).

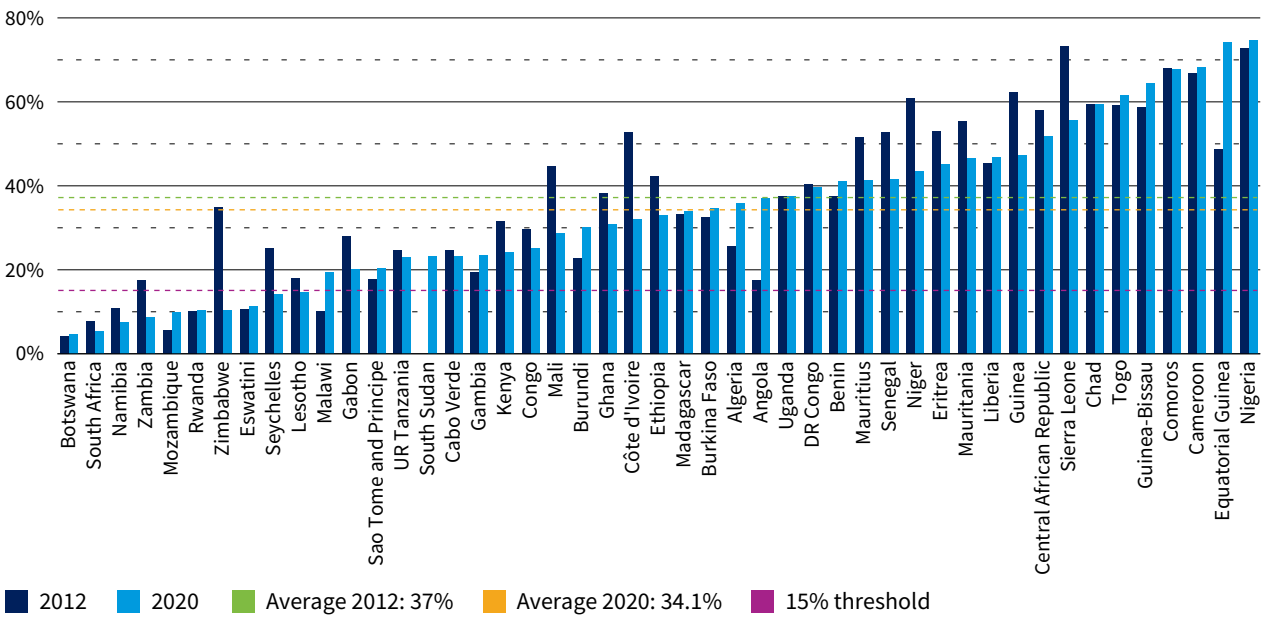
During the period 2000–2019, which included Dr Moeti's first term as Regional Director, the number of people impoverished or pushed further into poverty due to OOP health expenses actually fell by half, from 302 million to 152.2 million, a reduction partly attributed to overarching poverty reduction efforts. From 2012 to 2020, the regional average for OOP expenditure fell from 37% to 34.1%, marking an 8% decline. Again, the significant variations between countries, ranging from 5% in Botswana to 75% in Nigeria (see Figure 19), point to the challenge that still lies ahead.

To help turn the tide on this spending, which can have catastrophic impacts on families, WHO interventions have included assisting 32 Member States[49] to enhance their health financing systems through evidence-based strategies, while also providing relevant training to all 47 Member States. Of the former, 31 countries[50] received technical guidance in health financing assessments using the Health Financing Progress Matrix. To guide health financing policy decisions and reforms, capacity-building in cross-programmatic efficiency analysis (CPEA) was carried out

49 Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cabo Verde, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Ethiopia, Ghana, Guinea, Kenya, Liberia, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Togo, Uganda, United Republic of Tanzania/Zanzibar, Zambia and Zimbabwe.

50 Algeria, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Gabon, Guinea, Lesotho, Kenya, Madagascar, Malawi, Mali, Mauritania, Namibia, Niger, Rwanda, Sao Tome and Principe, Senegal, South Africa, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

Figure 19: Out-of-pocket expenditure in the WHO African Region



Source: Global health expenditure database

in 10 countries,[51] and technical expertise offered to 19 countries.[52] Public financial management (PFM) practices were tailored for effective health financing in 17 countries.[53]

A collaborative effort with the Africa Centres for Disease Control and Prevention (Africa CDC) Health Economics Programme and other partners delivered training to 23 countries[54] on evidence-informed priority-setting approaches for designing or revising health benefit packages. WHO also worked with the AU and other partners to streamline and enhance coordination of resource tracking activities.

Supporting countries to apply evidence-based decision-making does not automatically translate into effective implementation; rather, success is heavily dependent on political will and dedication. Given countries' fiscal constraints, WHO suggests that efforts should begin with the poorest and most vulnerable citizens by providing coverage for key drivers of OOP spending, such as medicines.

In a speech to the Africa regional conference on financing universal health coverage and health security in Ghana in October 2023, Dr Moeti called for greater political will and concerted action to arrest the worsening trend of financial hardship on the continent: "We need to scale up coverage of social protection mechanisms for people and continue to take every opportunity to advocate for increased investment in health and translate governments' commitment to health into reality," she noted.

51 Cameroon, Comoros, Côte d'Ivoire, Ghana, Kenya, Mozambique, Nigeria, South Africa, Uganda and United Republic of Tanzania.
52 Burkina Faso, Chad, Comoros, Ethiopia, Gabon, Gambia, Ghana, Kenya, Madagascar, Mali, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, South Africa, Togo, Uganda and Zambia.
53 Algeria, Benin, Burkina Faso, Burundi, Cameroon, Congo, Côte d'Ivoire, Gabon, Ghana, Kenya, Mozambique, Namibia, Nigeria, South Africa, Uganda, United Republic of Tanzania and Zambia.
54 Burkina Faso, Cabo Verde, Comoros, Côte d'Ivoire, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Liberia, Kenya, Madagascar, Mali, Mauritius, Nigeria, Rwanda, Senegal, Sierra Leone, Seychelles, South Sudan, Togo, Uganda and United Republic of Tanzania.

4.6

Strengthening diagnostic and laboratory services

The Regional strategy on diagnostic and laboratory services and systems 2023–2032 is very clear on the role of diagnostic and laboratory services in UHC. It says: "Improving availability and access to diagnostic services is essential for achieving universal health coverage and the health-related Sustainable Development Goals (SDGs)". Among its priorities is the integration of diagnosis into essential health services, to improve health care provision, disease control and outbreak response.

Over the past 10 years, WHO in the African Region has devoted itself to supporting the establishment of laboratory directorates or units under ministries of health, as part of technical support to improve delivery of laboratory services at national level. The onset of COVID-19 certainly accelerated progress as follows: in 2020 WHO and Africa CDC launched a network of laboratories to reinforce genome sequencing of the virus;[55] in 2021 WHO donated laboratory equipment and supplies to strengthen COVID-19 testing capacity to Ethiopia[56], Liberia[57] and Sierra Leone[58], among other countries; and in 2023 WHO officially launched its messenger ribonucleic acid (mRNA) vaccine technology hub in South Africa.[59]

The statistics reflect substantial improvement in laboratory services in the African Region as follows: between 2015 and 2023, the number of countries with an organized laboratory system increased from four to

55 https://www.afro.who.int/news/covid-19-genome-sequencing-laboratory-network-launches-africa
56 https://www.afro.who.int/news/world-health-organization-donates-laboratory-equipment-and-supplies-strengthen-laboratory
57 https://www.afro.who.int/news/who-donates-essential-medicines-and-laboratory-supplies-covid-19-and-evd-testings-government
58 https://www.afro.who.int/news/who-boosts-sierra-leones-covid-19-response-and-disease-surveillance-600000-worth-laboratory
59 https://www.who.int/news/item/20-04-2023-mrna-technology-transfer-programme-moves-to-the-next-phase-of-its-development

36.[60] A total of 41 countries[61] (88%) now have a national director/head of laboratory unit, 32[62] (68%) have a national laboratory policy and 38[63] (80%) have a national laboratory strategic plan.

About 70% of health care decisions are made based on diagnostic test results, yet diagnostic services are allotted only 3–5% of health care budgets.

The progress has its roots in WHO-led resolutions and strategies. These began in 2015 with the release of a Stepwise Laboratory Quality Improvement Process Towards Accreditation 10 (SLIPTA) guide[64], and a checklist to guide Member States with implementing the quality improvement process in laboratory services. Currently, all African Region Member States routinely use the SLIPTA guidelines document and checklist to manage the quality of services.

Two years later, the WHO African Region Emerging Dangerous Pathogens Laboratory Network (AFR EDPLN) was established, comprising 14 national emerging dangerous pathogen (EDP) reference laboratories. The network facilitated the standardization of approaches for diagnostic testing, sharing of knowledge, skills and laboratory samples, as well as establishing an external quality assessment scheme and a regional biobank.

In 2022, the Global Laboratory Leadership Programme (GLLP) was launched in Africa, with 25 nationals from five Central African countries[65] receiving in-depth training on strengthening and sustaining national laboratory systems. The programme has the potential to improve laboratory governance and so should be extended across the Region.

This is another area which calls for a paradigm shift in attitudes to allocated funding. About 70% of health care decisions are made based on diagnostic test results, yet despite the advances in Africa, diagnostic services are allotted only 3–5% of health care budgets. Going forward, this trend is likely to especially impact medical imaging services and the associated high costs of keeping pace with the rapidly evolving digital landscape.

60 Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Chad, Congo, Democratic Republic of the Congo, Equatorial Guinea, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Kenya, Liberia, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

61 Angola, Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Central African Republic, Chad, Comoros, Congo, Democratic Republic of the Congo, Equatorial Guinea, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Liberia, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

62 Benin, Botswana, Burkina Faso, Burundi, Cameroon, Chad, Congo, Equatorial Guinea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

63 Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

64 Stepwise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA).

65 Chad, Central African Republic, Congo, Democratic Republic of the Congo and Gabon.

4.7

Strengthening systems and capacities for data generation, analysis and use

As health information systems mature, they become increasingly valuable as tools for countries to monitor, assess and improve health systems towards UHC. The information provides an effective road map to countries, considering that it enables them to better allocate resources, improve health services and expand their reach.

In recognition of the potential for robust health data analysis and knowledge generation to strengthen health systems, WHO has made significant efforts to enhance regional capacities. These include the development and promotion of innovative tools, technical support and training, advocating for health system enhancements, providing timely and quality information for evidence-based decision-making, conducting monitoring and evaluation, and engaging in research and development initiatives.

Utilization of the District Health Information Software version 2 (DHIS2), a free and open-source software platform for the collection, reporting, analysis and dissemination of data, doubled between 2015 and 2023, from 21 (45%) to 43 countries (91%) (see Figure 20). This trend has notably improved the availability and reliability of routine health data, with high-quality routine data now accessible for at least 80% of the crucial health indicators. Efforts are under way to implement DHIS2 in the remaining four countries.

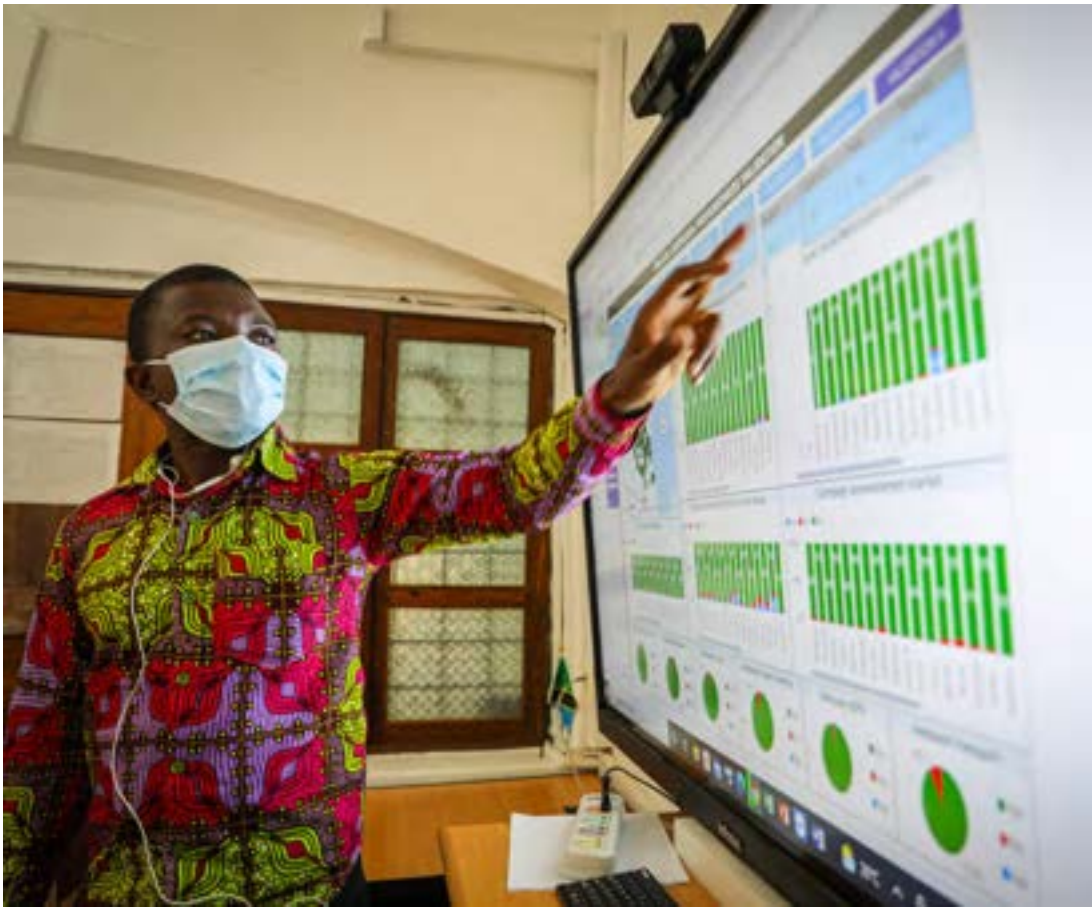
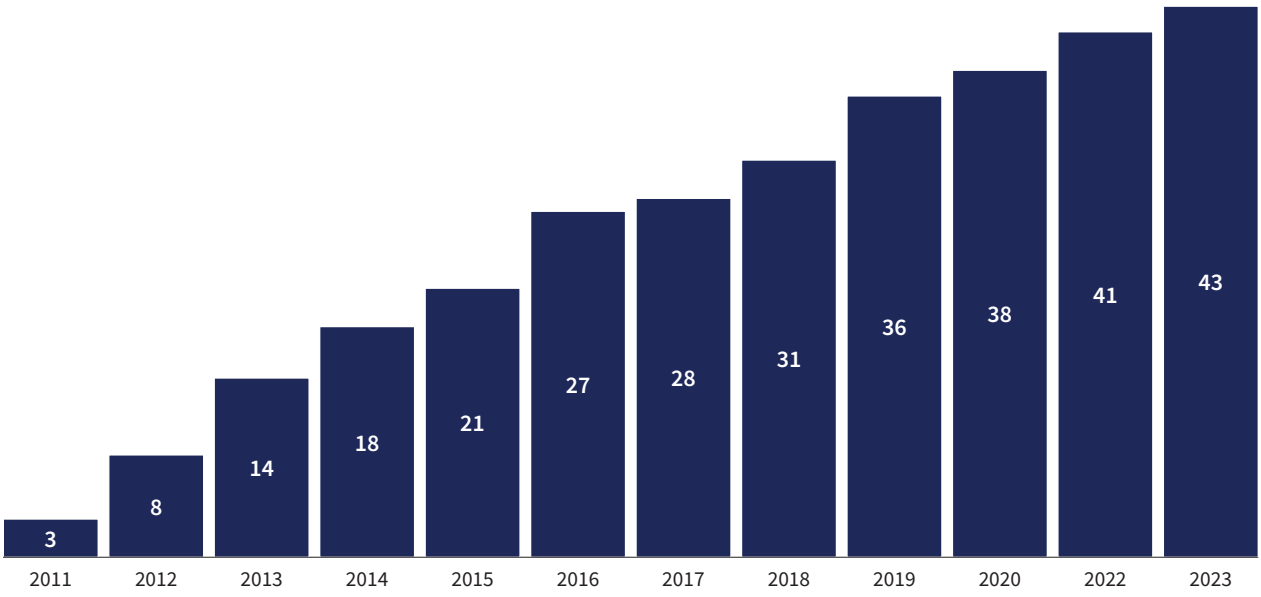


Figure 20: Cumulative number of countries implementing DHIS2 in the WHO African Region, 2011–2023



WHO formulated and promoted various regional frameworks and tools to support data generation, analysis and use, while also developing comprehensive tools for assessing national health information, consolidating data along the life course, tracking health sector performance, and analysing morbidity and mortality data. In collaboration with partners (Bill & Melinda Gates Foundation, European Observatory, London School of Economics and five academic institutions in Africa[66]), the African Health Observatory Platform on Health Systems and Policies (AHOP) was established for promoting evidence-informed policy-making decisions.

The integrated African Health Observatory (iAHO), which evolved from the African Health Observatory in 2020, together with the complementary national health observatories (NHOs), have provided vital insights into UHC- and SDG-related achievements, as well as other programme-specific regional and national indicators. As of 2024, 41 countries[67] had operationalized their NHOs.

Through another partnership with various agencies[68], WHO supported all African Member States to strengthen civil registration and vital statistics (CRVS) systems. This initiative engendered substantial improvements in the availability, quality and

66 Addis Ababa University, Health Policy Research Group University of Nigeria, Institut Pasteur de Dakar, Kenya Medical Research Institute and University of Rwanda.

67 Angola, Benin, Burkina Faso, Burundi, Cabo Verde, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

68 United Nations Economic Commission for Africa, Africa CDC, United States of America, Vital Strategies, United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), World Bank and African Development Bank.

use of birth, death and cause-of-death data. WHO, in collaboration with the South African Medical Research Council and Nelson Mandela University, also developed an online platform for training medical doctors on cause-of-death medical certification and coding.

The integrated African Health Observatory (iAHO), together with complementary national health observatories (NHOs), have provided vital insights into UHC- and SDG-related achievements.

All African Region countries now have systems to improve the reporting of births and deaths, including mortality surveillance; the availability of good quality mortality data has improved from less than 5% 10 years ago to around 40% currently. Countries including Botswana, Mauritius, Namibia and Seychelles have near-universal reporting of deaths, while Eswatini, Ghana, Kenya, Malawi, Rwanda and South Africa have achieved reporting rates over 80%. Meanwhile, birth registrations continue to improve, albeit slowly, rising from 51% of children registered in 2010 to 55% in 2022.[69]

A partnership with the Swedish International Development Cooperation Agency (SIDA), UNFPA, UNICEF and the Joint United Nations Programme on HIV/AIDS (UNAIDS) enabled WHO to help countries strengthen information systems for sexual and reproductive health and rights.

The Regional Data Hub (RDHub) is another key endeavour by WHO to monitor progress and performance in the African Region, which serves to integrate available data, generate information and enhance advanced analytics, including artificial intelligence (AI). It is envisaged that The Hub, which will have interoperability with country data systems, and a portal providing country-specific information, will address prevailing data fragmentation and serve as a single source of information in the Region. Health data collaboratives (HDC), which leverage partnerships for data to improve health outcomes, have also been established in 13 countries.[70]

Regional analytical products to track health patterns and trends in the WHO African Region include The State of Health in the African Region, the Atlas of African Health Statistics, Tracking Universal Health Coverage in the WHO African Region 2022, and the GPW13 country profiles, among others. Several technical briefs were developed to advise countries on a range of issues including optimal investment for enhanced health systems functionality and generating evidence on effective health services interventions, how to align health financing mechanisms with health systems goals, and managing change at different levels. These were complemented by regional analyses on health systems resilience, collectively providing rich and comprehensive evidence on the status of health, as well as the challenges and opportunities for attainment of UHC and the SDG-related health goals.

At national health system level, evaluations conducted included the 2019 SCORE[71] assessment of the state of health information systems in all countries of the African Region and comprehensive assessments of the state of health in five countries[72], with

69 UNICEF, 2022. A Statistical update on birth registration in Africa.
70 Botswana, Burkina Faso, Burundi, Cameroon, Ethiopia, Gambia, Kenya, Niger, South Sudan, Togo, Uganda, United Republic of Tanzania and Zambia.
71 SCORE is an acronym for: Survey of Populations, Count of Births, Optimization of routine or facility information system, Review of health sector strategies and policies, and Enabling data use.
72 Angola, Cabo Verde, Equatorial Guinea, Madagascar and Mauritius.

the information generated used to address identified gaps. Over the past 10 years, 43 WHO-supported health facility assessments were carried out, 22 of them in the past four years. They provided valuable data for improving the availability of services and the capacities of facilities.

WHO stands firmly behind the principle of utilizing data at the points of collection, such as health facilities, which boosts data availability and quality, given that health workers recognize its significance.

For district health systems, WHO developed tools and supported the assessment of functionality of district health systems in 18 countries.[73] This enabled countries to evaluate their oversight, management and health services capacity, and guided tailored action during the past four years. WHO stands firmly behind the principle of utilizing data at the points of collection, such as health facilities, which boosts data availability and quality, given that health workers recognize its significance. Ensuring data reporting by private health facilities is also important to enhance completeness of data.

Digital solutions have proven their worth in enhancing the quality and timeliness of data reporting, which in turn generates critical knowledge and insights to guide effective future health decision-making. For countries to maintain and accelerate the progress already made, enhanced government leadership is crucial. Commitments to prioritize health information system activities should be backed by functional mechanisms for coordinating partners and data systems, and a sufficiently capacitated workforce.

73 Botswana, Burundi, Cameroon, Chad, Democratic Republic of the Congo, Eswatini, Ghana, Guinea, Guinea-Bissau, Malawi, Mali, Mauritania, Mozambique, Namibia, Senegal, Sierra Leone, Uganda and United Republic of Tanzania.

4.8

Strengthening health leadership and governance

Given the centrality of governance to achieving the health-related SDGs[74], and the key roles of both governance and effective leadership in achieving optimal health systems functionality to enable UHC[75], WHO in the African Region has worked hard during Dr Moeti's dual terms to support Member States to update their national health policies and strategic plans.

According to WHO, health system governance relies on "the existence of strategic policy frameworks, combined with effective oversight, coalition building, regulation, attention to systems design, and accountability". As of 2023, 34 countries[76] in the Region had comprehensive and updated national health sector policies or strategic plans outlining clear visions, strategic objectives, and the actions and investments necessary to achieve their goals.

The UHC Partnership, a key collaboration which promotes a whole-of-society approach to addressing health priorities and empowering people to actively participate in decision-making that affects their health and well-being, assists all 47 Member States and provides health policy advisors to over 34[77] nations. To support

74 United Nations. Transforming our world: the 2030 Agenda for Sustainable Development. New York: United Nations; 2015.

75 Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action https://iris.who.int/bitstream/handle/10665/43918/9789241596077_eng.pdf

76 Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea-Bissau, Liberia, Malawi, Mauritania, Mauritius, Namibia, Niger, Nigeria, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

77 Botswana, Burkina Faso; Cabo Verde, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, South Africa, South Sudan, Togo, United Republic of Tanzania and Zambia.

implementation of the Health in All Policies framework, an approach on health-related rights and obligations aimed at improving the accountability of policy-makers for health impacts, WHO conducted capacity-building activities for 50 policy-makers across 15[78] countries.

Strengthening health ministry leadership through training, mentorship, capacity-building and on-site support has been front and centre of support efforts to countries focused on establishing institutionalized, multi-stakeholder health sector coordination mechanisms.

Strengthening health ministry leadership through training, mentorship, capacity-building and on-site support has been front and centre of support efforts to countries focused on establishing institutionalized, multi-stakeholder health sector coordination mechanisms. Countries including Burkina Faso, Congo, Côte d'Ivoire, Ethiopia, Ghana, Kenya, Senegal, South Africa, South Sudan and Zimbabwe now notably have active health coordination mechanisms as a result.

Along with promoting mutual accountability among health system actors, and aligning with partners for UHC and SDG acceleration, the work has improved national implementation of global health priorities, resource mapping, mobilization, emergency response and health coordination.

Collaboration has also improved between governments and the private sector, which plays a central role in health care provision to African populations. Through advocacy events and policy dialogues, WHO enhanced private sector involvement in health, a crucial achievement given that the private sector in the African Region delivers about 52% of outpatient care.

As a result, 18[79] countries in the Region have been supported to scale up improvement efforts, including national strategies, policy dialogues and national summits. Four countries[80] have established private sector engagement (PSE) committees at the national level within their ministries of health, while three countries[81] have revised their memorandums of understanding with the private sector.

Countries including Côte d'Ivoire and Ethiopia have taken the engagement even further, and received support to develop national strategies for effective private sector collaboration to advance UHC goals. Additionally, a comprehensive assessment of current public health legislation in the Region was conducted to guide the creation and/or revision of context-specific public health laws.

Numerous regional commitments and frameworks have also been endorsed in the African Region, including the Framework for health systems development towards UHC under the SDGs[82], adopted at the Sixty-seventh Regional Committee for the WHO African Region in 2017. The UHC in Africa: A Framework for Action[83] (2016), along with a regional forum for senior ministry of health officials, culminated in an action plan for strategic planning, investment priorities and progress monitoring. This forum

78 Benin, Botswana, Burundi, Cameroon, Eswatini, Kenya, Lesotho, Madagascar, Mozambique, Namibia, Senegal, South Africa, Uganda, Zambia and Zimbabwe.
79 Angola, Botswana, Burkina Faso, Burundi, Cabo Verde, Chad, Comoros, Congo, Côte d'Ivoire, Ethiopia, Kenya, Mauritania, Nigeria, Senegal, Sierra Leone, South Sudan, Uganda and Zambia.
80 Cameroon, Côte d'Ivoire, Nigeria and Sierra Leone.
81 Ghana, Sierra Leone and Uganda.
82 https://www.afro.who.int/sites/default/files/2018-01/AFR-RC67-10%20Framework%20for%20health%20systems%20development-Rev%2023.09.17.pdf
83 https://www.afro.who.int/publications/universal-health-coverage-africa-framework-action

was complemented by annual directors of planning regional summits from 2017 to 2020, engaging all 47 countries, which were unfortunately interrupted by the COVID-19 pandemic. Efforts are under way to resume these policy dialogues.

WHO needs to leverage its collaborative culture, sustain internal cooperation at all levels and provide comprehensive cross-disciplinary support packages to countries to address challenges.

The success of these collaborations delivered the decisive message that partnerships are crucial for enhancing support to countries, while a multisectoral approach to effective development and implementation of health systems and policies is a non-negotiable, especially during emergencies like the Ebola outbreaks and the COVID-19 pandemic. Updated policies and plans also assist in the mobilization and alignment of resources to country priorities.

The strength of the WHO approach lies in the recognition that the multi-faceted nature of health governance demands collaborative efforts across all levels. To build on its recent achievements, WHO needs to leverage its collaborative culture, sustain internal cooperation at all levels and provide comprehensive cross-disciplinary support packages to countries to address challenges. Maintaining its strategic leadership, by coordinating support from various partners as needed, is also key.

4.9

Strengthening research for informed decision-making

Widely divergent health systems and country-specific health challenges demand contextualized health care interventions to move towards UHC, raising the need for African countries to foreground the generation of contextualized evidence to inform solutions to local challenges.

Against a background of weak research capacity and inadequate resources that continue to impede quality research in the Region, WHO has prioritized the provision of strategic guidance to help Member States strengthen their national health research systems, including setting their own health agendas and contributing to regional ones.

To improve governance, funding and infrastructure for health research, the first African National Health Research System (NHRS) barometer[84] (with 17 parameters) was launched in December 2015, as part of the regional research strategy framework adopted that year. The regional average barometer scores have registered steady progress over the eight years to 2022: Governance of research for health (R4H) increased from 62% to 73% between 2014 and 2022. The capacity[85] to create and sustain research improved from 40% to 65% during the same period, and the number of countries with a dedicated budget line and financing for R4H from 51% to 62%.

Highlighting the value of collaborative partnerships in advancing research capabilities and supporting scientists, WHO partnered with the European and Developing Countries Clinical Trials Partnership

84 Kirigia JM, Ota MO, Senkubuge F et al. (2016) Developing the African national health research systems barometer. Health Research Policy and Systems 14, 53. This tool evaluates the performance of 17 parameters, including governance, finance, human and infrastructural resources, as well as the production and utilization of health research.

85 Assessment of capacity is based on: availability of a health research promoting unit within the ministry of health, universities/colleges that have a training programme in health research, and availability of a national health research institute/council.

(EDCTP), Tackling Infections to Benefit Africa (TIBA), the African Academy of Sciences (AAS) and Africa CDC, among others, to support African countries to conduct clinical trials and genomic sequencing, as well as develop COVID-19 counter measures.

The creation of knowledge translation platforms, such as Evidence Informed Policy Networks (EVIPNets), has been impactful in driving evidence-based policy-making more broadly.

During the pandemic, WHO also created standardized research protocols for crucial areas to expedite research. COVID-19 seroprevalence and vaccine effectiveness studies were carried out in 31[86] countries. As a result, tailored policy recommendations, based on the findings, were provided to countries to bolster and sustain vaccination efforts amid widespread perceptions of reduced disease risk.

The creation of knowledge translation platforms, such as Evidence Informed Policy Networks (EVIPNets), has been impactful in driving evidence-based policy-making more broadly. A 2023 mapping of knowledge translation platforms in the African Region revealed that 13[87] Member States (41%) had established EVIPNets, with the level of implementation of research rising significantly between 2014 and 2023. The number of research proposals to WHO in-

86 Algeria, Burkina Faso, Cameroon, Central African Republic, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Guinea-Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Senegal, Sierra Leone, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

87 Burkina Faso, Cameroon, Central African Republic, Eswatini, Ethiopia, Ghana, Kenya, Malawi, Mali, Nigeria, Uganda, United Republic of Tanzania and Zambia.

creased almost fourfold between 2015 and 2023, from seven to 26. In addition, the African Advisory Committee for Research and Development sustained multidisciplinary policy dialogues and knowledge exchanges to facilitate research in the Region.

More than 100 young researchers were supported to conduct research, in collaboration with multiple partners, with their findings adding significant value to public health interventions in the Region.

To encourage access to scientific data and knowledge through training programmes and digitization, with a view to enhancing access to scientific data and improving research capabilities, WHO conducted capacity-building on Hinari/Research4Life[88] in all African Member States. Hinari provides institutions in lower- and middle-income countries with online access to academic and professional peer-reviewed content.

To promote continuity and documentation of lessons learnt from the African Programme for Onchocerciasis Control (APOC), established with the goal of eliminating onchocerciasis from African countries where the disease remained endemic, WHO digitized all materials into an accessible and structured archive. These interventions contributed to improving access to information for further research and public health initiatives.

In celebration of the gains, WHO, in partnership with Hideyo Noguchi Africa Prize[89], recognized several African scientists for their global contributions to medical research and medical services. Winners have since been instrumental in mentoring young scientists. More than 100 young researchers were also supported to conduct research, in collaboration with multiple partners (WHO/Special Programme for Research and Training in Tropical Diseases (WHO/TDR), African Advisory Committee on Health Research and Development (AACHRD) and European and Developing Countries Clinical Trials Partnership (EDTCP)), with their findings adding significant value to public health interventions in the Region.

More work is needed to both establish and sustain functional health research systems, including allocating adequate funding, establishing strategic partnerships with academic institutions, and building local capacity for research. Regular evaluations of the functionality of health research systems to provide evidence-based solutions will translate to much-needed improvements in health research.

88 Hinari is part of Research4Life, the collective name for five programmes, with Hinari focusing on health.
89 https://www.jsps.go.jp/english/e-noguchiafrica/gaiyo.html

4.10

Advancing health through digital innovations

In 2018 in Benin, Dr Moeti told the second International Conference of Ministers of Health and Digital Economy on Health Security in Africa (CIMSA) that "digital solutions are the future of equitable, quality health care and resilient health systems". Notably, she said that mobile applications were being used to collect and transmit contact tracing and alert data during the Ebola outbreak in the Democratic Republic of the Congo at the time.[90] The launch of an electronic portal also allowed all response partners to access epidemiological data and information on entry points and health infrastructure, which significantly boosted understanding of the dynamics of the outbreak.

By the end of 2023, WHO had supported the development of national eHealth strategies in 38 African countries[91], with 18 countries[92] implementing interventions to improve digital health literacy. WHO, in collaboration with the International Telecommunication Union (ITU), had developed a digital health curriculum, and trained over 200 participants across 47 countries on AI.

By the end of 2023, WHO had supported the development of national eHealth strategies in 38 African countries, with 18 countries implementing interventions to improve digital health literacy.

90 https://www.afro.who.int/news/maximising-digital-health-technology-improve-quality-and-patient-safety-africa

91 Angola, Benin, Botswana, Burundi, Cabo Verde, Cameroon, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

92 Benin, Comoros, Congo, Gabon, Ghana, Guinea-Bissau, Kenya, Malawi, Mozambique, Niger, Nigeria, Rwanda, Senegal, South Sudan, Togo, Uganda, United Republic of Tanzania and Zambia.

Countries in the Region were also supported to implement mHealth initiatives, including mDiabetes in Senegal, MomConnect in South Africa, and Auto Visual Acute Flaccid Paralysis Detection and Response (AVADAR) for community-based polio surveillance in 11 countries.[93] Ghana, Nigeria, Rwanda, South Africa and Uganda were supported to implement telehealth and telemedicine opportunities, while WHO supported all countries to implement electronic Integrated Disease Surveillance and Response (eIDSR), Geographic Information System (GIS) and remote sensing interventions to enable real-time monitoring and response during outbreaks.

The WHO Innovation Challenge and Innovation Marketplace platforms highlighted a vibrant ecosystem of innovators, leading to the selection of 30 promising innovations for further support and upscaling.

An integrated campaign digitization toolkit was developed and implemented in several countries, specifically insecticide-treated nets (ITN digitization) in South Sudan in 2020, and the electronic Community Health Information System (eCHIS), a digital platform to digitize Kenya's community health workforce and advance UHC, in 2023. The WHO Innovation Challenge and Innovation Marketplace platforms were established in 2018 to identify, showcase and support promising health innovations. The more than 2400 applications highlighted a vibrant ecosystem of innovators, leading to the selection of 30 promising innovations for further support and upscaling. Their success demonstrated the value of creating platforms that connect innovators, funders and policy-makers.

Successful digital health interventions require collaboration across multiple sectors, whereas digital tools have a key role to play in managing disease outbreaks, including screening the population, tracking infections and minimizing direct human contact. At the same time, strong leadership is crucial to setting priorities, mobilizing resources, and building a shared understanding of the potential benefits of digital health, especially as AI technologies become increasingly integrated into health care and raise ethical considerations.

As WHO continues its work to sustain this momentum and build on the successes to date, focus on fostering a culture of innovation will help achieve the necessary strengthening of national digital health systems that is still required. Enhanced collaboration and partnerships will be central to the successful upscaling of digital innovations in African countries, as will the need to ensure ethical and responsible technology use.

93 Burkina Faso, Cameroon, Central African Republic, Chad, Democratic Republic of the Congo, Liberia, Mali, Niger, Nigeria, Sierra Leone and South Sudan.

Improving health and well-being along the life course

5

5.1

Breaking down health care silos

During the era of the Millennium Development Goals (MDGs), most countries in the WHO African Region were primarily focused on basic health packages targeting specific diseases and health challenges, through vertical or silo interventions. The WHO life course approach marked an essential paradigm shift to improve Africa's prospects of realizing the next-generation Sustainable Development Goals (SDGs), which came into force in January 2016, a year after Dr Moeti took office.

It was a time of transformation, with the life-course approach taking a temporal and societal perspective to the health and well-being of both individuals and generations. The model recognizes that all stages of life are intrinsically interconnected, not only with one's peers, but also with the lives and livelihoods of past and future generations.

Noncommunicable diseases were a formidable emerging health challenge, as were multi-morbidity conditions, such as diabetes-heart disease. This trend heightened the need for comprehensive health services for tackling not only diseases in isolation, but also healthy development, disease prevention, health promotion and the maintenance of long-term health.

The approach, central to the achievement of UHC and the SDGs, demands collaborative actions across sectors to tackle the social determinants of health and deliver comprehensive and seamless care at every life stage – pregnancy, infancy, childhood, adolescence, adulthood and old age.

At the start of the Transformation Agenda in 2015, the African Region was facing significant challenges in respect of primary health care (PHC) and reproductive, maternal, newborn, child and adolescent health (RMNCAH), both critical elements of the life course approach. In the aftermath of the 2014–2016 Ebola outbreak in West Africa,

The approach, central to the achievement of UHC and the SDGs, demands collaborative actions across sectors to tackle the social determinants of health and deliver comprehensive and seamless care at every life stage–pregnancy, infancy, childhood, adolescence, adulthood and old age.

essential health services across both rural and urban settings were served with the Declaration of Astana, which acknowledged the urgency of strengthening PHC systems as an essential step towards achieving UHC.

Despite these commitments, the COVID-19 pandemic left health systems struggling from 2020, causing widespread disruptions across all service delivery channels, including primary care and essential services for communicable and noncommunicable diseases, mental health, RMNCAH and nutrition. For the African Region, the crisis also delivered valuable lessons that prompted the adoption of strategies and innovations to overcome service disruptions and, crucially, to strengthen health system resilience for future emergencies.

The pandemic underscored the relevance of a life course approach, combined with robust PHC systems, which strategies have already begun engendering gradual improvements in key areas in the Region, including maternal, newborn and child mortality rates, access to quality sexual and reproductive health (SRH), and healthy ageing services. The progress needs to be significantly accelerated to address the remaining gaps towards achieving the SDG targets.

5.2

Advancing women's health

WHO played a key role in the substantial progress over the past decade to increase access to, and availability of SRH services in the African Region, with notable accomplishments including reducing the maternal mortality ratio (MMR), enhancing skilled birth attendance, increasing modern family planning utilization, advancing legal and policy frameworks for SRH services, and reducing harmful practices like gender-based violence and female genital mutilation (FGM).

The Organization advocated, developed policies and strategies, built capacity, disseminated guidelines and provided crucial technical assistance for the implementation of health sector strategic plans. Mobilizing resources was a top priority, and WHO in the African Region has helped raise more than US$ 100 million for this area of work over the past decade.

Many countries benefited from ongoing WHO technical assistance to integrate health system elements into grants from Gavi and the Global Fund, and to develop and implement national quality policies, strategies (NQPS) and initiatives to improve patient safety, and infection prevention and control. Guidelines were also disseminated and capacity-building webinars and trainings conducted.

WHO also led high-level policy dialogues and engagement initiatives to help countries develop overarching strategic plans for RMNCAH and, together with partners, supported 27 countries[94] to develop acceleration plans for maternal and newborn health (MNH). These plans aimed to prior-

94 Burkina Faso, Burundi, Chad, Comoros, Côte d'Ivoire, Eritrea, Ethiopia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, Zimbabwe and Zambia.

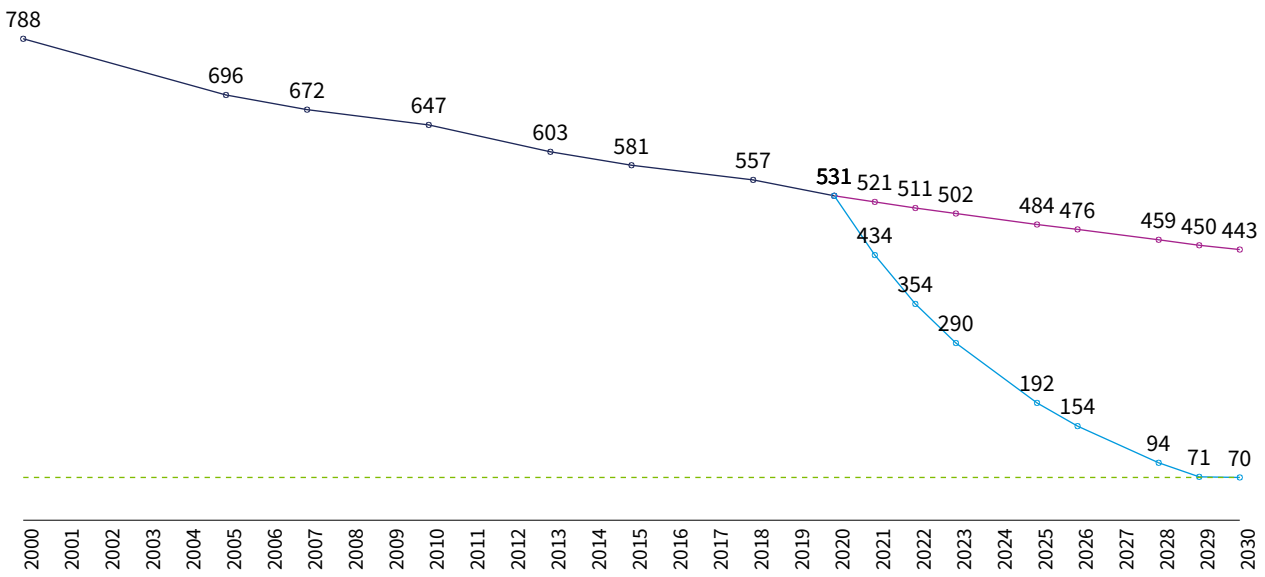
itize specific actions towards achieving the set targets by 2025.

The value of the interventions is reflected in maternal mortality rates, which have declined gradually in the African Region, signalling critical improvements in women's health. The MMR per 100 000 live births decreased by 38% (equivalent to an average annual reduction of 2%), from 857 to 531 between 2000 and 2020. It is noteworthy that the rate of decline was more rapid between 2000 and 2010 (3.3% per year), compared to 2010 and 2020 (1.5% per year). This discrepancy could be attributed to the considerable investments aimed at reducing maternal and child mortality during the MDG era.

Delving deeper into the statistics, however, the MMR reveals concerning disparities between countries, with West African nations typically recording higher MMR rates compared to other subregions on the continent (see Figures 21 and 22). For example, estimates for Chad, Nigeria and South Sudan are especially high, exceeding 1000 per 100 000 live births. A total of 43[95] countries have adopted national policies, guidelines and laws to notify, audit and/or

95 Angola, Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Ethiopia, Gabon, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Sudan, Sao Tome and Principe, Seychelles, South Africa, Togo, United Republic of Tanzania, Zambia and Zimbabwe. (Source: WHO 2023 SRMNCAH policy survey).

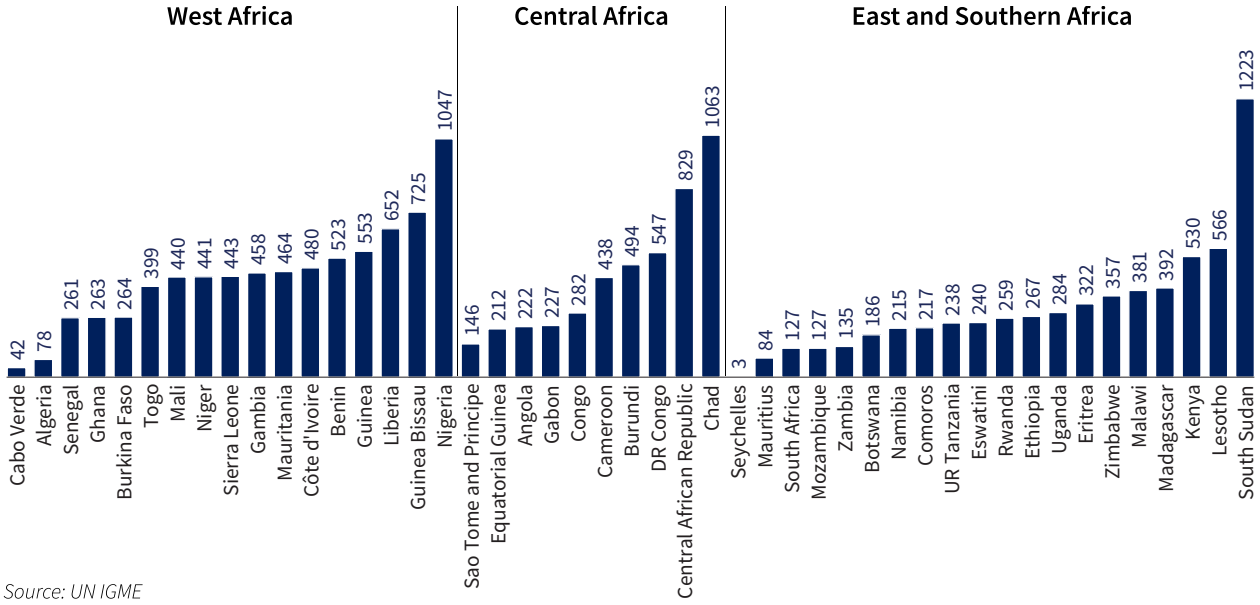
Figure 21: Trends in MMR (deaths per 100 000 live births) in the WHO African Region



Annual rate of reduction (ARR), 2015–2020: -1.8%
Expected ARR to reach SDG target, 2020–2030: -20.3%

Source: Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division

Figure 22: MMR (deaths per 100 000 live births) in the WHO African Region, 2020



Source: UN IGME

review every maternal death as a strategy to improve the quality of care for mothers, and end preventable deaths.

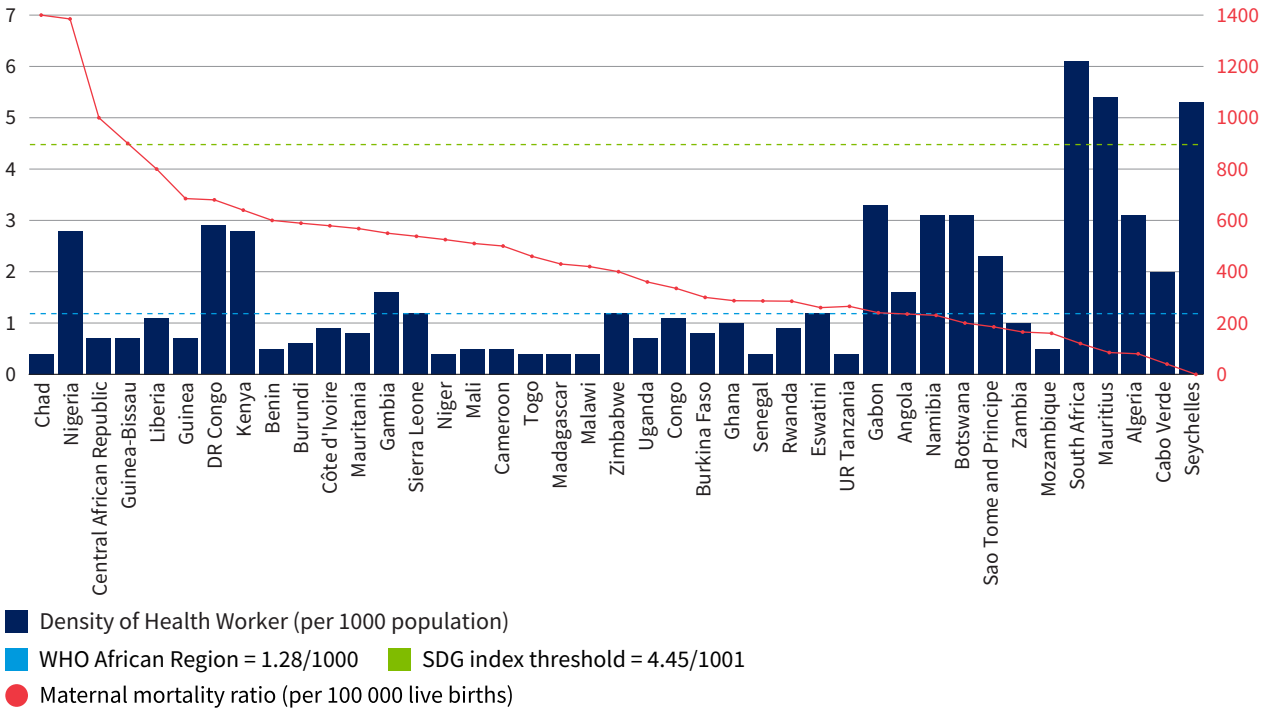
Progress to improve access to quality essential health services, particularly for reproductive and maternal health, has been especially evident in the field of HIV prevention. The proportion of pregnant women living with HIV who received effective antiretrovirals (ARTs) to prevent onward transmission of the virus to their children (excluding single-dose nevirapine), for example, rose from 71% to 84% between 2012 and 2022, marking a 17% increase. The percentage of countries with more than 60% postnatal care coverage also increased, from 28% to 46% between 2010 and 2023.

Another key improvement was in the percentage of births attended by skilled health professionals, which increased by 20%, from 54% in 2012 to 74% in 2022. The number of countries where over 80% of births are attended by skilled health professionals also increased, from 13 (28%) in 2010 to 28[96] (60%) in 2023. In the African Region, a higher density of health care workers, including skilled birth attendants such as doctors, midwives and nurses, is associated with lower maternal mortality rates (see Figure 23).

With regard to effective family planning, the proportion of women aged 15–49 years in the African Region whose needs were met by modern contraception methods increased from 47% to 58% between 2010

96 Algeria, Benin, Botswana, Burkina Faso, Cabo Verde, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Gabon, Gambia, Ghana, Kenya, Lesotho, Liberia, Malawi, Mauritius, Namibia, Rwanda, Sao Tome and Principe, Seychelles, Sierra Leone, South Africa, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

Figure 23: Density of qualified health personnel compared to MMR in the WHO African Region



Source: World Health Organization Global Health Observatory

and 2022. Five countries[97] surpassed 80%, while a further 10[98] achieved a proportion between 60% and 80%. Among women who are married or in a relationship in sub-Saharan Africa, the use of modern contraception methods rose from 25% to 30% between 2015 and 2023. As of 2022, around 41% of adolescent girls aged 15–19 who want to use modern contraception methods were using them, with support from community health workers contributing to increased usage in countries like Nigeria.

Harmful practices including FGM and sexual/gender-based violence, particularly among younger age groups, saw an encouraging decline, from 41% to 34% between 2010 and 2019 among women and girls aged 15–49. Again, however, prevalence varies significantly across countries, given that FGM still a major concern in the Western and Eastern subregions, where Eritrea, Guinea, Mali and Sierra Leone are reporting the highest rates.

Substantial progress was made in all countries towards creating supportive legal and policy frameworks for sexual and reproductive health and rights (SRHR) services, including abortion care. WHO supported 21 countries[99] to adopt updated guidelines on abortion care, as well as to boost skills and capacities of health-care providers to deliver high quality abortion care services.

In 2021, Benin and the Democratic Republic of the Congo revised their laws to expand access to abortion services, and similar legal revisions are underway in Malawi, Sierra Leone and Zimbabwe. Currently, 41 countries[100] allow abortion under specific conditions such as rape, incest, fetal impairment and in situations that endanger maternal health. In Cabo Verde, Mozambique, Sao Tome and Principe and South Africa, abortion is provided upon request to women up to a specific gestational limit. These advancements have prompted increased use of abortion care services, an important contributor to reducing maternal morbidity and mortality.

Despite the gains, high maternal mortality rates continue to be driven by delays in accessing or receiving care, provision of substandard care, and failure to utilize evidence-based practices in managing obstetric complications. Going forward, countries are encouraged to make optimal use of digital health innovations for tracking mothers, helping to monitor them from prenatal to postnatal care level.

97 Botswana, Eswatini, Lesotho, Namibia and Zimbabwe.
98 Algeria, Cabo Verde, Ethiopia, Kenya, Madagascar, Malawi, Rwanda, South Africa, Uganda and Zambia.
99 Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Central African Republic, Chad, Congo, Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Gabon, Ghana, Malawi, Mozambique, Nigeria, Rwanda, Sierra Leone, South Sudan, Zambia and Zimbabwe.
100 Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Malawi, Mali, Mauritius, Mauritania, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

SUCCESS STORY

Mozambique: driving down maternal mortality

"The hospital takes really good care of their patients. Everything went well and all three of us are fine up to today."

Maulete Joaquim

1 in 160

women in Mozambique were dying from pregnancy or childbirth complications in 2000

223

maternal deaths per 100 000 live births in Mozambique in 2023, representing a more than 50% reduction from the year 2000

15%

increase in overall health sector workforce between 2017 and 2021

Since 2018, Maulete Joaquim has experienced two complication-free births at Songo Rural Hospital in Mozambique's western Tete Province, the most recent in 2023.

For many years, this was not the case for women in Mozambique, where a protracted civil war had devastated public health services and infrastructure. Largely because of this legacy, Mozambique had one of the world's highest rates of maternal mortality in 2000, with about one in every 160 women dying from pregnancy or childbirth complications.

However, the country has since made significant strides to reverse the trend by prioritizing maternal health and saving the lives of thousands of women like Joaquim. In 2023, Mozambique's MMR was 223 deaths per 100 000 live births, equating to a more than 50% improvement since 2000.

Several critical interventions have contributed to this dramatic turnaround. Among them, health authorities have made concerted efforts to expand both the sector's infrastructure and its workforce. Between 2017 and 2021, 106 new health facilities were opened across the country, increasing access to health services. During the same period, the health sector's overall workforce complement increased by around 15%, with a similar increase in the number of health technicians.

"One of the actions that has made a major contribution to our efforts was the training of maternal and child health nurses, who play an extremely important role," says Dr Caetano Pereira, Chair of the Ministry of Health's National Committee on Maternal, Neonatal and Perinatal Deaths.

WHO has been a key partner in supporting Mozambique to establish a maternal death surveillance and response system and providing technical and financial support to the Ministry of Health in 2019 to update the training package on emergency obstetric and neonatal care. This was followed by the training of 40 national trainers across all 11 of the country's provinces.

In 2021, WHO also collaborated with health authorities to shape a comprehensive community health strategy. Implementation began in 2022, with a focus on increasing the capacity of community health workers for early risk identification among pregnant women.

"Mozambique has made commendable efforts to drive down maternal mortality," says Dr Severin Ritter von Xylander, the WHO Representative in Mozambique. "If the country can maintain the annual reduction it has observed, it is on course to reach the SDG for maternal mortality by 2030, saving countless lives in the process."

5.3

Advancing the health and development of every child

With the potential of Africa's fast-growing youth population to drive considerable regional growth, Member States and partners are significantly motivated to curb the persistent challenges of preventable stillbirths, and maternal, neonatal and child mortality in the Region. However, countries will have to fulfil their high-level commitments to promoting the health and well-being of children to accelerate lagging progress towards the achievement of health targets for child-related SDGs.

The continent's success stories are proof of what is possible. For example, five[101] countries across high, upper-middle and lower-middle income brackets have achieved the SDG target for under-five mortality, while a further nine,[102] including low-income nations, documented notable decreases in their under-five mortality rates between 2000 and 2022. Malawi, Rwanda and Sao Tome and Principe have successfully reduced under-five mortality by over 75%, while Angola, Burundi, Ethiopia, Senegal, Uganda and United Republic of Tanzania have recorded reductions of more than two thirds in their under-five mortality rates.

Over the past decade, death rates among children across the Region have continued to decline, with the under-five mortality rate per 1000 live births decreasing by 53% (equivalent to 2.5% annually), from 150 to 70 between 2000 and 2022 (see Figure 24). The rate of decline was more rapid between 2000 and 2010 (approximately 4% annually), compared to 2010 to 2022 (around 3% annually).

Similarly, the neonatal mortality rate per 1000 live births decreased by 35% (or

101 Algeria, Cabo Verde, Mauritius, Sao Tome and Principe and Seychelles.
102 Angola, Burundi, Ethiopia, Malawi, Rwanda, Sao Tome and Principe, Senegal, Uganda and United Republic of Tanzania.

"When we change the beginning of the story, we change the whole story. Note that maternal health and survival greatly impact the psychosocial growth of children. This level of achievement in the survival of women and children now justifies the need to invest and ensure that our children do not just survive but grow to their full potential."

Dr Charles Sagoe-Moses, WHO Representative
United Republic of Tanzania

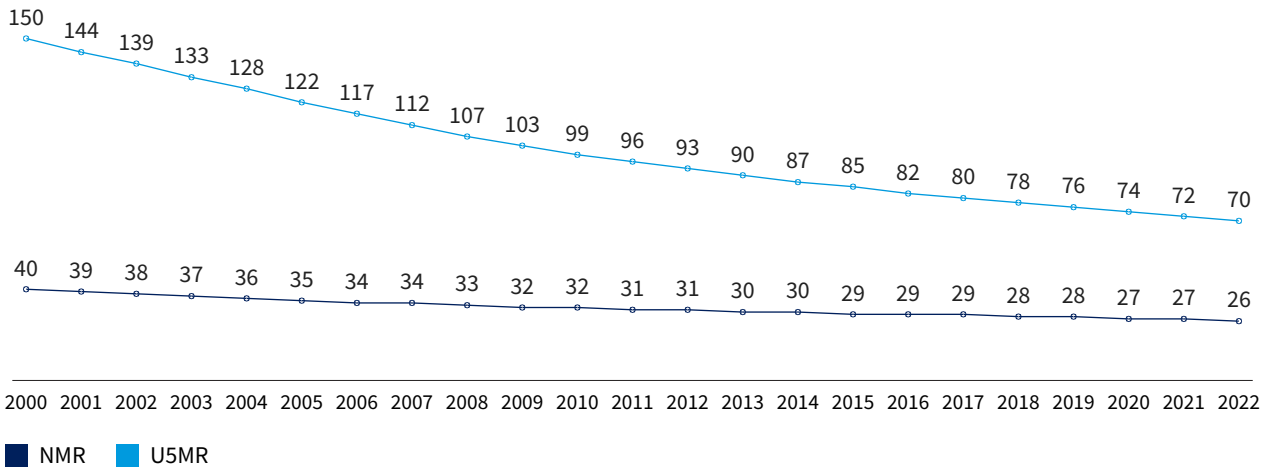
2% annually) from 40 to 26 between 2000 and 2022. If the estimated rate of reduction between 2000 and 2022 remains consistent, the under-five and neonatal mortality rates per 1000 live births will be 34 and 21 by 2030, respectively. However, these rates still would not meet the 2030 SDG targets for under-five (maximum of 25 per 1000 live births) and neonatal (maximum of 12 per 1000 live births) mortality rates.

To support progress towards the SDG targets, WHO in the African Region took the lead in developing a framework to enhance integrated child-focused services for ages 0-19 within the PHC context.[103] Rooted in and harmonized with the SDGs, the global strategy for women's, children's and adolescents' health (2016–2030), the PHC operational framework, and WHO framework for integrated, person-centred health services, it was co-created with various Member States and health programmes, and outlines key guiding principles, strategic action areas, expected outcomes and desired impacts.

WHO also led high-level policy dialogues and engagement initiatives, assisted countries to develop overarching strategic plans for RMNCAH, and helped formulate targeted acceleration/operational plans for various life stages. These endeavours involved devising essential health service packages catering to individuals of all age groups throughout the care continuum, along with strengthening capacity to implement and monitor progress.

103 Document being finalized.

Figure 24: Trends in under-five and neonatal mortality rates (deaths per 1000 live births) in the WHO African Region

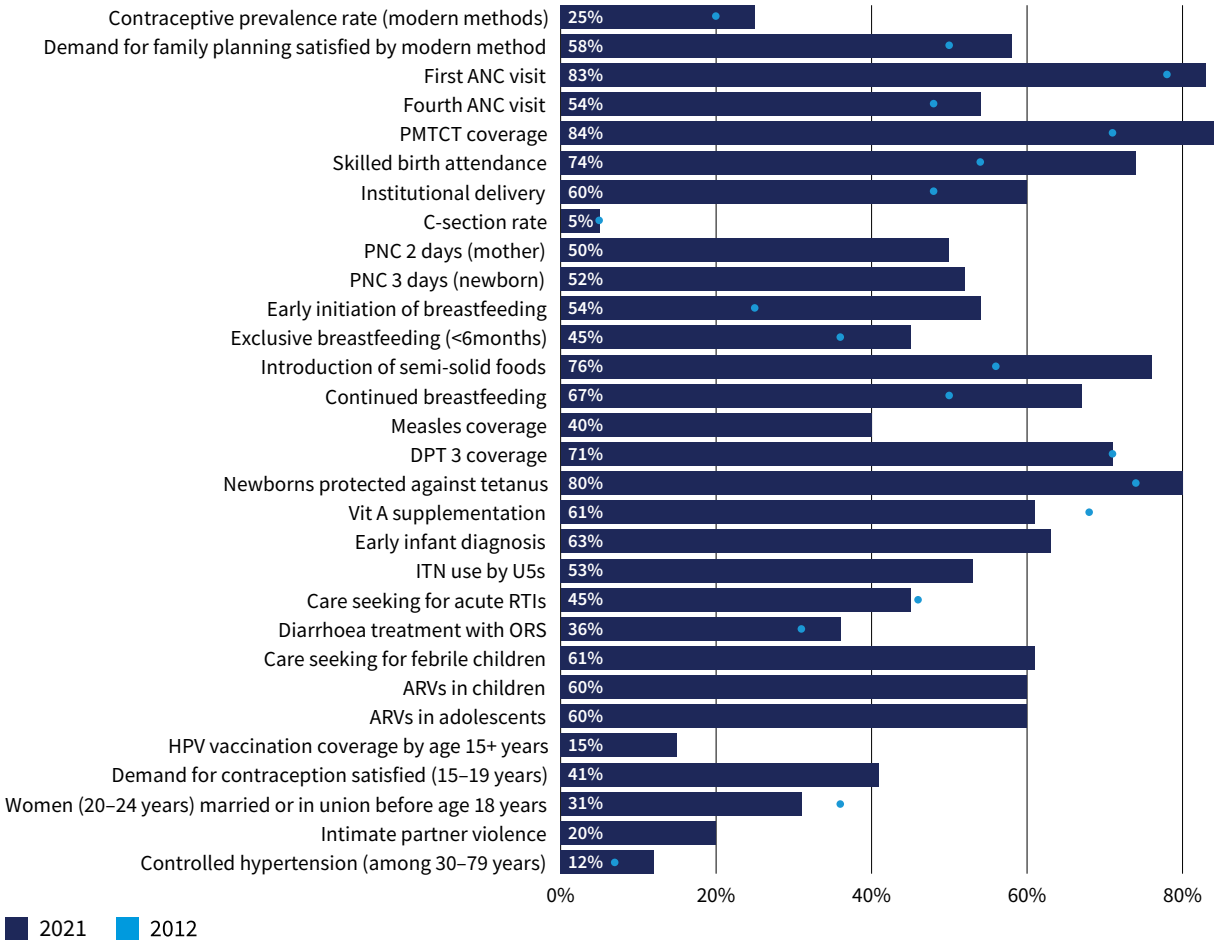


Source: UN IGME

To help capacitate countries to deliver the high-quality care needed, WHO provided practical guidance to integrate standards into health systems, while also working with partners to facilitate knowledge exchange among countries. As such, there was an uptake of best practices and innovations, which enhanced quality of care for maternal, newborn and child health, revitalized the Integrated Management of Childhood Illness (IMCI) strategy by adopting a systems approach to implementation, and embedded nurturing care into health systems.

Child health care interventions have seen increased coverage between 2015 and 2022. Other than skilled attendants at birth, the improvements are in areas including early initiation of breastfeeding, postnatal care for neonates, early infant HIV diagnosis, exclusive breastfeeding, antibiotics for pneumonia, oral rehydration solutions (ORS) and zinc use for diarrhoea (albeit from a very low baseline), insecticide-treated net usage against malaria, and ART for HIV.

Figure 25: Trends in coverage of selected interventions important for maternal, newborn and child health in the WHO African Region



On the ground, strategies to enhance access to, and the quality of integrated child health services (see Figure 25) have improved. A total of 35 countries[104] (74%) have national policies/guidelines on IMCI, while 32[105] (70%) have national quality-of-care standards for maternal and newborn care. In addition, 37[106] countries (77%) have enacted national policies, guidelines and laws to document each newborn death and stillbirth, while 24 countries[107] (55%) have a national strategy/implementation plan for the scale-up of care for small and sick neonates.

Early childhood development, spanning the cognitive, physical, language, motor, social and emotional growth of young children from conception to eight years old, is another focus area. Starting from conception, the initial years, particularly the first 1000 days, are characterized by rapid brain development, with early experiences wielding significant influence. Investing in nurturing care for early childhood development not only affects children's survival, healthy progression and maturation, but also influences healthy ageing, thus illustrating the necessity and advantages of adopting a life course perspective.

In the five years since the 2018 launch of the Nurturing care for early childhood development framework to help children survive and thrive, at a side event during the Seventy-first World Health Assembly (2018), WHO has supported a range of positive progress initiatives. As of December 2023, 32 African Region Member States[108] had embraced national multisectoral policies that create a supportive environment for delivering nurturing care. Within this approach, the health sector's response is particularly important, given the opportunities to capitalize on the frequent interactions young children and their caregivers have with the health system.

Ethiopia and Rwanda, for example, are operationalizing these multisectoral plans into health sector strategies, by outlining care packages for established contact points with young children and their caregivers, and enhancing the capacity of health workers to embed nurturing care for early childhood development into health systems to reach all young children.

WHO has also supported countries to adopt and implement guidelines aimed at improving the quality of health care for women, children and adolescents. These include the global Every Newborn Action Plan (2014), WHO Standards for enhancing maternal and newborn health (2016), children and young adolescents, and Operational guide for facility-based audit and review of paediatric mortality (2018). Others include guidelines and standards for small and sick neonates (2020), WHO recommendations for care of the preterm or low-birth-weight infant (2022), WHO recommendations on

104 Angola, Burundi, Benin, Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Cameroon, Democratic Republic of the Congo, Comoros, Eswatini, Ethiopia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe. (Source: 2023 SRMNCAH Policy Survey).

105 Benin, Burkina Faso, Burundi, Cabo Verde, Cameroon, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Namibia, Niger, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Sudan, Togo, Uganda, United Republic of Tanzania and Zambia. (Source: EPMM & ENAP tracking too 2023).

106 Angola, Burundi, Benin, Burkina Faso, Cabo Verde, Cameroon, Central African Republic, Chad, Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Ethiopia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe. (Source: 2023 SRMNCAH Policy survey).

107 Benin, Burundi, Cabo Verde, Cameroon, Chad, Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gabon, Gambia, Ghana, Liberia, Malawi, Namibia, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Sudan, Togo, Uganda and United Republic of Tanzania.

108 Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Comoros, Congo, Ethiopia, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Malawi, Mail, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, Uganda and United Republic of Tanzania.

SUCCESS STORY

Seychelles celebrates 50 years of saving children's lives through immunization

99%
coverage for the first dose of diphtheria-tetanus-pertussis vaccine (DTP1) in 2022

97%
coverage for the third dose of diphtheria-tetanus-pertussis vaccine (DTP3) in 2022

98%
coverage for the first dose of measles-containing vaccine (MCV1) in 2022

>95%
vaccination coverage for essential childhood vaccines, considered optimal to prevent disease outbreaks

Matteo Pragassen is almost a year old and his mother, Diane Uranie, has brought him to the Beau Vallon health centre in Victoria, the capital of Seychelles, for his measles-mumps-rubella vaccination. Shortly after arrival, nurse Brigitte Mathiot deftly administers the shot, and it is all over.

Routine childhood immunization is a key element of child health and survival services offered by the Ministry of Health in Seychelles. The country's immunization programme was formally established in 1974, with WHO support, and marked its 50th anniversary in 2024, along with WHO's Expanded Programme on Immunization.

Seychelles has attained high vaccination coverage for essential childhood vaccines, reaching above 95%, which is optimal to avert vaccine-preventable disease outbreaks in the population. In 2022, coverage for the first and third doses of the diphtheria-tetanus-pertussis-containing vaccine (DTP1 and DTP3), and the first dose of the measles-containing vaccine (MCV1), was estimated at 99%, 97% and 98% respectively, significantly higher than the comparative regional averages. The country also weathered COVID-19 disruptions very well, recording only a slight dip in coverage in 2021, before being restored to pre-pandemic levels the following year.

There has also not been a single case of measles or rubella in Seychelles since 2020, and immunization efforts have put the country on track to become the first in the African Region to receive certification for measles elimination.

The success of the immunization programme is multifaceted. Free and accessible child health services enable women to deliver at health facilities, ensuring timeous administration of vaccines at birth. Immunization is also integrated into other child survival interventions, with health workers educating mothers on the importance of immunization from early on.

"We start promoting immunization with the mothers from their antenatal clinic appointments, right through birth and postnatal clinic, until the children go to school," says Marylene Lucas, Director of Community Health Services in the Ministry of Health in Seychelles.

The stable economy of Seychelles, and high-level political commitment, have trans-

"As part of my postnatal care, the clinic advised me of the different shots Matteo would have to take as he grows older that are necessary for protection against various illnesses. I'm happy that he is getting the shots because it helps his body get immunity from diseases."

Diane Uranie

lated into sustainable financial resources and a dedicated budget line for immunization that cannot be used for other interventions. High literacy rates and access to media and information facilitate widespread acceptance of vaccination by the population.

Matteo will grow up protected against all vaccine-preventable diseases due to the dedication of his mother and a well-established health system. "I understand why Matteo needs to have his shots. I wouldn't want him to fall ill because we neglected to follow advice," Uranie says.

"WHO commends the Government of Seychelles for its commitment to childhood immunization. The Organization was there 50 years ago when the country established the programme, we have continued to be there for the last five decades, and we look forward to being there as the country reaches even bigger milestones."

Dr Rex Mpazanje
WHO Representative in Seychelles

antenatal care for a positive pregnancy experience (2016), WHO recommendations: intrapartum care for a positive childbirth (2018), and WHO recommendations on maternal and newborn care for a positive postnatal experience (2022).

Additionally, WHO supported countries to adopt standards for a positive antenatal and postnatal experience, and to manage childhood illnesses through the IMCI strategy. The full potential of this innovative child-centred strategy has yet to be realized. Following a stakeholder consultation in November 2022 in the United Republic of Tanzania, a recommendation was made for an "IMCI renewal" agenda, aimed at leveraging the ongoing revitalization of PHC and capitalizing on the existing alignment between the two.

Investing in nurturing care for early childhood development influences children's survival, healthy growth and development, and also impacts healthy ageing (see 5.5). Integrating nurturing care into all interactions involving young children and their caregivers within existing health care systems is feasible, and has the potential to enhance the overall quality of engagement between health care professionals and caregivers.

Ongoing initiatives to bolster the foundations of PHC for UHC, health security and the promotion of healthier populations, along with the WHO framework for integrated, person-centred health services, are all connected, given that together they play a central role in supporting a comprehensive agenda for promoting the health and well-being of children. Effective coordination and collaboration among health programmes, as well as across various sectors, are essential prerequisites for reshaping the trajectory of progress in the area of children's health.

5.4

Improving adolescent health and well-being

With an estimated 250 million adolescents (aged 10–19 years) in sub-Saharan Africa alone in 2020, accounting for one fifth of all adolescents worldwide and expected to rise to 24% by 2030, the African Region's burgeoning youth population offers an important window of opportunity to benefit from the demographic dividend, and enhance human capital.

Promoting healthy behaviours during adolescence, and taking steps to better protect young people from health risks, are critical for the prevention of health problems not only during this life phase, but also impact into adulthood. This is especially true considering the challenging social contexts particular to adolescents growing up on the continent, where poverty, early school leaving, child marriage and pregnancy, low health literacy, poor health-seeking behaviour and a relatively high burden of infectious diseases all negatively impact their health status.

In recognition of the depth of the challenge, there has been high level government commitment to multisector interventions across the continent. In April 2023, ministers of education, health, gender and youth from West and Central African countries signed a commitment to ensure an educated, healthy and thriving adolescent population. A similar commitment had been made three years previously by countries in Eastern and Southern Africa, while the governments of 10 African countries[109] pledged their support for the Agenda for Action for Adolescents' Health and Well-Being during the Global Forum for Adolescents in October 2023.

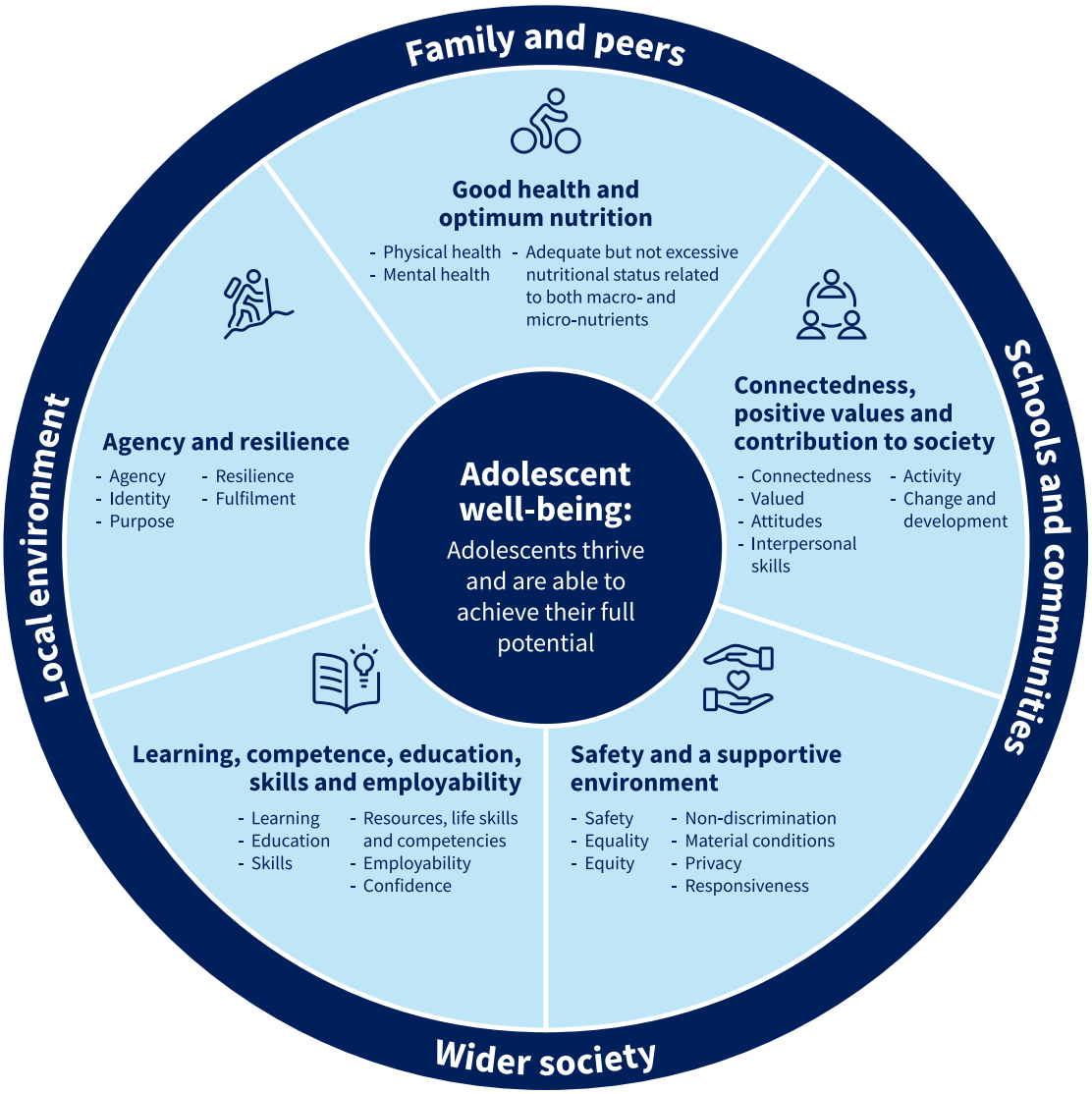
One of the notable changes has been the decrease in adolescent pregnancies, from 114 per 1000 live births in 2010, to 96

109 Botswana, Congo, Ethiopia, Ghana, Liberia, Malawi, Namibia, Nigeria, South Africa and Zambia.

in 2023 – a 16% reduction.

In 2017, early on in her first term as Regional Director for Africa, Dr Moeti launched the Adolescent Health Flagship Programme to improve adolescent health and well-being. It offered guidance and support for countries to implement evidence-based interventions, in line with the Global Accelerated Action for the Health of Adolescents (AA-HA!) guidance. The programme, with the Regional Director's initial catalytic funding, notably enhanced WHO's leadership capability. This was demonstrated by policy dialogue with governments, and the convening and rallying of UN agencies and other development partners towards a common agenda of government-led, systematic and comprehensive programming to secure the health and well-being of this vulnerable group.

Figure 26: Adolescent well-being domains



From the lessons learnt, and guided by the second edition of AA-HA! launched in October 2023, WHO set out to redesign the approach to implementing the programme as a holistic and interdisciplinary one. Internally at the WHO Regional Office for Africa, the key function of the programme is coordinating actions across clusters to facilitate integrated support to countries, and high-level results accountability, including reporting. WHO has also facilitated policy dialogues, Member State consultations and stakeholder consensus-building, driving a strategic shift from NGO-led projects to government-led national programmes for adolescent health.

Currently, 40[110] countries have developed strategic plans focused on adolescent health and well-being, contributing to significant improvement over the past decades, and have incorporated components of the AA-HA! guidance. Countries are also addressing gender inequities in adolescent health services. With support from WHO, 33 countries[111] are now utilizing the adolescent health services barriers assessment (AHSBA) tool, with a pool of 15 consultants trained for ongoing support. This tool is used for situation analysis to inform the development of gender-transformative, equity-focused and rights-based national policies and strategies.

High-level policy dialogue, with subsequent government commitment, is key in facilitating the implementation of transformative programmes. The East and Southern (2020) and West and Central African (2023) ministerial commitments to the education, health and well-being of adolescents and young people is successfully facilitating multisector programming for the health and well-being of adolescents.

110 Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cabo Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, Gabon, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

111 Algeria, Benin, Botswana, Burkina Faso, Cabo Verde, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Lesotho, Liberia, Madagascar, Mali, Mauritania, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, South Sudan, Togo, Uganda, Zambia and Zimbabwe.

Countries including Botswana, Seychelles and South Africa have requested support from WHO towards this endeavour.

There is also a need for increased focus on changing the mindsets of all stakeholders to transition adolescent health programming from a disease-focused medical approach, to one centred on well-being that necessitates inter-sectoral actions.

Crucially, inhibitory policies and laws are being revised to improve adolescents' access to health services. For example, Benin, with WHO and UNFPA support, revised its SRH law in 2021 to provide a framework for abortion care, and other SRH services. Nine countries[112] have established systems for accrediting health facilities as adolescent and youth friendly, using WHO standards. Between 2018 and 2021, 7910 health facilities were assessed, and 5532 certified as adolescent friendly. Furthermore, countries are scaling up adolescent health interventions, including human papillomavirus (HPV) vaccination for girls aged nine to 14 years in 28 countries.[113] WHO supports these countries to integrate HPV vaccination into broader people-centred care.

One of the learnings is that adolescent involvement is a key principle. In Kenya and Zimbabwe, youth-led organizations raised awareness during the COVID-19 pandemic and facilitated access to health services, reaching 7926 adolescents through local radio and social media.

To help counter the limited availability of adolescent-specific data, which impedes evidence-based decision-making, WHO has supported 12 countries[114] to review their health management information systems (HMIS) and District Health Information Software version 2 (DHIS2), to include disaggregated data on adolescents and youth. Since 2018, these countries have been collecting and reporting disaggregated data which has already been seen to inform policy and strategy development in Côte d'Ivoire, Democratic Republic of the Congo, Nigeria and Zimbabwe.

High-level government commitments to increase investments and improve policies and programmes targeting adolescents have the potential to yield impactful results going forward. There is also a need for increased focus on changing the mindsets of all stakeholders to transition adolescent health programming from a disease-focused medical approach, to one centred on well-being that necessitates inter-sectoral actions.

112 Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Malawi, Nigeria, Sierra Leone, South Africa and Zimbabwe.

113 Botswana, Burkina Faso, Cabo Verde, Cameroon, Côte d'Ivoire, Eritrea, Eswatini, Ethiopia, Gambia, Kenya, Lesotho, Liberia, Malawi, Mauritania, Mauritius, Mozambique, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

114 Burkina Faso, Central African Republic, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Kenya, Liberia, Mozambique, Nigeria, Senegal, South Africa and Zimbabwe.

SUCCESS STORY

DRC: improving adolescent and youth health services

1/3
of the population in DRC is aged between 10 and 24 years

17%
of youth and adolescents accessed health services in 2021

600
adolescents who visited Saint Clément Hospital Centre between July and December 2020, up from 280 for the same period the previous year

Nineteen-year-old Armande* recalls her disastrous first visit to a health centre. "It was awful," says the teen from Kongo Central, in western Democratic Republic of the Congo. "I was younger then and looking for information on HIV, and the nurse there made fun of me in front of everyone because of my age."

In the Democratic Republic of the Congo, the government is working to provide access to quality SRH services for adolescents and youth. According to the Strategic Plan for Health and Well-being for Adolescents and Youth (2021–2025), a third of the population is aged between 10 and 24 years. Yet only 17% of youth and adolescents accessed health services in 2021.

WHO supported the implementation of an innovative collaborative learning project backed by the Global Fund. Service providers work together to identify, discuss and propose solutions for common problems – all while strengthening capacity and developing positive attitudes, which then feed into the health services provided to adolescents.

"It's important to understand the individual. From there, we must take the time to listen, patiently and without judgment."

Jeannette Mudipanu
Nurse in Makala's Saint Clément Hospital Centre

"Young people and adolescents need services that are tailored to them," says Fidèle Mbadu Muanda, Director of the National Programme of Adolescent Health. "Collaborative learning is about strengthening capacities and changing attitudes among service providers. We've aligned the norms and policies linked to youth-oriented health services, according to WHO guidance."

In addition to providing technical guidance for the project, WHO supported trainings and the design of quality materials for providers.

The project was launched in six districts in the provinces of Western Kasai (Mbuji-Mayi) and Kinshasa in 2018 and 2019. Jeannette Mudipanu, a nurse in Makala's Saint Clément Hospital Centre who participated in one of the trainings, says she experienced a profound shift in perspective.

Youth attendance is now up at Saint Clément, with available data showing that around 600 adolescents visited the centre between July and December 2020, up from 280 for the same period the previous year. Exit interviews showed a 100% satisfaction rate.

The new approach was immediately evident to Armande. "It was night and day," she says, comparing it with her first experience. "The first thing I noticed was the way I was greeted. The nurse saw me in a private space and responded to my questions without judgment. Most importantly, she corrected some of the misinformation that was going around."

* Name has been changed

5.5

Promoting health and well-being in older people

With birth rates dropping and people living longer, global life expectancy has doubled since 1900 and continues to rise.[115] The population of over-60s in sub-Saharan Africa is expected to triple by 2050, requiring countries to address the historic inadequate implementation of policies tailored for older people, and establish systems to cater to their health care requirements.

Healthy life expectancy (HALE) increased from 46 in 2000, to 55 in 2019 in the African Region, with the number of older people growing fastest in Africa, and expected to triple from 54 million in 2020, to 163 million by 2050.[116]

In progress to date, African health ministers endorsed a regional framework on healthy ageing (2021–2030) in 2021, with 30 countries[117] subsequently developing national strategies for healthy ageing. Additionally, 12 countries[118] have established multisectoral coordination committees on ageing, while 29[119] have enacted legislation to combat discrimination based on

115 United Nations Decade of Healthy Ageing (2021–2030). In: United Nations General Assembly Seventy-Fifth session. Agenda item 131: Global health and foreign policy. New York (NY): The United Nations; 2020 (https://undocs.org/en/A/75/L.47 accessed 13 April 2021).

116 United Nations Department of Economic and Social Affairs, Population Division (2023). World Population Ageing 2023: Challenges and opportunities of population ageing in the least developed countries, UN DESA/ POP/2023/TR/NO.5.

117 Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Central African Republic, Chad, Comoros, Congo, Eritrea, Gabon, Ghana, Guinea, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritius, Namibia, Niger, Nigeria, Senegal, Sierra Leone, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

118 Botswana, Cabo Verde, Eritrea, Ghana, Kenya, Mozambique, Namibia, Nigeria, Rwanda, Senegal, United Republic of Tanzania and Zimbabwe.

119 Benin, Botswana, Burkina Faso, Burundi, Comoros, Congo, Côte d'Ivoire, the Democratic Republic of the Congo, Equatorial Guinea, Gabon, Ghana, Guinea, Kenya, Lesotho, Madagascar, Malawi, Mali, Mozambique, Namibia, Nigeria, Niger, Senegal, Sierra Leone, South Africa, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

age. Twenty-one[120] countries have also devised policies to offer cost-free services to older individuals in the public sector, and 18[121] have begun the process of creating age-friendly environments.

"Creating age-friendly environments to reduce inequity and transforming understanding of ageing and health are key first steps. Working with national health systems to help them adapt to the needs of the elderly, and to invest in appropriate personnel, should also be a priority."

Dr Matshidiso Moeti, WHO Regional Director for Africa

WHO has been an important advocate for programmes to enhance the health and well-being of older people, in line with the tenets of the United Nations Decade of Healthy Ageing (2021–2030). Under the Decade of Healthy Ageing programme, WHO has assisted countries to combat age-based discrimination, create age-friendly environments and provide integrated care for older people (ICOPE).

Specifically, WHO supported five countries[122] to adapt their guidelines and tools to implement an ICOPE approach. This ICOPE shift has enabled health-care providers to better understand and meet the unique needs of older people in PHC. In 2021, WHO also collaborated with HelpAge International to launch a campaign aimed at raising awareness about age-based discrimination (ageism). WHO's efforts in this area were honoured with the Amadou Mahtar Mbow Honorary Award during the First International Summit of African Elders and the Diaspora (SIAAD 2022), organized by the International Francophone Network of Elders (RIFA) in Senegal in 2022.

120 Algeria, Burundi, Cabo Verde, Comoros, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ghana, Lesotho, Madagascar, Mozambique, Namibia, Rwanda, Senegal, Sierra Leone, South Sudan, South Africa, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

121 Benin, Botswana, Cabo Verde, Chad, Congo, Democratic Republic of the Congo, Eritrea, Guinea, Kenya, Madagascar, Malawi, Mali, Niger, Nigeria, Sierra Leone, Rwanda, United Republic of Tanzania and Zimbabwe.

122 Botswana, Kenya, Mauritius, Nigeria and Senegal.

Advancing efforts to control and eliminate communicable diseases

6

SDG target 3.3:
By 2030, end* the epidemics of AIDS, tuberculosis, malaria and NTDs, and combat hepatitis, water-borne diseases and other communicable diseases.

**'Ending' is used to describe a process of setting targets, as prescribed by the SDGs, with measurable endpoints that are monitored and evaluated using scientifically determined indicators.*

6.1

Intensifying support for disease prevention and control systems and governance

Before the advent of COVID-19, the WHO African Region had been making real progress in disease prevention and control. The Region had reduced the incidence of malaria, tuberculosis (TB), polio, HIV, measles and hepatitis B, introduced new vaccines and improved access to clean water and sanitation. Like 92% of countries across the globe, however, the continent did not escape the profound disruptions to health services caused by the pandemic. Malaria and TB incidence increased, global TB deaths rose for the first time since 2015, and 22.7 million children missed out on basic immunization.

In the African Region specifically, the pandemic posed a major threat to the gains made, including the elimination of polio in 2020, and significant reductions in the number of new HIV infections and new TB cases, the latter by 22% (2015–2020). While momentum towards the 2030 Sustainable Development Goals (SDGs) stalled, the pandemic exposed the fragility of Africa's health systems, highlighting the urgent need to restore services to pre-pandemic levels in the short term, as well as the importance of investing in stronger systems capable of withstanding health emergencies in the future.

Prior to the adoption of universal health coverage (UHC) in 2015, global health focused on attaining the Millennium Development Goals (MDGs), which prioritized disease control and largely verticalized implementation. The adoption of UHC was an opportunity to shift to systems thinking, including the integration of health services delivery. To foster this, WHO reorganized the clusters to focus on UHC and integration.

One of the strategic shifts was the merging of previously separate communicable and noncommunicable diseases (NCDs) clusters into one, with UHC as the overarching strategic direction. This prompted

the establishment of the Universal Health Coverage Communicable and Noncommunicable Diseases Cluster (UCN) in 2019. The limitations of sectoral and vertical planning and programme implementation were already well recognized before the pandemic, as highlighted in the previous chapter. It was time for a new integrated systems approach to disease prevention, control, elimination and eradication.

It was time for a new integrated systems approach to disease prevention, control, elimination and eradication.

New strategies and guidance to fast-track priority actions were published, encouraging countries to shift their approach from vertical disease control programmes to integrated and cross-cutting approaches. Later, the introduction of four special initiatives[123] informed by national and international post-pandemic successes, accelerated technical support to countries to enhance pandemic preparedness in the Region. The interdependent initiatives aimed to intensify support for disease prevention and control systems and governance and stimulate new partnerships with African institutions to expand the pool of localized technical support available to national health authorities. Additionally, they focused on increasing investments in data science to further boost evidence-based decision-making, and strengthen research and innovation.

To implement the "Ending disease in Africa: vision, strategies and special initiatives, 2023–2030" strategic vision, the Region's disease prevention and control team has also been reorganized into four thematic teams: tropical and vector-borne diseases, including malaria and neglected tropical diseases (NTDs); HIV, TB and hepatitis; noncommunicable diseases and mental health (addressed in Chapter 7); and vaccine-preventable diseases). The restructuring also included a special flagship initiative called the expanded special programme on NTDs, and two cross-cutting teams: precision public health metrics focused on capacity-building for evidence generation and use for disease interventions; and strategic planning and policy focused on coherent policies and strategies across diseases and strategic partnerships.

123 These interdependent initiatives were designed to energize and diversify models of technical support delivered by WHO through intensive support to disease prevention and control systems and governance; new partnerships with African institutions and bodies to expand the pool of localized technical support available to national health authorities; investments in data science capacities for evidence-driven decision-making; and strengthened research and innovation addressing current and future public health priorities in the African Region.

6.2

Tropical and vector-borne diseases

6.2.1 Malaria

Two safe and effective vaccines, RTS,S and R21, recommended by WHO in a breakthrough for malaria control saw the introduction of pilot malaria vaccine programmes in Ghana, Kenya and Malawi.

In January 2024, Cabo Verde became the third country in the Region to be certified for malaria elimination, after Mauritius in 1973 and Algeria in 2019, in what was a significant public health triumph for the continent.

These programmes reached over 2.5 million children between 2019 and 2024, resulting in a 30% reduction in severe malaria, a 13% drop in overall child deaths and substantive reductions in hospitalizations. In 2024, WHO in the African Region also launched the Accelerated Malaria Vaccine Initiative Roll-out in Africa (AMVIRA) to further expand uptake and delivery.

In January 2024, Cabo Verde became the third country in the Region to be certified for malaria elimination, after Mauritius in 1973 and Algeria in 2019, in what was a significant public health triumph for the continent. It was a sea change from 2015 when Dr Moeti took office, a time when funding for malaria had begun to stall amidst increasing socioeconomic and emerging biological threats. Despite prior progress, which saw malaria incidence reduce by 41% and mortality rates by 62%[124] thanks to increased uptake of vector control tools, diagnostics and artemisinin-based combination therapies (ACTs), malaria was still having a devastating impact.

Regional targets were set to reduce malaria incidence and death rates by at least

124 WMR 2016

90% (2015–2030). Additionally, the targets aimed to eliminate malaria from at least six countries where it was transmitted in 2015 and prevent the re-emergence of malaria in all malaria-free countries. Milestones were set for 2025, 2028 and 2030, requiring Member States to report on biological threats and access to services.[125] WHO provided support with a range of special initiatives, including the AFRO II Project on Integrated Vector Management, an innovative research project in 13 countries[126] (2016–2022) that increased capacity for sustained evidence-based planning and implementation of vector control interventions. The project demonstrated the potential for reducing DDT use from 433.1 tons in 2017 to 114.5 tons in 2021 (a 73.6% reduction) and advocated for environmentally-friendly vector control techniques for reducing transmission.

The high burden to high impact initiative (HBHI), launched in 2018 by WHO and the RBM Partnership to End Malaria, was designed to support the 11 countries with the highest malaria burden,[127] 10 of which are in Africa. The initiative aimed to enhance political will to reduce the malaria burden, ensure the targeted use of strategic information, provide better guidance and coordinate the response effectively. Between 2020 and 2022, deaths from malaria in the 10 HBHI countries declined by 5%, from 443 771 to 420 468, with the biggest decreases in Burkina Faso (13%) and Mali (11%).

Malaria elimination in Algeria and Cabo Verde was galvanized by the E2020 initiative, which provided technical and financial support to 21 countries, including six[128] in Africa, while the E2025 initiative in 2021 resulted in a 25% and 5% reduction in malaria cases in Botswana and Eswatini respectively. Regionally, an 8.6% decrease in cases and a 12.6% reduction in malaria deaths was recorded between 2015 and 2022, with five countries[129] on track to achieve the GTS malaria mortality reduction tar-

125 Framework for the integrated control, elimination and eradication of tropical and vector-borne diseases in the African Region 2022–2030.
126 Botswana, Eswatini, Gambia, Kenya, Liberia, Madagascar, Mozambique, Namibia, Senegal, South Africa, Uganda, Zambia, Zimbabwe.
127 Burkina Faso, Cameroon, Democratic Republic of the Congo, Ghana, India, Mali, Mozambique, Niger, Nigeria, Uganda, United Republic of Tanzania.
128 Botswana, Cabo Verde, Comoros, Eswatini, São Tome and Principe, South Africa.
129 Cabo Verde, Ethiopia, São Tome & Principe, South Africa, Zimbabwe.

Table 5: Progress towards 2020 and 2025 milestones in HBHI countries, with a 95% uncertainty interval in brackets

Indicators/variable	Baseline (2015)	Latest data (2022)	Target for period (2022)	Observation
Malaria case incidence	243.6 per 1000 population at risk	222.6 per 1000 pop. at risk	106.7 per 1000 pop. at risk	52% off track
Malaria mortality rate	63.5 per 100 000 pop. at risk	55.5 per 100 000 pop. at risk	27.8 per 100 000 pop. at risk	50% off track
Number of countries having eliminated malaria	0	2 (in 2024)	2 (in 2024)	On track
Percentage of population using an insecticide-treated net (ITN)	53%	49% (56% in pregnant women and children under five)	At least 80%	Increased ITN use in target groups and stagnation in access and bed net use in general population, due to delays in mass campaigns because of the COVID-19 pandemic
Percentage of pregnant women attending antenatal clinic who underwent intermittent preventive treatment (IPT) at least three times	<20%	42%	At least 80%	Significant increase but still off-track due to missed opportunities in the delivery of integrated person-centred services
Number of children treated with at least one dose of seasonal malaria chemoprevention (SMC)	5 870 382 (nine countries)	4 371 905 (17 countries)	N/A	Increased coverage of SMC in scope and scale
Percentage of countries reporting on biological threats to malaria	N/A	23* (49%)	90%	Widespread insecticide resistance and detection of artemisinin partial resistance since 2016
Number of countries that have introduced the malaria vaccine	0	8†		
Number of children who received the malaria vaccine	0	2 500 000 (eight countries)		

* Angola, Burkina Faso, Burundi, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Niger, Nigeria, Senegal, Sierra Leone, South Africa, Uganda, United Republic of Tanzania, Zambia, Zimbabwe
† Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Ghana, Kenya, Liberia, Malawi, Sierra Leone, South Sudan (by July 2024)

get and five[130] slated to achieve adequate incidence reduction.

In March 2024, Ministers of Health from the 10 HBHI countries met to renew their commitment to ending malaria deaths, signing the Yaoundé Declaration.[131] Nigeria became the first of these countries to convene a national ministerial meeting on rethinking malaria elimination in the context of wider health sector reforms and

130 Cabo Verde, Ethiopia, Rwanda, South Africa, Zimbabwe.
131 https://www.who.int/news-room/events/detail/2024/03/06/default-calendar/malaria-ministerial-conference-tackling-malaria-in-countries-hardest-hit-by-the-disease

increased national budgets.

WHO played a central role throughout the past decade, providing technical support for data analyses, risk stratification and subnational tailoring of interventions. All 44 endemic countries[132] were assisted in conducting malaria programme reviews and revising their national strategic plans, while WHO also initiated capacity-building on risk stratification for subnational tailoring (SNT) for 30 endemic countries[133] and universities in 2023.

6.2.2 Neglected tropical diseases

With the African Region accounting for more than one in every three of the over 1.6 billion global neglected tropical diseases (NTD) cases, the response has been targeted, effective and efficient, with an impressive catalogue of advancements to address the considerable associated stigma, debilitating pain, gross disfigurement and death.

Despite all 47 countries in the African Region being endemic for at least one NTD, and 42[134] co-endemic for at least five, WHO has supported 13 countries[135] to be officially validated or certified for the elimination of at least one NTD as a public health problem (2015–2024), including Guinea worm disease, which is targeted for eradication. Togo became the first country in the Region, and indeed, globally, to be validated by WHO for eliminating four NTDs[136] in 2022.

Three countries[137] were certified free of Guinea worm disease transmission after 2015, bringing to 42 the cumulative number of countries certified in the Region, while nearly all countries[138] have achieved and sustained leprosy elimination, with eight[139] close to achieving interruption of transmission. Four countries[140] have also halted preventive chemotherapy (PC) for soil-transmitted helminthiases, following the reduction of burdens to levels where PC is no longer needed, for more than 17 million people.

Other achievements included 12 countries[141] becoming eligible for certification as free of yaws, and eight countries (including Togo) eliminating human African trypanosomiasis as a public health problem.[142] Significant progress was also made towards reducing the burden of other NTDs, such as visceral leishmaniasis, with over 4000 deaths averted annually through early case detection and prompt treatment. The number of Buruli ulcer cases reported decreased from 5871 to 1573 cases (2004–2023), representing a remarkable reduction of over 70%.

A key intervention was WHO's introduction in 2016 of the expanded special project for the elimination of NTDs (ESPEN), a flagship project to address five preventive chemotherapy NTDs (PC-NTDs) which represent 90% of the burden. ESPEN has coordinated technical assistance for

132 Angola, Botswana, Cameroon, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Guinea, Madagascar, Mali, Nigeria, Rwanda, Sao Tome and Principe, Senegal, South Africa, Uganda.
133 Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Equatorial Guinea, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Mali, Mozambique, Niger, Senegal, Sierra Leone, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe; University of Antananarivo, University of Malawi, Makerere University School of Public Health, Muhimbili University of Health and Allied Sciences, University of Nairobi, University of Zambia, University of Zimbabwe.
134 All 47 African countries co-endemic for at least five NTDs, except Cabo Verde, Comoros, Mauritius, Sao Tome and Principe, Seychelles.
135 Benin, Chad, Côte d'Ivoire, Equatorial Guinea, Ghana, Rwanda, Togo, Uganda (Human African Trypanosomiasis); Malawi, Togo (Lymphatic filariasis); Benin, Gambia, Ghana, Malawi, Mali, Togo (Trachoma).
136 Dracunculiasis (Guinea worm disease), Human African trypanosomiasis (sleeping sickness), Lymphatic filariasis trachoma.
137 Ghana (2015), Kenya (2018), Democratic Republic of the Congo (2022).
138 Except Comoros.
139 Algeria, Botswana, Cabo Verde, Eswatini, Lesotho, Mauritius, Sao Tome and Principe, Seychelles.
140 Burkina Faso, Ghana Mali, Niger.
141 Algeria, Botswana, Cabo Verde, Eritrea, Eswatini, Lesotho, Mauritania, Mauritius, Namibia, Seychelles, Sao Tome & Principe, South Africa.
142 Benin, Chad, Côte d'Ivoire, Equatorial Guinea, Ghana, Rwanda, Togo, Uganda.

building national capacity for integrated NTD programme planning, epidemiological assessments, and evidence-driven targeting of delivery of medicines for mass drug administration to endemic countries.

The NTD programme was later integrated into the tropical and vector-borne disease (TVD) programme as a way to leverage existing regional and country resources for addressing multiple diseases that co-exist in communities. This required the strengthening of primary health care services, and the use of integrated data analytics for the targeted delivery of integrated person-centred health care, using innovative strategies and tools. Specifically, the regional NTD programme is organized in two subcategories: those that benefit from preventive chemotherapy (PC-NTDs), and those addressed by case management (CM-NTDs).

The work is guided by several WHO policy and operational guidance and manuals, supporting countries to set clear country-specific priorities, adopt effective strategies and mobilize domestic resources, among other things. The Kigali summit on NTDs and malaria in June 2022 mobilized US$ 1.5 billion in financial commitments, with 18 billion tablets donated by pharmaceutical companies. During the 2023 Reaching the Last Mile Forum at COP28 in Dubai, donors committed over US$ 777 million to help accelerate progress towards achieving WHO's 2030 roadmap on NTD targets.[143] ESPEN also raised over US$ 74 million by September 2023, providing funding to 44 countries[144] in the Region. Significant funding gaps for NTDs remain, however, especially due to pandemic-related interruptions, which are challenging sustained efforts.

143 https://www.reachingthelastmile.com/rlm-forum/
144 All except Algeria, Mauritius and Seychelles.

Table 6: NTD indicators 2015–2026

Indicators/variable	Baseline (2015)	Latest data (2024)	Target for period (2026)	Observation
Percentage of population requiring interventions, who received or are receiving interventions for at least one NTD	65*	54†	75	Decline (from 65% in 2019) in coverage due to the COVID-19 pandemic in 2020–2021, and impact assessment surveys during 2021–2022. COVID-19 pandemic data for 2023 still being analysed.
Number of countries fully mapped for NTDs	41‡	47	47	
Number of countries that have updated/completed their national master plans	-	42	47	
Number of countries with NTD plans integrated into national health plans	-	35§	47	

* Represents 2016
† Represents 2022
‡ As at 2016: WHO CDS Annual report 2016_web version, page 26
§ Status of NTDs and Progress of NMP development in Member States, May 2024

6.3

HIV, tuberculosis and hepatitis

6.3.1 HIV

The African Region has the highest HIV burden in the world and comparatively fewer human resources dedicated to the fight against the epidemic. Yet, it is the leading Region globally in advancements towards the achievement of UNAIDS's 95-95-95[145] targets for optimizing HIV care by 2030, with seven countries[146] already achieving these targets. Overall, the African Region has achieved 90-82-76 to date, with 92-83-77 for Eastern and Southern Africa, and 80-76-69 for Western and Central Africa.

Data[147] confirms the remarkable progress made by Eastern and Southern Africa (ESA), the subregion with the highest HIV burden, which has reduced the number of new HIV infections and AIDS-related deaths by more than half (57% and 58% respectively) since 2010. The Western and Central Africa (WCA) subregion also made notable progress, reducing new HIV infections by 49%, and AIDS-related deaths by 52%.

Meanwhile, efforts to curb mother-to-child transmission (MTCT) of HIV saw Botswana (silver tier, 2021) and Namibia (bronze tier, 2024) both achieve the required indicators for the "Path to elimination of HIV" criteria introduced in 2017. Silver tier status requires an HIV case rate of fewer than 500 per 100 000 live births, a vertical HIV transmission rate of under 5%, and the provision of antenatal care and antiretroviral treatment to more than 90% of pregnant women.

This change in the trajectory of the epidemic in the Region over the past 10 years, reflecting successes in HIV control

145 95% of people living with HIV know their HIV status, 95% of people who know their status are receiving HIV treatment, and 95% of people on treatment are virally suppressed.
146 Botswana, Eswatini, Kenya, Malawi, Rwanda, Zambia, Zimbabwe.
147 UNAIDS DATA 2023. Geneva: Joint United Nations Programme on HIV/AIDS; 2023.

and response, is evidenced by a range of key metrics. These include a decrease in new HIV infections and an increase in the number of diagnosed people living with HIV (PLWHIV), and those who have achieved viral suppression due to treatment. Marking a pivotal moment in the global battle against the virus, new HIV infections declined by 56% over the period, with more new infections now occurring outside of sub-Saharan Africa for the first time in the history of the epidemic.

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The impact on children's health has been particularly noteworthy, with the number of new infections in those aged 0–14 decreasing most dramatically by 60% (244 000 to 98 000) between 2010 and 2023. This was directly impacted by the increase in the number of PLWHIV benefiting from prevention and treatment services, which accelerated reductions in new infections, AIDS-related deaths and MTCT rates. In ESA specifically, 93% of pregnant women living with HIV received antiretroviral therapy to prevent vertical transmission of HIV, with five countries[148] achieving an MTCT rate of <5% in 2022. More efforts are needed in WCA, where only 53% of pregnant women living with HIV receive antiretroviral therapy. Similarly, the number of people dying from HIV-related causes declined by more than half (56%) between 2010 and 2023, and the number of child deaths from HIV-related causes plummeted from 680 000 to 65 000, a 78% decrease. The comparative decrease for adults was 51%.

The focus on children was heightened in 2023 with the formal launch of the Global Alliance, an initiative to prevent paediat-

148 Botswana, Eswatini, Namibia, Rwanda, South Africa.

ric HIV infections and increase testing and treatment coverage. A total of 12[149] countries in the Region, accounting for 80% of global unmet needs for this population, committed to accelerating efforts to control the HIV epidemic among children and improve the response. Today, all these countries have conducted reviews of their HIV paediatric epidemic and response and developed acceleration plans.

Increased access to lifesaving antiretroviral therapy has been key to the gains, with the number of people receiving treatment surging from 5.04 million to 21.3 million in the 13 years to 2023. This expanded access contributed to an increase in average life expectancy among people living with HIV in the Region, from 56.3 years (2010) to 61.1 years (2023). The African Region is also implementing effective biomedical HIV prevention methods. The majority of people globally who started pre-exposure prophylaxis (PrEP) in 2022 were in Africa[150] (1 million of the 1.6 million), with countries quickly adopting and implementing PrEP recommendations and ensuring options, and making oral and long-acting injectable PrEP and the dipivefrine vaginal ring increasingly available.

Since 2016, these achievements have been guided by WHO policy and operational guidance and manuals, most recently the Framework for an Integrated Multisectoral Response to TB, HIV, STIs and Hepatitis in the WHO African Region 2021–2030, which prioritizes integrated interventions using a primary health care approach.

The marked differences in the HIV burden and response between the two subregions are a source of concern. Progress among WCA countries has been inconsistent, with some lagging far behind, and the coverage of HIV testing, treatment and viral suppression at less than 50%. The disparities have been attributed to ESA historically being at the centre of the global HIV epidemic, and therefore receiving major international attention for several years. WCA, on the other hand, has always received lower levels of attention, financing and other resources, while the governments in that subregion have been slower to show political commitment to the response against HIV.

Most of the new HIV infections in children are due to the failure to provide ART to their mothers during pregnancy and breastfeeding, combined with uneven testing rates among pregnant women. For instance, testing coverage of under 5% in four countries,[151] and under 50% in five others,[152] led to the high 21% MTCT rate recorded in WCA at the end of 2022, highlighting the need for an urgent scale-up of HIV treatment coverage for pregnant and breastfeeding women living with HIV.

6.3.2 Tuberculosis

Strengthening national TB programmes and improving access to quality TB diagnosis, treatment, and care were critical priorities for reducing the unacceptably high TB morbidity and mortality in the African Region in 2015, with the aim of achieving a 70% detection rate in 2022, the highest ever for the Region. Although this illustrates the significant progress made during Dr Moeti's tenure, about 2.5 million people fell ill with TB and around 424 000 died of the disease that same year.

Control efforts were impeded by low case detection rates, poor treatment outcomes, the growing threat of drug-resistant TB, in-

149 Angola, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Kenya, Mozambique, Nigeria, South Africa, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.

150 UNAIDS DATA 2023. Geneva: Joint United Nations Programme on HIV/AIDS; 2023.

151 Benin, Cabo Verde, Liberia, Mauritania: https://www.childrenandaids.org/sites/default/files/2023-11/231130%20WCARO_Snapshot_HIV%20FINAL_0.pdf

152 Central African Republic, Congo, Democratic Republic of the Congo, Gabon, Niger: https://www.childrenandaids.org/sites/default/files/2023-11/231130%20WCARO_Snapshot_HIV%20FINAL_0.pdf

adequate access to appropriate treatment, weak health systems and underfunded national TB programmes. In response, the Region adopted the End TB Strategy in 2017, aimed at scaling up the use of rapid molecular diagnostic tools, with shorter, more effective treatment regimens for TB as well as for multi drug-resistant TB (MDR-TB). The Region also expanded TB preventive therapy for people living with HIV.

By 2022, TB incidence had decreased from 255 to 205 per 100 000 people, marking a 23% reduction. During the same period, the TB mortality rate declined by 38%, from 67 to 42 per 100 000, and the proportion of patients with drug-resistant TB receiving appropriate treatment increased from 54% to 72%. The treatment success rate rose from 83.5% in 2019 to 85.2% in 2022, while the coverage of rapid testing for TB almost doubled between 2015 and 2022, from 24% to 48%, reflecting marked progress in the use of WHO-recommended rapid diagnostics.

By 2022, TB incidence had decreased from 255 to 205 per 100 000 people, marking a 23% reduction. During the same period, the TB mortality rate declined by 38%, from 67 to 42 per 100 000.

While the ESA subregion was a key driver of reduced TB incidence, with rates declining from 466 to 229 per 100 000 population (2000–2022) and TB deaths from 153 to 52 per 100 000, the WCA subregion saw only marginal decreases in incidence (309 to 286 per 100 000). Western Africa did, however, successfully halve TB-related deaths from 66 to 32 per 100 000.

As with HIV, the diversity of results at the country level highlights the importance of tailored strategies and targeted interventions. Congo and Gabon recorded increases in TB death rates, for example, while Ethiopia and the United Republic of Tanzania consistently recorded reduced rates. Meanwhile, Cabo Verde, Eswatini and South Africa achieved TB incidence reductions of 50% or more, while Mozambique and the Democratic Republic of the Congo recorded increases.

WHO's interventions and actions focused on five key areas: early diagnosis and treatment; preventive treatment; active case-finding; patient-centred care and support; strengthening laboratory systems; and management of drug-resistant TB. Through the West and Central African Regional Network for TB control, WHO also supported countries in strengthening TB surveillance and conducting implementation research. Specifically, 29 national TB programme reviews were conducted, 17 in 2022 and 12 in 2023.

Collaboration with partners helped expand access to new TB drugs and regimens, improving treatment outcomes. The establishment of a regional TB research network facilitated the generation of evidence for innovative approaches and the promotion of TB service integration with other primary health care services to improve access and coverage. Integrating TB services with other health programmes, particularly HIV, has proven effective due to shared resources, enhanced patient tracking and holistic care approaches.

6.3.3 Hepatitis

Viral hepatitis is the second leading infectious cause of death globally. Although the African Region bears 63% of the burden of new hepatitis B infections, only 18% of its newborns receive the hepatitis B birth dose vaccine.[153] Progress is being made, with

153 https://www.who.int/news/item/09-04-2024-who-sounds-alarm-on-viral-hepatitis-infections-claiming-3500-lives-each-day

WHO supporting 21 countries[154] to develop national strategic plans (NSPs) for hepatitis and 17 others[155] to put in place hepatitis testing and treatment guidelines. However, there is an urgent need to significantly scale up prevention, diagnosis and treatment to save lives and protect health.

Although various partners invest in initiatives to address viral hepatitis, the programme faces significant financial challenges and is severely underfunded. Domestic funding is the main pillar of support for hepatitis elimination in most African Region countries, despite evidence from several cost-effective models illustrating that the global elimination of hepatitis B and C would avert 4.5 million premature deaths between 2016 and 2030.

In the African Region, where nearly 65 million people are living with hepatitis B and nearly 8 million with hepatitis C, a total of 770 000 new hepatitis B infections and 172 000 new hepatitis C infections are recorded annually. In 2022 alone, more than 270 000 people died from hepatitis B and more than 35 000 from hepatitis C.[156]

The regional response is primarily guided by efforts from WHO and its partners to ensure the uptake and implementation of the Global health sector strategies on viral hepatitis for the period 2022–2030. This is done through the Framework for an Integrated Multisectoral Response to TB, HIV, STIs and Hepatitis in the WHO African Region 2021–2030. The ambitious goal is to reduce new cases of hepatitis B and C by

154 Algeria, Benin, Burundi, Burkina Faso, Cameroon, Democratic Republic of the Congo, Ethiopia, Ghana, Guinea, Kenya, Mali, Mauritania, Mauritius, Niger, Nigeria, Rwanda, Senegal, South Africa, South Sudan, Uganda, United Republic of Tanzania.
155 Algeria, Benin, Burkina Faso, Burundi, Cameroon, Ethiopia, Ghana, Guinea, Mali, Mozambique, Niger, Nigeria, Rwanda, Senegal, South Sudan, United Republic of Tanzania, Zambia.
156 Global hepatitis report 2024: action for access in low- and middle-income countries. Geneva: World Health Organization; 2024.

Table 7: Disease burden and service coverage in WHO focus countries for the viral hepatitis response

Countries	Hepatitis B (2022)			Hepatitis C (2022)		
	Total infections	Diagnostic coverage *(of all infected)*	Treatment Coverage *(of all infected)*	Total infections	Diagnostic coverage *(of all infected)*	Treatment Coverage *(of all infected)*
Cameroon	1 617 773	1.9%	0.2%	157 542	17%	11%
Côte d'Ivoire	2 155 631	1.5%	0.1%	211 114	8%	0%
DR Congo	2 785 244	2.4%	0.4%	432 499	13%	0%
Ethiopia	7 660 095	4.8%	0.0%	691 928	8%	1%
Ghana	2 865 177	0.7%	0.0%	442 797	5%	0%
Nigeria	14 385 770	0.6%	0.1%	1 349 056	5%	1%
Rwanda	207 232	66.8%	4.0%	62 170	100%	50%
South Africa	2 741 289	23.1%	0.1%	243 978	24%	1%
UR Tanzania	1 855 605	4.5%	0.0%	99 576	7%	0%
Uganda	1 123 667	35.3%	0.5%	356 043	9%	0%

Source: Global hepatitis report 2024: action for access in low- and middle-income countries

90% and associated deaths by 65% by 2030.

To do so, the Hepatitis B vaccine birth dose must be introduced in 35 Member States, while one third of infected people must be diagnosed and one third placed on treatment. Currently, despite some progress, the percentage of people living with hepatitis B and C who have been diagnosed with the disease is very low, at 4.2% and 13% respectively, with only 5.5% (hepatitis B) and 3% (hepatitis C) receiving treatment. In addition, hepatitis B birth-dose vaccine coverage remains low at about 18%.

Going forward, high-level political buy-in will be essential to develop primary health care service capacity, including workforce and technical capacity, to ramp up these statistics.

On World Hepatitis Day in 2022, WHO also launched a regional hepatitis scorecard to compare data from 2019 to 2021. Countries are now using the data for advocacy and strategic planning. To support this effort, training is being provided through 15 modules, which countries are using to update their own material for national and decentralized training. Also, webinars on priority topics, such as eliminating vertical hepatitis transmission, are being conducted. Additionally, WHO is supporting the virtual and in-person dissemination of hepatitis guidelines, in collaboration with WHO headquarters technical officers, to improve the quality of hepatitis care and services. Efforts are being made to address the challenge of submitting funding applications to the Global Fund, specifically to accelerate the integration of viral hepatitis interventions.

Member States have also continued to push for improvements, particularly in the availability, quality and timeliness of routine surveillance and monitoring and evaluation of routine hepatitis surveillance systems. For example, all countries were able to use available hepatitis datasets (surveys, routine programme data, individual data from private clinics) to feed the latest global hepatitis report using 2022 data.[157] Some countries have also displayed strong governance efforts to increase access to hepatitis services.

However, in 2023, only three countries[158] offered free hepatitis B diagnosis and treatment, while two[159] offered other partially free services (in the public health sector). For hepatitis C, two countries[160] offered free self-testing, diagnosis and treatment, while Ghana offered free treatment and Benin partially free treatment.[161] Going forward, high-level political buy-in will be essential to develop primary health care service capacity, including workforce and technical capacity, to ramp up these statistics.

157 Global hepatitis report 2024: action for access in low- and middle-income countries. Geneva: World Health Organization.
158 Rwanda, South Africa, Uganda.
159 Benin, Burkina Faso.
160 Rwanda, South Africa.
161 Global hepatitis report 2024: action for access in low- and middle-income countries. Geneva: World Health Organization.

6.4

Vaccine-preventable diseases

When Dr Moeti launched the Transformation Agenda in 2015, control of diseases, including vaccine-preventable diseases (VPDs), was identified as a key focus area. Swift action followed, with WHO in the African Region facilitating the Addis Declaration on Immunization in 2016 and the endorsement of the Immunization Agenda 2030 to achieve universal access to vaccines by 2030.

The onset of COVID-19 had a monumentally negative impact, with several routine immunization indicators backsliding, thereby threatening pre-pandemic gains.

However, the onset of COVID-19 had a monumentally negative impact, with several routine immunization indicators backsliding, thereby threatening pre-pandemic gains. Between 2019 and 2022, for example, coverage for the third dose of DTP-containing vaccine (DTP3) declined from 77% to 73%, opening the way to a resurgence of diphtheria, while the number of zero-dose (children who have never received a single dose of vaccine) and under-immunized children escalated by 16%. Several countries in the Region also reported outbreaks of circulating vaccine-derived poliovirus, measles, meningococcal meningitis and yellow fever.

African Vaccination Week in 2023 was marked by the Big Catch-Up campaign, a global push by WHO, working with UNICEF, Gavi, the Vaccine Alliance and other partners to reach these children and strengthen routine immunization programmes. By the end of that year, DTP3 coverage had increased to 74% regionally, while the number of zero-dose children decreased from 7.3 million in 2022 to 6.7 million in 2023.

Considering the statistics for the entire period from 2015 to 2023, there had been

several improvements despite the pandemic: DTP3 coverage increased from 70% to 74%, while 17[162] out of 47 (38%) African countries maintained a high DTP1 coverage of 90%; BCG tuberculosis vaccine coverage improved from 77% to 83%; and by the end of 2023, about 368 million people (32% of the Region's population) had completed the primary COVID-19 vaccination series. An additional 440 million people (37% of the Region's population) received at least one COVID-19 vaccine dose.

Between 2000 and 2022, annual measles deaths dropped by 76%, with an estimated 19.5 million deaths averted over the last 22 years. A total of 135 preventive mass measles vaccination campaigns were conducted in the 10 years to 2024, resulting in the vaccination of over 729.7 million children.

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Also, by 2024, 43 countries[163] had achieved maternal and neonatal tetanus elimination, showcasing progress in disease control efforts. For yellow fever, the number of outbreaks in the Region decreased from 12 to just three between 2013 and 2023, and meningitis deaths declined dramatically by up to 39% between 2000 and 2019. As of 2023, at least 377 million (86%) people in high-risk Member States were protected against yellow fever.

A total of 14 countries[164] introduced the meningitis vaccine into routine immunization programmes, and by the end of 2023, over 350 million at-risk people living in the meningitis belt had been vaccinated against meningitis A. Meningitis A, which used to be the leading cause of epidemic meningitis in the meningitis belt, has now effectively been eliminated from the belt. Successful supplementary immunization activities for meningitis C epidemics in Nigeria and Niger saw over 1 million people between 1 and 29 years vaccinated with the new WHO-prequalified multivalent meningitis conjugate vaccine by May 2024.

Efforts to increase human papillomavirus (HPV) vaccine coverage in the Region are also yielding results, with girls in 28 countries[165] (87%) benefiting from its introduction into routine immunization programmes by 2023, while boys in three[166] countries now also have access to the vaccine. Coverage by the first dose of HPV among girls in the Region increased to 40% by the end of 2023.

Other new vaccines introduced included the rubella-containing vaccine (RCV), by 75% of African Region countries and the measles-containing vaccine second dose (MCV2) by 91% of countries.

Improvements in domestic funding for immunization are supporting the upturn,

162 Algeria, Botswana, Burkina Faso, Cabo Verde, Eritrea, Ghana, Kenya, Lesotho, Mauritius, Niger, Rwanda, Senegal, Seychelles, Sierra Leone, Uganda, United Republic of Tanzania, Zimbabwe.

163 Algeria, Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.

164 Benin, Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Eritrea, Gambia, Ghana, Guinea, Guinea Bissau, Mali, Niger, Nigeria, Togo.

165 Botswana, Burkina Faso, Cabo Verde, Cameroon, Côte d'Ivoire, Eritrea, Eswatini, Ethiopia, Gambia, Kenya, Lesotho, Liberia, Malawi, Mauritania, Mauritius, Mozambique, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Uganda, United Republic of Tanzania, Togo, Zambia, Zimbabwe.

166 Cabo Verde, Cameroon, Mauritius.

with more countries covering vaccine costs through government resources. For example, the share of expenditure on vaccines used for routine immunization paid by governments increased from 35% to 59% between 2018 and 2022, marking a positive trend towards sustainable financing. By the end of 2023, WHO had also supported 43[167] Member States to establish national immunization technical advisory groups (NITAGs), pointing to enhanced governance structures for immunization programmes.

The gains have been supported by WHO's comprehensive approach to enhancing immunization programmes, strengthening disease surveillance, promoting research and innovation and collaborating with partners. Assistance to countries took the form of strategic planning and guidance, disease surveillance and monitoring, new vaccines and disease-specific interventions, immunization coverage monitoring, and the establishment and capacitation of laboratory networks for VPD diagnosis and genomic sequencing.

Regional laboratory and surveillance networks have been established to provide accurate and timely laboratory confirmation of infections, an essential component of disease surveillance systems, with WHO coordinating laboratory surveillance of VPDs. One such network is the Invasive Bacterial Vaccine-Preventable Disease Surveillance Network. Additionally, WHO has provided technical assistance and data tools to help identify gaps and improve these systems.

WHO also established the African Vaccine Regulatory Forum (AVAREF) in 2016, a platform for building ethics and regulatory capacity for clinical trials in Africa and ensuring access to safe, effective and quality vaccines. By fostering collaboration among key stakeholders through joint reviews and the sharing of work and expertise, AVAREF has helped to combat diseases including COVID-19, Ebola, meningitis, malaria, rotavirus and pneumococcal pneumonia.

Key lessons to further strengthen immunization efforts on the continent include the need for robust health systems to ensure equitable vaccine access across diverse populations, investment in cold chain infrastructure, integration of immunization with other programmes, and recognition of the pivotal role played by community health workers in building trust, dispelling myths and promoting vaccine uptake.

6.4.1 Polio eradication

The African Region's certification as wild poliovirus-free in 2021 marked a significant achievement in its public health efforts. This milestone was a testament to the unwavering dedication and progress towards eradicating the disease globally and a demonstration of the effectiveness of vaccination campaigns and surveillance systems in preventing the spread of polio. The achievement followed Nigeria's successful interruption of endemic wild poliovirus (WPV) transmission, with the last case reported in 2016.

However, polio eradication efforts suffered a setback when WPV regained a foothold in Africa. Although the imported virus from Pakistan into Malawi did not alter the certification of the Region as free of indigenous wild polio, it went on to paralyse nine children in Malawi and Mozambique, before it was halted.

WHO supported a concerted subregional response, which saw more than 50 million children vaccinated against polio in five

167 Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.

Figure 27: Reported cases of polio in the WHO African Region

Source: WHO/UNICEF, revision 2023

Southern African countries,[168] leading to the interruption of WPV transmission in 2024. This followed assessments in Malawi and Mozambique by an independent polio outbreak response assessment team, which recommended the closure of the outbreak. Through robust surveillance, quality vaccination campaigns and enhanced community engagement, both countries effectively controlled the spread of the virus, safeguarding the health and well-being of their children.

"Health workers have been the true heroes of Africa's polio programme. Daily, they overcome conflict, trek through marshlands to reach remote villages and build trust with communities to ensure that all children receive lifesaving polio vaccines. Across Africa, we need to invest in and empower health workers, making sure they have the training, skills and incentives to continue delivering for our communities."

Dr Matshidiso Moeti, WHO Regional Director for Africa

The strategy to halt the outbreak relied on detailed microplanning, including mapping of cross-border communities, migratory routes, cross-border entry/exit points and transit routes for each of the cross-border facilities. Synchronization and coordination of vaccination plans across the five countries, as well as the monitoring of vaccination activities, were key to identifying and reaching all eligible children in the cross-border areas. Vaccination efforts continued into 2024, with house-to-house campaigns of various scopes and sizes in 12 countries[169] in the first quarter of 2024, resulting in more than 88 million children receiving at least one dose of the polio vaccine.

Vaccination against polio received a significant boost in 2020 when the novel oral polio vaccine type 2 (nOPV2) became the first vaccine to be authorized under the WHO emergency use listing. The vaccine was initially rolled out for limited use in countries to tackle outbreaks of the circulating vaccine-derived poliovirus type 2 (cVDPV2). This variant affected 20 countries[170] in the Region in 2023, with the Democratic Republic of the Congo being the worst impacted, with 223 cases.

The nOPV2, a modified version of the monovalent oral polio vaccine (mOPV2) type 2, provides comparable protection against the poliovirus type 2 but with increased stability. This means there is less risk of mutations and reverting to virulence, which in turn reduces the risk of polio-related paralysis among children living in areas with low immunization coverage and outside of targeted mass immunization campaigns. Ultimately, nOPV2 poses less risk of seeding new polio outbreaks.

With acute flaccid paralysis (AFP) surveillance being the gold standard for poliovirus detection, African Member States, with the support of partners, have established robust surveillance systems for detecting AFP cases. This surveillance is supported by 16 laboratories in the Region, which form part of the Global Polio Laboratory Network. Each country has a designated laboratory where its samples are tested. Over 24 000

168 Malawi, Mozambique, United Republic of Tanzania, Zambia, Zimbabwe.
169 Algeria, Benin, Cameroon, Central African Republic, Congo, Democratic Republic of the Congo, Kenya, Mauritania, Niger, Nigeria, South Sudan, Zimbabwe.
170 Burundi, Benin, Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Guinea, Kenya, Madagascar, Mali, Mozambique, Mauritania, Niger, Nigeria, South Sudan, United Republic of Tanzania, Zambia, Zimbabwe.

AFP cases are reported annually, and stool samples are tested as part of the surveillance.

The use of geospatial tracking systems (GTS) to track vaccinators and visualize coverage in real time has been important for polio mop-up activities, ensuring that every child is reached with vaccination.

The 16 laboratories within the African Region Polio Laboratory Network are in 15[171] different countries, supported by two environmental surveillance (ES) sample concentration laboratories in two[172] other countries. These efforts aim to enhance laboratory capacity, including the expansion of sequencing capabilities through various methodologies and new technologies. The number of sequencing laboratories is being increased from the present two to 16, while new nonpolio laboratories are also being added to the network in six countries[173] to perform poliovirus sequencing using new technology.

ES is key to poliovirus detection but is hampered in the African Region by the limited availability of formal sewer networks, delays in sample transportation across international borders, financial constraints, and inadequately trained personnel. In 2017, WHO established the Geographic Information System (GIS) Centre, with capacity-building programmes implemented in all 47 Member States to strengthen the use of GIS and technological innovations to support a variety of disease surveillance programmes, including COVID-19 subsequently. The use of geospatial tracking systems (GTS) to track vaccinators and visualize coverage in real time has been important for polio mop-up activities, ensuring that every child is reached with vaccination.

Surveillance was also enhanced in the two years to 2024 through the establishment of 15 new wastewater surveillance sites in countries affected by the imported WPV outbreak. These played a critical role in detecting the silent circulation of poliovirus in wastewater, ensuring that quality samples were sent to laboratories for timely confirmation and response to the presence of poliovirus.[174] Environmental surveillance began in Nigeria in 2011 and has expanded to all the countries in the Region, except for Comoros, where there are no suitable ES sites. Over 500 sample collection sites have initiated ES.

171 Algeria, Cameroon, Central African Republic, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Madagascar, Nigeria (2), Senegal, South Africa, Uganda, Zambia, Zimbabwe.
172 Angola, Niger.
173 Angola, Eritrea, Malawi, Mozambique, Rwanda, United Republic of Tanzania.
174 https://www.afro.who.int/news/timely-outbreak-response-enhanced-surveillance-halts-wild-poliovirus-transmission-southern


KN95

Tackling noncommunicable diseases and mental health

7

SDG target 3.4:
By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being

SDG target 3.a:
Tobacco control: Strengthen the implementation of the WHO Framework Convention on Tobacco Control in all countries, as appropriate

SDG target 3.5:
Substance abuse: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

7.1

Noncommunicable diseases (NCDs)

"The growing burden of noncommunicable diseases poses a grave threat to the health and lives of millions of people in Africa: over a third of deaths in the Region are due to these illnesses. What is particularly concerning is that premature deaths from noncommunicable diseases are rising among people younger than 70 years."

Dr Matshidiso Moeti, WHO Regional Director for Africa

7.1.1 The rise of NCDs in the African Region

Since the turn of the century, the incidence of noncommunicable diseases in Africa has surged. Home to 54 low- and middle-income countries, the continent is expected to see the world's largest increase in related deaths over the next decade, with WHO predicting that NCDs will become the leading cause of death in the African Region by 2030.

Unlike the more familiar battles against infectious diseases, NCDs often advance quietly, yet their impact is profound. As a sustainable development issue, they create a significant health and economic burden while devastating families and communities. By 2019, these silent killers had been responsible for 37% of deaths in the Region, a sharp increase from 24% in 2000. Without meaningful interventions, they are set to overtake communicable diseases and maternal, neonatal and nutritional conditions combined in the next five years.

Understanding the common NCDs and their shared risk factors is the first step towards developing a comprehensive response. The top four killers, which together account for 80% of premature NCD-related deaths globally,[175] are cardiovascular diseases, cancers, diabetes and chronic respiratory diseases. An estimated 80% of NCDs are deemed preventable, heightening the urgency for increased prevention and lifestyle changes to target the modifiable risk factors.

The top risk factors include tobacco use, a well-known enemy of health which is linked to heart disease, cancer and chronic respiratory diseases; harmful use of alcohol, which contributes to liver disease and certain cancers, while exacerbating mental

175 https://www.thelancet.com/journals/langlo/article/PIIS2214-109X%2819%2930370-5/fulltext

health conditions and increasing the risk of accidents and injuries; unhealthy diets due to a shift towards processed foods high in salt, sugar and unhealthy fats; and physical inactivity.

Urbanization and changing lifestyles have led to reduced physical activity levels among many African populations. This sedentary lifestyle, coupled with poor dietary habits, has contributed significantly to the growing NCD burden. A surge in obesity, driven by unhealthy diets and inactivity, for example, has significantly elevated the prevalence of diabetes and hypertension, while the mental health burden has added another layer of complexity. Over 100 million people in the Region are affected by mental, neurological and substance use disorders.

The prevalence of cardiovascular diseases has doubled over the past three decades in Africa, while fewer than one third of people living with hypertension in the African Region are on treatment. Only about 12% of people with this life-threatening condition have it under control.

These risk factors are not just isolated behaviours, they are deeply rooted in the socioeconomic, cultural and environmental context of the Region. Tackling these issues requires a holistic approach that goes beyond individual behaviour change to address the broader determinants of health.

When Dr Moeti took office in 2015, the response was guided by the Global action plan for the prevention and control of NCDs 2013–2020 (extended to 2030). Member States committed to reducing the avoidable NCD burden and the number of premature deaths from NCDs by 25% each by 2025.

Between 2013 and 2019, age-standardized NCD mortality showed a modest decline, from 615.9 to 587.1 per 100 000 people in the African Region. The probability of dying from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases between the ages of 30 and 70 years also saw a modest improvement, decreasing from 22% to 20.8%.

However, inequitable access to care that is readily available in higher-income countries[176] still meant that in 2020, a 10-year-old child with diabetes in sub-Saharan Africa would live 40 years less than his or her peer in Europe. In 2021, Africa had the second lowest diabetes-related expenditure (US$ 13 billion), accounting for only 1% of global diabetes-related expenditure,[177] despite the African Region having the highest proportion of undiagnosed diabetes cases, at 54%.

In addition, the prevalence of cardiovascular diseases has doubled over the past three decades in Africa, while fewer than one third of people living with hypertension in the African Region are on treatment. Only about 12% of people with this life-threatening condition have it under control.

Progress against NCDs also suffered setbacks due to disruptions to essential health services generated by the COVID-19 pandemic. About 80% of countries in the Region reported disruptions to health services between May and September 2021, including to diabetes[178] and cancer[179] care, on account of the low resilience of health systems.

To help reduce the avoidable burden of NCD-related deaths, illnesses and disabilities, WHO is providing technical expertise to countries to devise and implement effective intervention strategies and track progress.

176 https://www.bmj.com/content/383/bmj.p2382
177 https://files.aho.afro.who.int/afahobckpcontainer/production/files/iAHO_Diabetes_Regional_Factsheet.pdf
178 https://www.afro.who.int/news/covid-19-more-deadly-africans-diabetes
179 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10656081/

The Organization has also developed a set of practical and cost-effective measures that countries can deliver at the primary health level. These measures emphasize promoting health and preventing disease and include steps such as increasing tobacco taxes, restricting alcohol advertising, reformulating food products with less salt, sugar and fat, vaccinating girls against cervical cancer, and treating hypertension and diabetes.

7.1.2 Surveillance of NCD risk factors – the STEPS approach

To effectively combat NCDs, it is crucial to understand the extent and distribution of these diseases, and their risk factors among populations. Surveillance of NCD risk factors provides the necessary data to inform policies, guide resource allocation and design targeted interventions. However, in many African countries, collecting reliable data on NCDs and their risk factors has been a persistent challenge, hampered by limited resources, competing health priorities and underdeveloped health information systems.

Recognizing this gap, WHO developed a standardized method known as the STEPwise approach to surveillance (STEPS). STEPS provides a simple yet comprehensive framework for collecting, analysing and disseminating data on key NCD risk factors. This enables countries to monitor trends in NCDs and their risk factors over time, identify high-risk groups and evaluate the effectiveness of interventions.

The strategy is designed to be flexible and adaptable to different country contexts, making it particularly suitable for resource-limited settings. The first step in the strategy entails gathering information on key behavioural risk factors. These include tobacco and alcohol use, physical inactivity and unhealthy diets, as well as biological risk factors such as overweight and obesity, elevated blood pressure and blood glucose levels, and abnormal blood lipids. This data is typically collected through household surveys using standardized questionnaires.

For example, in Burkina Faso, findings from WHO's 2021 Stepwise approach to surveillance survey revealed a prevalence of hypertension of 18.2% among 18 to 69-year-olds, underscoring the need for interventions. Burkina Faso, with support from WHO and the Danish Government, is

now making NCD services available at district health facilities, decentralizing these from tertiary hospitals to broaden access.

In Mauritania, the STEPS 2008 survey revealed that 22.6% of the country's adolescents aged between 13 and 15 use tobacco, owing to easy access to tobacco products for everyone, including children.

In Mauritania, the STEPS 2008 survey revealed that 22.6% of the country's adolescents aged between 13 and 15 use tobacco, owing to easy access to tobacco products for everyone, including children. Legal steps to introduce graphic health warnings on tobacco packaging followed, with the 2021 Global Adult Tobacco Survey showing that tobacco use in Mauritania had declined by 8% between 2012 and 2021, from 18% to 10%.

The second step involves collecting physical measurements such as height, weight and blood pressure. These measurements help to identify key indicators of NCD risk, including the prevalence of overweight and obesity, as well as elevated blood pressure.

In the final step, biological measurements such as blood glucose and cholesterol levels are collected. These biomarkers provide insights into the prevalence of conditions like diabetes and dyslipidaemia. In Mauritius, STEPS revealed a high prevalence of diabetes, leading to the implementation of national screening programmes and interventions to promote healthier lifestyles.

By using this standardized approach, countries can monitor trends in NCD risk factors over time, compare data across different regions, and identify emerging health threats. Between 2014 and 2024, 24[180] African Region countries conducted STEPS surveys, some more than one, providing a wealth of data to guide national strategies to address the NCD epidemic.

However, implementing the STEPS approach is not without challenges. In some countries, logistical constraints, limited funding and a lack of trained personnel have hindered the regular collection and analysis of data. Despite these challenges, the success stories demonstrate that when reliable data is available, it can drive impactful policy changes and public health interventions. It also enables countries to track progress towards global targets, especially SDG 3.4, to reduce premature mortality from NCDs by one third by 2030.

7.1.3 Prevention of NCDs through modifiable risk factors

Public health awareness and education are key elements of the overall response. WHO has supported extensive campaigns to share information about the primary risk factors associated with NCDs, including tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol. These efforts also aim to improve health literacy and prompt behavioural change.

Community-based interventions, including education and screening programmes, were also implemented to raise awareness and enhance the early detection of NCDs.

Addressing tobacco use

Tobacco use is one of the most preventable causes of NCDs, yet it remains a significant public health threat. To combat this, African Region countries have implemented various strategies to curb tobacco consumption. WHO's Framework Convention

180 Algeria, Benin, Botswana, Burkina Faso, Cabo Verde, Central African Republic, Eswatini, Ethiopia, Gambia, Ghana, Kenya, Liberia, Malawi, Mauritius, Mozambique, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Togo, Uganda, United Republic of Tanzania, Zambia.

on Tobacco Control (FCTC), which has been ratified by 45[181] of the 47 Member States, has been a cornerstone in these efforts, providing countries with a comprehensive set of policies and interventions to reduce tobacco use.

In addition, WHO supported the accelerated implementation of key tobacco demand reduction strategies in the MPOWER package, a policy package that builds on the FCTC measures proven to reduce smoking prevalence through monitoring of tobacco use, protecting people from second-hand smoke, offering help to quit smoking, enforcing bans on tobacco advertising and raising taxes on tobacco products.

52% of the population (632 million people) in the Region are now covered by graphic health warnings on tobacco packs, and over 89% (1.1 billion people) are protected by smoke-free laws.

Mauritius embarked on a concerted drive to reduce smoking in 2022, introducing a raft of new measures, including stricter anti-smoking regulations and taxation, while also scaling up awareness campaigns and free cessation support. All this forms part of the country's National Action Plan for Tobacco Control (NAPTC) 2022–2026, which saw Mauritius become the third country globally and the first in the African Region to adopt all the MPOWER measures to the highest level. Mauritius also became the first African country to successfully implement plain packaging, with a set of eight rotating pictorial health warnings.

A total of 22[182] countries also ratified the Protocol to Eliminate Illicit Trade in Tobacco Products, with the interventions contributing to nearly half of the countries in the Region being on track to achieve a 30% relative reduction in "current daily tobacco use" prevalence by 2025, based on 2010 baselines. The prevalence of tobacco use among adults aged above 15 years has dropped significantly, from 13.5% to 9.5% (2015–2023),[183] with prevalence projected to drop even further by 2025,[184] to 8.9%.

Meanwhile, 52% of the population (632 million people) in the Region are now covered by graphic health warnings on tobacco packs, and over 89% (1.1 billion people) are protected by smoke-free laws. Additionally, the average total tax share of the retail price of a pack of 20 cigarettes for the most popular brands increased from 37% to 41% (2016–2023).[185]

Nineteen per cent of Member States have successfully reduced exposure to second-hand smoke among children aged 13–15 years by more than 10% (2008–2018).[186] Similarly, nearly 20% of Member States achieved a 10% reduction in passive exposure to tobacco smoke among those aged 13 to 15 years through effective health promotion campaigns.

Kenya's tobacco-free farms have been a particularly innovative intervention to curb tobacco growing in the country. In 2021, Kenya joined forces with WHO and a coalition of international partners to help shift tobacco farmers to climate-resilient crops such as beans and maize. These provide a healthier source of income and improve food security.

The project, which began with hundreds of farmers in Kenya in 2022, is expanding

181 Except Eritrea and South Sudan.
182 Benin, Burkina Faso, Cabo Verde, Chad, Comoros, Congo, Côte d'Ivoire, Eritrea, Gabon, Gambia, Ghana, Guinea, Kenya, Madagascar, Mali, Mauritius, Niger, Nigeria, Rwanda, Senegal, Seychelles, Togo.
183 WHO global report on trends in prevalence of tobacco use 2000–2030. Geneva: World Health Organization; 2024.
184 https://www.who.int/publications/i/item/9789240088283
185 WHO report on the global tobacco epidemic, 2023. https://www.who.int/publications/i/item/9789240077164
186 Progress report on the implementation of the regional strategy for cancer prevention and control afr/rc69/inf.doc/3

to other tobacco-growing regions. These efforts are more than just economic, they also represent a significant shift in how communities view their health and future.

Harmful use of alcohol

Alcohol has long been a part of cultural and social practices in many African societies, but its harmful use is a significant contributor to NCDs, including liver disease, cardiovascular diseases and certain cancers. Excessive alcohol consumption also exacerbates mental health conditions and increases the risk of accidents and injuries, putting a considerable burden on health care systems.

WHO's SAFER initiative, named for the five[187] most cost-effective interventions to reduce alcohol-related harm, provided a strategic framework for countries to address the harmful use of alcohol through, among other things, increasing taxes on alcoholic beverages, enforcing drink-driving laws, and enhancing access to screening and treatment for alcohol-use disorders.

In Ethiopia, for example, the implementation of policies to limit alcohol marketing, increase taxation on alcoholic beverages, and promote community-based education programmes has led to a significant decline in per capita alcohol consumption, from 6.3 litres per person in 2016, to 4.2 litres per person in 2020.

Regionally, alcohol-attributable deaths per 100 000 people dropped from 70.6 to 52.2 (2016–2019), reflecting a steady decline in alcohol use recorded since 2015, with indications of a 20% or more relative reduction in per capita alcohol consumption. This decrease is, however, being driven by only about half of the Region's Member States,[188] with WHO's World Health Statistics 2023 report estimating, for example, that Uganda was consuming 12.2 litres of alcohol per person annually, about double the regional average.[189]

The gains are expected to be accelerated by the Framework for implementing the

187 Strengthen restrictions on alcohol availability; advance and enforce drink-driving counter measures; facilitate access to screening, brief interventions and treatment; enforce bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion; raise alcohol prices through excise taxes and pricing policies.

188 Comparative data for APC from the 2018 and 2024 publications on the Global Status Report on Alcohol and Health.

189 https://www.afro.who.int/countries/uganda/news/whos-safer-initiative-timely-intervention-reduce-alcohol-related-harm-uganda

global alcohol action plan 2022–2030 in the African Region, which was presented to the WHO Regional Committee for Africa in 2023. This Framework updates the previous 13-year-old strategy, by operationalizing new action points in the Global alcohol action plan, and addressing challenges in the implementation of alcohol harm reduction activities in the Region.

Healthy diets and physical activity

As urbanization continues to reshape African societies, promoting healthy diets and physical activity has become a public health imperative, with people who are overweight or obese at increased risk for developing a range of serious NCDs, including type 2 diabetes, hypertension, heart disease and some cancers.

The African Region recorded a significant reduction in the prevalence of physical inactivity from 22.1% to 16% between 2016 and 2022. This makes it the only Region on track to meet the 2030 global reduction target.

Guided by WHO's ACTIVE package, which sets out goals to achieve a relative reduction in global levels of physical inactivity of 10% by 2025 and 15% by 2030, the African Region recorded a significant reduction in the prevalence of physical inactivity from 22.1% to 16% between 2016 and 2022. This makes it the only Region on track to meet the 2030 global reduction target.[190]

However, sedentary lifestyles associated with rising urbanization or changing modes of transport in many countries remain significant drivers of obesity, exacerbated by dietary habits such as the consumption of energy-dense foods. Additionally, the lack of robust policies in key sectors – including health, agriculture, urban planning and environment – that promote healthier lifestyles, poses a threat to the gains made.

Obesity prevalence in Africa ranges between 4.5% and 32.5%, while overweight/obesity-related hypertension prevalence in children and adolescents is approximately 18.5%. In South Africa and Nigeria, two sub-Saharan African countries with the highest prevalence of hypertension, a sedentary lifestyle associated with a shift from rural to urban or westernized living has been cited as a major contributor to the high prevalence of hypertension.[191]

WHO in the African Region has supported countries to promote healthy diets and create a healthy food environment through the adoption and implementation of fiscal and regulatory interventions with respect to food production, transportation and marketing, including food labelling, food-based dietary guidelines and sugar-sweetened beverage taxation. By 2022, 31[192] out of the 47 countries had implemented national tax policies on sugary drinks to fight obesity in children and adults.

WHO has also assisted in reformulating food products to reduce the content of saturated fats, trans fats, free sugars and salt/sodium, and eliminating industrially produced trans fats. WHO's technical packages to promote healthy diets include SHAKE for salt reduction, with the first intercountry regional workshop on salt reduction hosted by Malawi in 2018,[193] and REPLACE to eliminate artificial trans fats from national food supplies.

Member States have committed to

190 Global levels of physical inactivity in adults: off track for 2030.
191 https://www.nature.com/articles/s41371-024-00913-6#:~:text=Obesity%20prevalence%20in%20Africa%20ranges,approximately%2018.5%25%20%5B97%5D
192 Benin, Burkina Faso, Burundi, Cabo Verde, Cameroon, Central African Republic, Côte d'Ivoire, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Ghana, Guinea Bissau, Kenya, Madagascar, Malawi, Mali, Mauritius, Mozambique, Namibia, Niger, Rwanda, Senegal, Seychelles, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.
193 https://www.afro.who.int/news/malawi-hosts-first-salt-reduction-intercountry-workshop-african-region

halting the rise in diabetes and obesity in adults and adolescents, and childhood overweight, and reducing salt intake by 30%, by 2025. Through a multipartner programme called Global Regulatory and Fiscal Capacity-Building Programme (RECAP), Kenya, Uganda and the United Republic of Tanzania have made progress towards adopting nutrition profile modelling and food labelling standards, as a precursor to regulations for marketing food and non-alcoholic beverages.

Burkina Faso, Mali and Sierra Leone have also aligned their national nutrition labelling policies with the regional strategy and Codex[194] standards while strengthening nutrition labelling regulations to reduce risk factors for diet-related NCDs.[195]

7.1.4 Treatment and management of NCDs

Prevention is key, but equal attention needs to be paid to access to quality health care services for those already living with an NCD to boost early detection, treatment and management, and save lives. In many African countries, health care systems have traditionally focused on acute infectious diseases, and limited access to screening services contributes to the late presentation of NCDs, resulting in poorer outcomes and higher death rates.

To bridge the gap, efficient use of limited health care resources is required, along with sustainable health financing mechanisms, access to basic diagnostics and essential medicines, and organized medical information and referral systems delivered equitably at the primary health care level.

Through collaborations and partnerships, WHO in the African Region has made some progress towards integrating NCDs into primary health care, notably through the adoption of the WHO package of essential noncommunicable (PEN) disease interventions for primary health care by 34[196] of the Region's 47 countries. PEN, first published in 2010, was innovative and action-oriented, prioritizing a set of cost-effective interventions that could be

194 Joint FAO/WHO Food Standards Programme that serves as the international food safety code.
195 https://www.afro.who.int/sites/default/files/2023-03/WHO%20AFRO%20UHP%20brochure_0.pdf
196 Angola, Benin, Botswana, Burkina Faso, Cabo Verde, Congo, Eritrea, Eswatini, Ethiopia, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Mali, Mauritania, Mauritius, Namibia, Niger, Nigeria, Madagascar, Mozambique, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.

delivered with acceptable quality of care, even in resource-poor settings.[197]

The package enabled WHO to support countries to begin to decentralize the management of NCDs, offering screening and other services, including diagnosis, treatment, lifestyle modification, patient education and self-management, at the primary care level.

One patient who benefited from the package was Samuel, a 45-year-old farmer from a rural village in Zambia. He had been experiencing symptoms of fatigue, frequent urination and blurred vision for months but was unable to afford specialized care. When the local health centre implemented WHO PEN, he was finally diagnosed with type 2 diabetes and began treatment, including medication and lifestyle counselling. With regular follow-up visits, he learned to manage his condition, preventing complications and improving his quality of life.

Ethiopia, for example, established NCD clinics at district hospitals, expanding its capacity to diagnose and manage conditions such as cancer and chronic respiratory diseases, by offering services including chemotherapy, specialized respiratory therapy and advanced diabetes management.

Building on the success of WHO PEN, the PEN-Plus initiative was launched in 2022 to address the growing need for more comprehensive care. Through PEN-Plus, WHO supported countries in reinforcing the capacity of district hospitals and other first-level referral facilities for early diagnosis and subsequent management of severe NCDs.

Ethiopia, for example, established NCD clinics at district hospitals, expanding its capacity to diagnose and manage conditions such as cancer and chronic respiratory diseases, by offering services including chemotherapy, specialized respiratory therapy and advanced diabetes management.

Health worker training programmes, delivered in tandem with the PEN and PEN-Plus initiatives, were also expanded to enhance the capacity for the prevention, diagnosis and treatment of the major NCDs. This was achieved through the WHO PEN and PEN-Plus strategies as well as the HEARTS package, which provides a strategic approach for policy-makers and programme managers to improve cardiovascular primary health care delivery in countries.

Other frameworks supported the interventions, including the regional Oral Health Strategy (2016–2025), adopted in 2016 to catalyse action by Member States to prevent and control oral diseases; the Regional framework for integrating essential noncommunicable disease services in primary health care,[198] adopted in 2017; and the Framework for the implementation of the Global strategy to accelerate the elimination of cervical cancer[199] as a public health problem in the WHO African Region (2021).

Meanwhile, the Regional Office is also working on the Diabetes Blueprint for Africa under the framework of the Global Diabetes Compact, the WHO global diabetes control initiative launched in 2021, to mark the centenary of the discovery of insulin.

197 https://www.afro.who.int/sites/default/files/2017-06/9789241506557_eng.pdf
198 Regional framework for integrating essential noncommunicable disease services in primary health care. https://iris.who.int/bitstream/handle/10665/334349/AFR-RC67-12-eng.pdf?sequence=1&isAllowed=y
199 Framework for the implementation of the global strategy to accelerate the elimination of cervical cancer as a public health problem in the WHO African Region. https://iris.who.int/bitstream/handle/10665/345324/AFR-RC71-9-eng.pdf?sequence=1&isAllowed=y

7.2

Mental health

A decade ago, mental health was an under-recognized and highly stigmatized area, globally and regionally, despite being a critical element of health and well-being and a basic human right. While 24[200] of the 47 African Region countries had standalone mental health policies or plans to direct mental health activities, only 41% of these plans or policies were compliant with international human rights instruments.

Mental health conditions affect about one in every eight people globally and account for 6% of the total disease burden in Africa. While the response to the mental health burden has been slow, the Region has made significant progress in improving mental health services and addressing this key area of health.

As of 2020, three quarters of countries in the Region had a national mental health policy, either stand-alone or integrated into other national health plans, to help direct mental health activities.[201] Nearly 70% of the countries that participated in the Mental Health Atlas 2020 survey had mental health policies compliant with international human rights instruments,[202] and 54% had mental health laws compliant with inter-

200 Algeria, Botswana, Burkina Faso, Burundi, Côte d'Ivoire, Central African Republic, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Liberia, Madagascar, Mali, Mozambique, Namibia, Nigeria, Rwanda, Sao Tome and Principe, South Africa, Togo, Uganda, Zambia, Zimbabwe.

201 Mental Health ATLAS 2020 (https://www.who.int/publications/i/item/9789240036703): 29 of the 39 responding African Region countries in the 2020 Mental Health Atlas: Algeria, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Kenya, Liberia, Madagascar, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Togo, Uganda, Zambia, Zimbabwe.

202 Mental Health ATLAS 2020 (https://www.who.int/publications/i/item/9789240036703): 26 of the 39 responding African Region countries in the 2020 Mental Health Atlas: Algeria, Benin, Botswana, Burundi, Cabo Verde, Chad, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, Gambia, Ghana, Guinea, Liberia, Mauritius, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Togo, Uganda, Zambia, Zimbabwe.

national human rights instruments,[203] up from 31% in 2014.

At the start of Dr Moeti's first term, financial investment in mental health care in the Region was limited, with countries spending an average of only US$ 0.10 per capita per year on mental health in 2017. There was a severe shortage of specialist mental health workers, including mental health nurses, psychiatrists, clinical psychologists, clinical social workers and occupational therapists, with 1.4 specialist mental health workers per 100 000 population.

Financial investment in mental health care in the Region was limited, with countries spending an average of only US$ 0.10 per capita per year on mental health in 2017.

Furthermore, primary care workers had received very limited mental health care training. Only 0.6% of doctors and 4% of nurses and midwives at the primary care level in the Region had received that training. Instead, mental health was largely focused on pharmacological care, often offered at tertiary-level referral hospitals with limited integration into primary care and community health care structures.[204] This heightened the stigma surrounding mental health challenges and severely limited access to appropriate care, treatment and support.

By 2020, efforts to strengthen the mental health workforce were having an impact. Since 2014, the Region has recorded an estimated 14% increase in specialist mental health workers, from 1.4 to 1.6 mental health workers per 100 000 population.[205] Through decentralization and integration of mental health, including capacity-building at the primary care level, 79% of countries offered mental health training for primary care workers in 2020.

The Regional Office led the development and endorsement by Member States of the Regional framework to strengthen the implementation of the Comprehensive Mental Health Action Plan 2013–2030 in the WHO African Region.[206] Clear indicators to monitor progress were defined, and progress reports on this framework will be presented to the Regional Committee in 2025 and 2028.

WHO encourages countries to reform or develop mental health policies and plans that are compliant with international human rights instruments. Through the Quality Rights Initiative, the Organization has provided guidance and training for health workers, people with lived experience, nongovernmental organizations and others on how to implement a human rights and recovery approach to mental health care.[207]

This programme is being rolled out regionally[208, 209] transforming mindsets and improving the quality of mental health care. In Ghana, for example, WHO supported the country to develop quality improvement

203 Mental Health ATLAS 2020 (https://www.who.int/publications/i/item/9789240036703): 21 of the 39: Algeria, Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Côte d'Ivoire, Gabon, Gambia, Ghana, Guinea, Liberia, Mauritius, Namibia, Niger, Senegal, Seychelles, South Africa, , Uganda, United Republic of Tanzania, Zambia.

204 Regional strategy for mental health: https://iris.who.int/handle/10665/1941

205 Mental Health ATLAS 2020: https://www.who.int/publications/i/item/9789240036703

206 Framework to strengthen the implementation of the comprehensive mental health action plan 2013–2030 in the WHO African Region: report of the Secretariat: https://iris.who.int/handle/10665/361849

207 QualityRights materials for training, guidance and transformation: https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools

208 QualityRights in Mental Health – Ghana Project – Ministry of Health (Ghana): https://www.moh.gov.gh/qualityrights-in-mental-health-ghana-project

209 A human rights assessment of a large mental hospital in Kenya | Semantic Scholar (Kenya): https://www.semanticscholar.org/paper/A-human-rights-assessment-of-a-large-mental-in-Muhia-Jaguga/36cef9717b1fe02f146a63a8937687a2a20a41d1

plans for three psychiatric and five general hospitals with psychiatric units in 2023.[210,211] The Nursing and Midwifery Council of Ghana has now made it mandatory for nurses working in psychiatric facilities to have a Quality Rights certificate as part of quality improvement efforts.[212]

Through the Mental Health Gap Action Programme (mhGAP) training package,[213] countries have been supported with a standard training package on integrated mental health in primary health care for nonspecialist health workers. This programme has been rolled out in the Region as in-service or continuing medical education[214, 215, 216, 217] and is now being included by some countries in medical and nursing school training as part of pre-service mental health training.[218, 219] This is having a transformational impact on the approach to mental health training, empowering non-specialists and operationalizing an integrated approach to mental health care.

In Zimbabwe, for example, WHO, through the Special Initiative for Mental Health and MhGAP, has trained health workers in mental health and psychosocial support. This has helped 1.8 million more people in the

210 WHO Special Initiative for Mental Health – Ghana: https://www.who.int/initiatives/who-special-initiative-for-mental-health/ghana#
211 QualityRights materials for training, guidance and transformation: https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools
212 WHO Special Initiative for Mental Health - Ghana: https://www.who.int/initiatives/who-special-initiative-for-mental-health/ghana#
213 mhGAP Intervention Guide - Version 2.0: https://www.who.int/publications/i/item/9789241549790; Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders: https://www.who.int/publications/i/item/9789240084278
214 Training on Mental Health using the Mental Health - GAP (mh-GAP) Guideline | WHO | Regional Office for Africa (Eritrea): https://www.afro.who.int/news/training-mental-health-using-mental-health-gap-mh-gap-guideline
215 A survey of the mental healthcare systems in five Francophone countries in West Africa: Benin, Burkina Faso, Côte d'Ivoire, Niger and Togo - PMC (nih.gov): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6735152/
216 Health and care system assessment aimed at cultural adaptation of MhGAP modules | European Psychiatry | Cambridge Core (Nigeria): https://www.cambridge.org/core/journals/european-psychiatry/article/health-and-care-system-assessment-aimed-at-cultural-adaptation-of-mhgap-modules/FA4C1B8AF3C2E03ACBA6C0EEC0EBD0A4
217 Mainstreaming mental health in Ethiopia (who.int) (Ethiopia): https://www.who.int/news-room/feature-stories/detail/mhgap-ethiopia
218 WHO Mental Health Gap Action Programme Intervention Guide (mhGAP-IG): the first pre-service training study | International Journal of Mental Health Systems | Full Text (biomedcentral.com) (Liberia, Nigeria, Sierra Leone): https://ijmhs.biomedcentral.com/articles/10.1186/s13033-020-00379-2
219 Enhancing mental health pre-service training with the mhGAP Intervention Guide: experiences and lessons learned: https://www.who.int/publications/i/item/9789240007666

country gain access to crucial mental health services, with more than 3000 receiving services for mental, neurological and substance use conditions for the first time in 2023.[220]

The changes have been especially impactful on the Region's suicide rate, which, while remaining unacceptably high, saw a 21% decrease (age-standardized suicide rates) between 2014 and 2020, from 14.2 to 11.2 per 100 000 population.[221, 222] The mhGAP training programme has been key, while Cabo Verde and Côte d'Ivoire have been assisted to carry out national suicide situation analyses.[223]

WHO has also provided leadership and guidance on the mental health response to crisis situations, collaborating with the Christian Blind Mission (CBM), World Vision International and UNICEF to develop the African Regional facilitation guide for providing psychological first aid during the Ebola crisis.[224] During the COVID-19 pandemic, the Organization guided a rapid assessment of its impact on mental and substance use services in the Region, providing recommendations on how countries could better adapt mental health services during crises.[225]

Towards improved financing for mental health, WHO has advocated for improved structured and consistent financing for mental health care among Member States,[226] and provided guidance on the development of mental health investment cases.[227] With this guidance, several countries have successfully included mental health care in their national health insurance schemes,[228, 229, 230, 231] while others have developed investment cases for mental health.[232, 233, 234] Government expenditure on mental health, while still far short of the global average, has increased by over US$ 0.30 per capita in the Region (from US$ 0.1 in 2014 to US$ 0.46 in 2020).[235, 236] As of 2022, Kenya, Uganda and Zimbabwe, with support from WHO, had developed country mental health investment cases, which are now being used to advocate for improved financial investment in mental health.[237, 238, 239]

220 WHO Special Initiative for Mental Health – Zimbabwe: https://www.who.int/initiatives/who-special-initiative-for-mental-health/zimbabwe
221 Mental Health Atlas 2014: https://www.who.int/publications/i/item/mental-health-atlas-2014
222 Mental Health ATLAS 2020: https://www.who.int/publications/i/item/9789240036703
223 Reversing suicide, mental health crisis in Africa | WHO | Regional Office for Africa: https://www.afro.who.int/news/reversing-suicide-mental-health-crisis-africa
224 Facilitation manual: Psychological first aid during Ebola virus disease outbreaks: https://www.who.int/publications/i/item/9789241548977
225 The impact of COVID-19 on mental, neurological and substance use services: results of a rapid assessment in the African Region | WHO | Regional Office for Africa: https://www.afro.who.int/publications/impact-covid-19-mental-neurological-and-substance-use-services-results-rapid
226 https://iris.who.int/bitstream/handle/10665/87232/9789241564618_eng.pdf
227 Mental health investment case: a guidance note: https://www.who.int/publications/i/item/9789240019386
228 News (Ghana): https://www.nhis.gov.gh/News/nhis-benefit-package-to-be-expanded-to-include-mental-health-treatment--5561
229 Universal Health Coverage in Rwanda | WHO | Regional Office for Africa (Rwanda): https://www.afro.who.int/node/9169
230 Strengthening the National Health Insurance Bill for mental health needs: response from the Psychological Society of South Africa - Sharon Kleintjes, Daniel Hilbrand den Hollander, Suntosh R Pillay, Anne Kramers-Olen, 2021 (sagepub.com) (South Africa): https://journals.sagepub.com/doi/full/10.1177/0081246320954317
231 HFG Technical Report: https://www.hfgproject.org/wp-content/uploads/delightful-downloads/2017/02/Insurance-Report-JG-10.5.16-2016-MCDV-4-FINALwith-PEPFAR.pdf
232 Investment case for Ghana: https://www.who.int/publications/m/item/investment-case-for-ghana
233 Kenya Mental Health Investment Case 2021 - Mental Health (MoH Kenya) (Kenya): https://mental.health.go.ke/download/kenya-mental-health-investment-case-2021/
234 Investment case for Zimbabwe (2): https://www.who.int/publications/m/item/investment-case-for-zimbabwe-(2)
235 Mental Health Atlas 2014: https://www.who.int/publications/i/item/mental-health-atlas-2014
236 Mental Health ATLAS 2020: https://www.who.int/publications/i/item/9789240036703
237 Investment case for Zimbabwe (2): https://www.who.int/publications/m/item/investment-case-for-zimbabwe-(2)
238 Investment case for Ghana: https://www.who.int/publications/m/item/investment-case-for-ghana
239 Kenya Mental Health Investment Case 2021 - Mental Health (MoH Kenya): https://mental.health.go.ke/download/kenya-mental-health-investment-case-2021/

A decade of contributions to improved mental health:

Providing strategic direction.*

Curbing preventable deaths from suicide.†, ‡

Strengthening the mental health workforce to improve access to mental health care.§

Transforming mental health systems by decentralizing and integrating mental health into primary health care.

Advocating for increased financial investment into mental health care (from US$ 0.1 to US$ 0.46 per capita 2014–2020).¶, #

Strengthening mental health metrics and data to inform policy and investment.**

* Framework to strengthen the implementation of the comprehensive mental health action plan 2013–2030 in the WHO African Region: report of the Secretariat – https://iris.who.int/handle/10665/361849
† Mental Health Atlas 2014: https://www.who.int/publications/i/item/mental-health-atlas-2014
‡ Mental Health ATLAS 2020: https://www.who.int/publications/i/item/9789240036703
§ Mental Health ATLAS 2020: https://www.who.int/publications/i/item/9789240036703
¶ Mental Health Atlas 2014: https://www.who.int/publications/i/item/mental-health-atlas-2014
# Mental Health ATLAS 2020: https://www.who.int/publications/i/item/9789240036703
** Mental Health ATLAS 2020: https://www.who.int/publications/i/item/9789240036703

The number of African Region countries that collect mental health-specific data for the public and private sectors increased from 3% to 11% between 2014 and 2020.[240] As of 2020, twenty-eight per cent of countries that participated in the 2020 Mental Health Atlas survey had integrated mental health and psychosocial support (MHPSS) into their disaster preparedness plans.[241] In Ethiopia, the Ministry of Health, with support from WHO, improved its capacity to provide MHPSS through the training of 1230 health workers in the war-affected Tigray, Afar and Amhara regions by 2023.[242]

240 Mental Health ATLAS 2020: https://www.who.int/publications/i/item/9789240036703
241 Mental Health ATLAS 2020: https://www.who.int/publications/i/item/9789240036703
242 Scaling up mental health and psychosocial support in conflict settings | WHO | Regional Office for Africa: https://www.afro.who.int/countries/ethiopia/news/scaling-mental-health-and-psychosocial-support-conflict-settings

Addressing the social determinants of health

8.1

The challenge of health equity

The social determinants of health are the nonmedical factors that influence health outcomes, such as the conditions in which people are born, grow, work, live and age, and the broader set of forces and systems that shape their lives every day. They include economic policies and systems, development agendas, social norms, social policies and political systems, all having a major impact on health inequities – the unfair and avoidable differences in health status within and between countries that often mean the difference between life and death. Health and disease follow a social gradient at all income levels in countries: the lower the socioeconomic status of people, the worse their health.

With research suggesting that social determinants of health account for between 30% and 55% of health outcomes, it is clear that health is not only influenced by medical care in hospitals and clinics. In fact, estimates show that the contribution of non-health sectors to the health outcomes of populations exceeds that of the health sector itself. Recent and ongoing crises, including the COVID-19 pandemic, widespread flooding and the conflict in Sudan that has displaced hundreds of thousands of people, are cases in point.

Against this background, Dr Moeti sought to emphasize these connections from the outset by prioritizing a whole-of-government and whole-of-society approach to addressing the social, environmental and economic determinants of health and well-being in the African Region, including gender, equity and human rights. The approach built on WHO's long history of working with governments and partners to minimize the health threats posed by human activity and climate change.

Factors such as rapid and unplanned urbanization, the globalization of unhealthy lifestyles, weak regulatory and enforcement capacity, along with the well-documented

health impacts of climate change, were already threatening the substantial progress achieved through the Millennium Development Goals. While living standards had improved for some, shared prosperity was far from equitable and social inequalities were widening, particularly in the African Region.

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Building on the achievements under the Millennium Development Goals, WHO's Thirteenth General Programme of Work, a unified approach to accelerating progress towards the SDGs, aimed for the Triple Billion targets. The targets were one billion more people benefiting from universal health coverage, one billion better protected from health emergencies, and one billion enjoying better health and well-being. To address the broad range of health impacts in the African Region, interventions were necessary to help people and health systems become more resilient to climate change, while reducing air pollution and improving access to water, sanitation and hygiene (WASH), among other things. Governments also needed support to effectively tackle the range of other contributors to ill health, including the harmful use of tobacco and alcohol, as highlighted in the previous chapter, unhealthy diets and the impact of violence on children.

People with disabilities are a significant proportion of the population: an estimated one in six people worldwide lives with a significant disability. For the most part, these people do not receive the health care they need. They are more likely to live in poverty, with poorer quality housing and lower levels of education and employment. They routinely face barriers to care that negatively impact health outcomes across all Sustainable Development Goal 3 (SDG 3) indicators.

In the African Region, data from four countries showed that only 26% to 55% of people with disabilities received the medical rehabilitation they needed, while only 17% to 37% received assistive devices such as wheelchairs, prostheses and hearing aids. People with disabilities also live an average of 20 years less than non-disabled people, experience poorer health and are twice as likely to develop conditions such as diabetes, stroke and depression.

8.2

Engaging communities to promote health, address social determinants and respond to emergencies

One of the core objectives of WHO's work in the Region, which experiences at least 100 major public events each year, including disease outbreaks and human-made and natural disasters, has been to engage and empower communities to address these social determinants of health. The premise is simple: empowering communities, improving their understanding of health, and giving them the tools to manage their own well-being lays the foundation for achieving sustainable improvements in public health.

Botswana is an example of best practices in multisectoral engagement from early in Dr Moeti's tenure. In 2015, the country introduced the Health in All Policies approach, with a multisectoral collaboration task force which remains active and comprises health, transport, police and other stakeholders. Through WHO's work with the Motor Vehicle Accident Fund, health has been incorporated into road safety compliance measures, such as seat belt use as a health and compliance issue, while roadblocks routinely include mobile testing labs to identify drink-drivers. This approach deters drink-driving, helping to reduce accidents and save lives. Meanwhile, the Ministry of Finance introduced levies on tobacco (2014) and on sugar-sweetened beverages (2021). Raising the price of these commodities leads to a reduction in consumption, thereby also reducing exposure to these risk factors for noncommunicable diseases.

In the same year, the Healthy Cities approach was launched in the Region, leading to the establishment of an Africa-wide Partnership for Healthy Cities in 2017, coordinated by the WHO Regional Office for Africa and partners. Each of the cities selected one of 14 interventions to prevent NCDs and injuries, such as food policy, tobacco control, road safety, safe active mobility and air quality monitoring. For example, Abidjan and Dakar developed

nutrition standards to reduce excessive salt consumption in public schools, while Freetown raised awareness among vendors to the dangers of excessive salt consumption and trained them to communicate the message to their customers. Ouagadougou developed nutritional standards and a policy for food served in schools and hospitals, with a focus on reducing salt and sugar intake.

Kigali introduced car-free days twice a month with several roads blocked off for people to walk, run or cycle freely.

Addis Ababa also improved its drink-driving laws to improve road safety, through the Policy Accelerator programme, while Kumasi improved infrastructure to reduce road injuries and deaths. Cape Town expanded smoke-free spaces by amending local workplace policies on smoke-free compliance in public buildings, and Kigali introduced car-free days twice a month with several roads blocked off for people to walk, run or cycle freely.

During health emergencies, including the 2014–2016 Ebola virus disease (EVD) outbreak in West Africa and subsequent EVD outbreaks in the Democratic Republic of the Congo, the COVID-19 pandemic and the increasing number of cholera outbreaks since 2022, WHO and its partners endeavoured to include technical working groups on community engagement in response mechanisms. This helped to ensure that interventions included efforts to mitigate adverse impacts on the social determinants of health.

For example, in the cholera response in Ethiopia, Kenya, Malawi, Mozambique, South Sudan, Zambia and Zimbabwe, these strategies successfully reinforced disease surveillance, infection prevention and treatment approaches while promoting community engagement and bolstering multisectoral coordination to improve sanitation standards and ensure access to safe water. In particular, the community feedback mechanism helped build trust


World Health Organization
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World Health
Organization

SUCCESS STORY

Clean water supply improves health in Cameroon

1 500

number of boreholes providing safe, potable water to residents of Douala's third municipal district for the first time

As part of the Regional Laboratory on Urban Governance for Health and Well-being initiative, which empowers cities to develop structures and systems to address the social, economic and environmental determinants of health, the city of Douala in Cameroon adopted a governance model in 2020 to identify and address common challenges.

All municipal departments, communities and their leaders, religious organizations, business owners, taxi and motorcycle associations and many other stakeholders took part in discussions on how to prioritize the challenges.

The outcome was an unprecedented, costed multisectoral action plan with practical impacts, including the provision of safe, potable water from 1500 boreholes to residents of the city's third municipal district for the first time. This has significant health implications, as contaminated water can transmit often fatal diseases, including diarrhoea, cholera, dysentery, typhoid and polio.

The community also elected a water management committee to oversee the use and maintenance of the boreholes to ensure sustainability.

and ensure equitable access to assistance and services, taking account of factors such as gender and inclusion, as well as power dynamics and protection needs.

When WHO conducted a comprehensive evaluation of the Regional Health Promotion Strategy (2013–2022) in 2023, the results revealed both progress and remaining gaps. A total of 29[243] (61.7%) of the Region's 47 Member States had developed or revised their national health promotion policies and strategic plans, and 18[244] (40%) had launched them. Eight countries[245] were implementing multisectoral and multidisciplinary strategies, addressing both risk factors and the social determinants of health; 26[246] (58%) had established a health promotion directorate in their ministries of health; and 25[247] (56%) had established multisectoral coordination mechanisms. The assessment also found that 22[248] (49%) Member States had established at least one national mechanism for multisectoral engagement in innovative financing, using tax systems.

However, while 18[249] (40%) countries reported having conducted research related to health promotion, almost all the

243 Benin, Botswana, Burkina Faso, Cabo Verde, Central African Republic, Congo, Côte d'Ivoire, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, Uganda, Zambia and Zimbabwe.

244 Benin, Burkina Faso, Cabo Verde, Congo, Gabon, Gambia, Ghana, Guinea, Liberia, Madagascar, Malawi, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sierra Leone and Uganda.

245 Botswana, Chad, Côte d'Ivoire, Ethiopia, Gambia, Kenya, Mauritania and Seychelles.

246 Algeria, Angola, Burkina Faso, Burundi, Cabo Verde, Chad, Comoros, Congo, Democratic Republic of the Congo, Eritrea, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Madagascar, Malawi, Mozambique, Niger, Nigeria, Seychelles, South Africa, United Republic of Tanzania, Togo, Uganda and, Zambia.

247 Botswana, Burkina Faso, Cabo Verde, Central African Republic, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Gambia, Ghana, Guinea-Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritius, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa and Uganda.

248 Algeria, Angola, Cabo Verde, Central African Republic, Comoros, Congo, Côte d'Ivoire, Ethiopia, Gambia, Ghana, Guinea-Bissau, Kenya, Madagascar, Malawi, Mozambique, Niger, Senegal, Seychelles, South Africa, South Sudan, Uganda and Zambia.

249 Algeria, Angola, Benin, Botswana, Burundi, Cabo Verde, Central African Republic, Eritrea, Gambia, Ghana, Kenya, Mozambique, Rwanda, Senegal, Seychelles, South Africa, Uganda and Zambia.

research was focused on COVID-19. National academic training institutions with a core health promotion module were reported in 27[250] (60%) Member States, but 18[251] (40%) still lack national training institutions with the capacity to deliver a basic health promotion module. Finally, more than half of the responding countries (58%) lacked a framework for planning, implementing and evaluating health promotion activities.

In Liberia, for example, a national health literacy survey in January 2024 revealed that health literacy was inadequate among almost half (45.5%) of all respondents, with limited proactive health information-seeking behaviour, particularly among older adults. This signalled an urgent need for comprehensive health education programmes, tailored to different age groups and literacy levels. Many people also said that they struggled to find, understand and navigate health information online, highlighting the importance of improving digital health literacy, and providing accessible resources.

The need to close the gaps in community engagement and health promotion strategies in light of the cultural, social and economic realities on the ground, not just in times of crisis, led to the adoption of a multisectoral strategy in 2023 to promote health and well-being in the African Region.

250 Algeria, Angola, Benin, Botswana, Cabo Verde, Comoros, Congo, Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Gabon, Gambia, Ghana, Kenya, Liberia, Madagascar, Malawi, Mozambique, Nigeria, Rwanda, Seychelles, Sierra Leone, South Africa, United Republic of Tanzania, Togo, Uganda and Zimbabwe.

251 Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Eritrea, Eswatini, Guinea, Guinea-Bissau, Lesotho, Mali, Mauritania, Mauritius, Namibia, Niger, Sao Tome and Principe and South Sudan.

Building on the Health in All Policies approach, it proposes deliberate engagement between health and other sectors, with population well-being at the centre of a shared agenda.

Clinicians also have a critical role to play in improving health literacy. When trained in effective communication strategies and consistently providing health education during patient consultations, they can have a significant impact on the understanding of public health issues, especially promotive and preventive interventions.

8.3

Addressing the double burden of malnutrition and ensuring food safety

In the African Region, malnutrition manifests itself in two apparently contradictory forms: undernutrition and the equally alarming rise in the incidence of overweight and obesity. In many communities, both extremes coexist within the same household, or even the same individual, a phenomenon known as the double burden of malnutrition.

The key drivers of this complex burden are multiple and interrelated. Inadequate access to nutritious and sufficient food leads to undernutrition, while increasing consumption of highly processed, energy-dense foods combined with low levels of physical activity contributes to overweight, obesity and related diseases such as type 2 diabetes and cardiovascular disease.[252, 253] If current trends continue, the goal of ending hunger and all forms of malnutrition by 2030 will not be achieved.[254]

The challenge is exacerbated by a serious deterioration in food security in the Region, a crisis most acutely felt in the Greater Horn of Africa, Madagascar and the Sahel owing to climate change, conflict and disease outbreaks. This has a profound impact on vulnerable populations, including women, young children and internally displaced persons, who are increasingly at risk of disease and severe malnutrition.

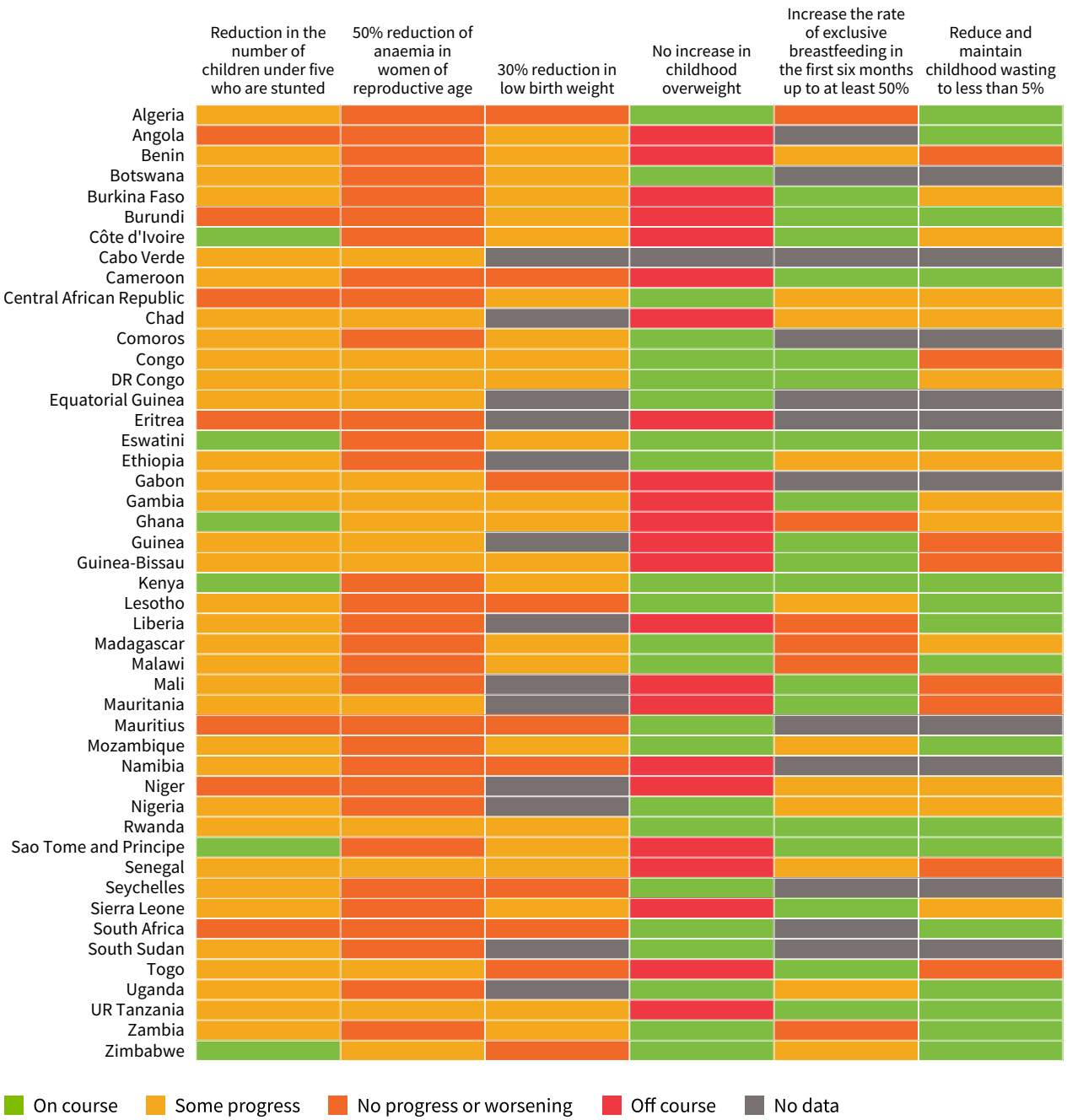
Currently, few countries are on track to meet the 2025 nutrition targets set at the World Health Assembly in 2012 (see Fig-

252 Swinburn BA et al. The global syndemic of obesity, undernutrition, and climate change: The lancet Commission Report. Published online January 27, 2019, http://dx.doi.org/10.1016/S0140-6736(18)32822-8, accessed on 12 January 2023).

253 FAO, IFAD, UNICEF, WFP and WHO. 2022. The State of Food Security and Nutrition in the World 2022. Repurposing food and agricultural policies to make healthy diets more affordable. Rome, FAO. https://doi.org/10.4060/cc0639en

254 Global Nutrition Report. 2021 Global Nutrition Report: The state of global nutrition. Bristol, UK: Development Initiatives. Available at https://globalnutritionreport.org/reports/2021-global-nutrition-report/

Figure 28: Countries' progress towards the World Health Assembly six nutrition targets by 2025 in the WHO African Region



Source: Global Nutrition Report 2021: https://globalnutritionreport.org/reports/2021-global-nutrition-report/

ure 28). As regards stunting targets, only six countries[255] are likely to reduce the number of stunted children by 40% from 2012 levels. The problem of childhood overweight and obesity remains stubbornly persistent, with prevalence stagnating at around 4% (2012–2022). With significant disparities among countries, the prevalence is rising notably in the East, the South, and Small Island Developing States

Specific improvements include increased exclusive breastfeeding among infants under six months, from 41.9% to 48% (2012–2022). Based on data from 35 countries, 18 are well placed to meet the 2025 target of at least 50% exclusive breastfeeding.

Meanwhile, data on low birth weight are sparse. The most recent estimates date back to 2015, at which point the Region appeared unlikely to meet the 2025 target of a 30% reduction from the 2012 baseline. Anaemia among women of reproductive age was another sobering challenge, with a steady prevalence of 40% from 2012 to 2019. Despite some progress in 16 countries,[256] no country is likely to meet the global target of a 50% reduction by 2025

However, despite these challenges, there have been signs of hope. A notable example of the pivotal role WHO plays in the African Region was the implementation of the road map for the African Union Year of Nutrition 2022. A key outcome was the adoption of the Abidjan Declaration on Nutrition, which urged Member States to prioritize investment in nutrition as a catalyst for economic transformation, and has helped to elevate the nutrition agenda across the continent.

Specific improvements include increased exclusive breastfeeding among infants under six months, from 41.9% to 48% (2012–2022). Based on data from 35 countries, 18[257] are well placed to meet the 2025 target of at least 50% exclusive breastfeeding.[258]

255 Côte d'Ivoire, Ghana, Kenya, Sao Tome and Principe, Eswatini and Zimbabwe.
256 Cabo Verde, Chad, Congo, Democratic Republic of the Congo, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Mauritania, Rwanda, Senegal, Togo, United Republic of Tanzania and Zimbabwe.
257 Burkina Faso, Burundi, Côte d'Ivoire, Cameroon, Congo, Democratic Republic of the Congo, Eswatini, Gambia, Guinea, Guinea-Bissau, Kenya, Mali, Mauritania, Rwanda, Sao Tome and Principe, Sierra Leone, United Republic of Tanzania and Togo.
258 Global nutrition report 2021.

SUCCESS STORY

Sierra Leone exceeds exclusive breastfeeding target

52.7%

exclusive breastfeeding rate reached in Sierra Leone by 2022, surpassing the global target of 50% by 2025

21%

children aged 0–23 months who are still bottle-fed in Sierra Leone

In a small rural clinic in Sierra Leone, new mothers gather to learn about breastfeeding. The practice of exclusive breastfeeding has long been touted as a critical step in combating child malnutrition and, in Sierra Leone, it has become a success story.

By 2022, exclusive breastfeeding in the country reached 52.7% from 31.2% in 2010, surpassing the global target of 50% by 2025. This remarkable achievement is a testament to the combined efforts of the government, WHO and other partners and community health workers who are committed to ensuring that every child has the best possible start in life.

The turning point came when the country adopted the Breast Milk Substitutes Act in 2021 and launched the "No Water, Stronger with Breast Milk Only" campaign. The campaign aimed to dispel misconceptions about breastfeeding, particularly the harmful belief that neonates need water in addition to breast milk. Through targeted education and engagement, the campaign resonated deeply with mothers, and Sierra Leone's exclusive breastfeeding rate steadily increased.

However, 21% of children aged 0–23 months are still bottle-fed and traditional beliefs about colostrum and the nutritional needs of male infants persist, highlighting the cultural nuances that continue to affect health behaviours.

Despite the remaining challenges, Sierra Leone's story is an example of how a dedicated focus on maternal and child nutrition, coupled with strong legislation and community-based interventions, can change the trajectory of a country's nutrition profile.

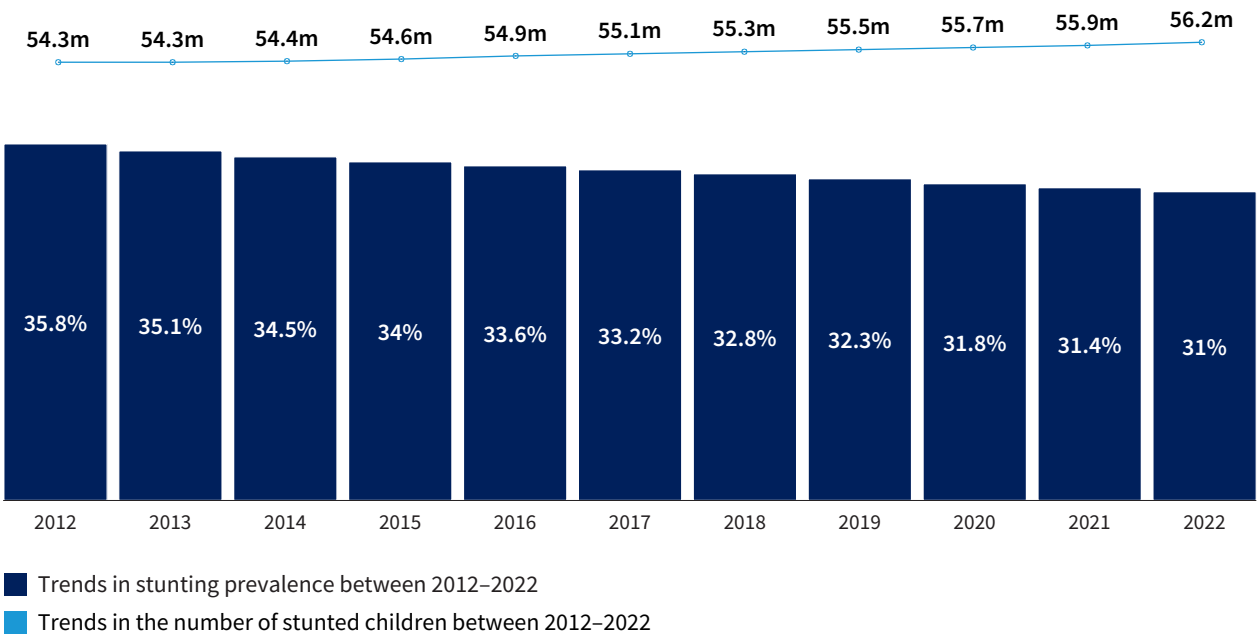
Through its standardized, evidence-based guidelines and institutional capacity-building for government services, WHO also helped to improve the prevention and management of acute malnutrition in children under five, contributing to better outcomes and reduced mortality. For instance, its support for stabilization centres in high-burden areas such as South Sudan integrates quality health services with safe WASH practices, significantly improving survival rates for children with severe acute malnutrition and medical complications.[259]

Despite the overall stunting statistics, a closer review of the nutritional situation across countries in the Region shows a significant decrease in prevalence among children under five, from 35.8% to 31.0% (2012–2022) (see Figure 29). Although population growth has led to an increase in the absolute number of stunted children, from 54.3 million to 56.2 million over the period, six countries[260] in the Region are on track to meet the national target of a 40% reduction in the number of stunted children from the 2012 baseline. These reductions can be attributed to strong political commitment, effective nutrition governance, a focus on maternal-child nutrition during the first 1000 days, and the implementation of both nutrition-specific and nutrition-sensitive interventions through multisectoral approaches.

There has been significant progress across the Region towards enhancing food safety for improved public health, through

259 https://www.afro.who.int/news/who-supports-stabilization-centres-treat-malnourished-children-south-sudan
260 Côte d'Ivoire, Eswatini, Ghana, Kenya, Sao Tome and Principe and Zimbabwe.

Figure 29: Trends in the prevalence and number of under five children who are stunted in the WHO African Region



Source: United Nations Children's Fund (UNICEF), WHO, World Bank Group Joint Malnutrition Estimates, May 2023 edition

active membership and participation in the International Food Safety Authorities Network. Between 2016 and 2023, the number of countries with a designated Emergency Contact Point increased from 30 to 45.[261] Since the official launch of the Codex Trust Fund 2 in 2016, as of 2022 a mentoring scheme in collaboration with FAO has helped 28[262] countries to obtain funding for implementing projects that strengthen food standards, in line with the Codex Alimentarius. In addition, 240 food business operators and about 170 country experts have been trained.

In Senegal, for example, this led to the establishment of a system to collect and analyse data on food consumption and contamination for groundnuts in high-exposure areas. The country has since contributed data to the Codex Committee on Contaminants in Food. A total of 20[263] countries were also supported to design and implement food safety promotion initiatives based on the "WHO Five Keys to Safer Food", while WHO has also played a key role in supporting countries to implement the Healthy Food Market Initiative, aimed at enhancing hygiene practices and sanitation in traditional food markets. Between 2015 and 2023, market improvement projects were successfully established in Cameroon, Guinea, Mali, Senegal and Togo.

261 Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cabo Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Eritrea, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, United Republic of Tanzania, Togo, Uganda, Zambia and Zimbabwe.

262 Benin, Burkina Faso, Burundi, Cabo Verde, Côte d'Ivoire, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritius, Comoros, Niger, Sierra Leone, Nigeria, Rwanda, Senegal, South Sudan, United Republic of Tanzania, Uganda, Zambia and Zimbabwe.

263 Angola, Benin, Burkina Faso, Cabo Verde, Chad, Comoros, Congo, Côte d'Ivoire, Gambia, Ghana, Guinea, Lesotho, Mali, Mauritania, Mozambique, Niger, Togo, Senegal and Sierra Leone.

8.4

Addressing environmental health risks and proactively adapting to climate change

Environmental degradation and health are inextricably linked: climate change not only damages ecosystems, but also directly threatens human life. Water scarcity, air pollution and extreme weather events such as floods and droughts have set the stage for an unprecedented public health crisis, with Africa being the most vulnerable continent.

Recognizing this interconnectedness, WHO has been at the forefront of efforts to help African countries adapt to the growing threats posed by climate change. While much remains to be done to implement the commitments of the Libreville Declaration signed by 52 African countries in 2008, WHO's critical technical and financial support over the past decade has helped place the challenge firmly on the regional agenda.

Among the first steps taken to implement the declaration, WHO supported 26 countries to conduct vulnerability assessments and develop health national adaptation plans. Of these countries, 21[264] were supported to develop health national adaptation plans within overall national adaptation plans to address the impact of climate change on people's health and health systems. Positive outcomes included the training of more than 50 regional experts and 300 national stakeholders to conduct these assessments. Unfortunately, the lack of resources hampered implementation.

At the Conferences of Parties (COPs) to the United Nations (UN) Framework Convention on Climate Change, WHO joined other stakeholders in advocating for climate action for health. These efforts culminated in the launching of a Health Initiative at COP26 in 2021. This committed

264 Benin, Burkina Faso, Cabo Verde, Côte d'Ivoire, Eritrea, Ethiopia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Niger, Nigeria, Rwanda, Sao Tome and Principe, United Republic of Tanzania, Togo and Zambia.

countries to building climate-resilient and sustainable, low-carbon health systems. During COP27 in 2022, WHO championed the establishment of the Alliance for Transformative Action on Climate and Health and, through continued advocacy and collaboration with COP presidencies, COP28 featured the first-ever Health Day with ministerial dialogues, a health declaration and new funding opportunities to support adaptation and resilience-building in health systems.

Between 2015 and 2022, the population coverage of safely managed sanitation facilities increased slightly, from 22% to 24% (and from 30% to 34% for basic sanitation), and open defaecation rates decreased from 21% to 17%.

WHO in the African Region proactively mobilized countries to join these initiatives, with 29 countries[265] signing the COP26 health commitment and joining the Alliance for Transformative Action on Climate and Health. Some 15 African health ministers and high-level representatives participated in the Health Day at COP28, renewing commitments to building resilient health systems and implementing the Libreville Declaration during a series of inter-ministerial dialogues. The African Group of Negotiators led WHO's contribution to the development of the common African position, an advocacy effort that resulted in the inclusion of health content in the global goal on adaptation.

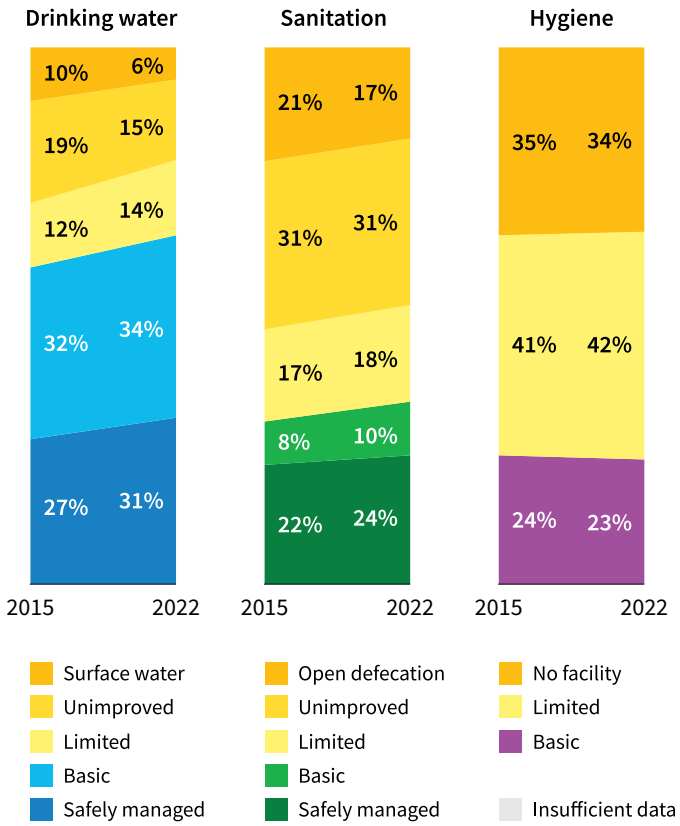
As part of follow-up action by the Secretariat during 2024 on various fronts, WHO is working with the African Group of Negotiators to define Africa-relevant health indicators for the global goal on adaptation, and training health experts for future participation in climate negotiations. WHO is also working with governments to mobilize resources from new funding opportunities, such as the Adaptation Fund, and AFRO has submitted the first WHO-led project proposal to support the building of climate-resilient health systems in Guinea, Sao Tome and Principe and in Kenya. If successful, these efforts would raise US$ 14 million to support the three countries.

In the area of WASH, a WHO/UNICEF Joint Monitoring Programme (JMP) routinely monitors coverage in cycles that focus on communities (population coverage), health facilities and schools. Between 2015 and 2022, the population coverage of safely managed sanitation facilities increased slightly, from 22% to 24% (and from 30% to 34% for basic sanitation), and open defaecation rates decreased from 21% to 17%. A total of 31% of the population benefited from safely managed water facilities in 2022, up from 27% in 2015, while basic water service coverage increased from 59% to 65% over the period. Correspondingly, reliance on surface water sources decreased from 10% to 6%.

While there were modest improvements in community water and sanitation services, hygiene services stagnated at around 24% between 2015 and 2022, such that few countries are likely to meet the WASH targets in SDG6 by 2030.

265 Botswana, Burkina Faso, Cabo Verde, Central African Republic, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gabon, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, United Republic of Tanzania, Togo, Uganda, Zambia and Zimbabwe.

Figure 30: WHO-UNICEF Joint Monitoring Programme access to WASH services at household level in the WHO African Region, 2023



- Achieving globally universal access to safely managed services for drinking water by 2030 will require a sixfold increase in current rates of progress (**20-fold in least developed countries, 19-fold in fragile contexts**).
- Achieving globally universal access to safely managed sanitation services by 2030 will require a fivefold increase in current rates of progress (**16-fold in least developed countries, 15-fold in fragile contexts**).
- Achieving globally universal access to basic hygiene services by 2030 will require a threefold increase in current rates of progress (**12-fold in least developed countries and eightfold in fragile contexts**).

WASH assessments in health facilities in 2019 found that nearly three quarters (73%) had hand hygiene facilities at points of care – 87% for hospitals and 68% for other facilities, a slight increase from 84% and 64% respectively (2016–2019). A study of 30 countries showed that appropriate hand hygiene in hospitals reduces the transmission of harmful bacteria and viruses among patients and thus reduces the risk of community outbreaks.[266]

The JMP for health care facilities found that basic water service coverage stagnated between 2016 (51%) and 2021 (52%). More worrying was the finding that the corresponding coverage for basic sanitation services fell from 23% in 2016 to 13% in 2021.[267] However, this drastic decline could be driven by improved monitoring following the UN Secretary-General's 2018 call for action to improve access to WASH services in health facilities to address poor prevailing conditions.

Meanwhile, all WHO countries in Africa have received training in the use of the WASH facility improvement tool, WASH-FIT, developed by WHO and UNICEF for assessing WASH in health facilities. From six countries in 2015, 33 countries[268] have now implemented WASHFIT in their facil-

266 WHO/UNICEF (2020) Global Progress report on WASH in health care facilities: Fundamentals First. https://www.washinhcf.org/wp-content/uploads/2021/07/WHO_UNICEF_GlobalProgressReportWASHinHCF_forWeb_2020V2.pdf

267 WHO-UNICEF JMP WASH in health care facilities 2022.

268 Angola, Benin, Burundi, Burkina Faso, Chad, Comoros, Democratic Republic of the Congo, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Sudan, United Republic of Tanzania, Togo, Uganda, Zambia and Zimbabwe.

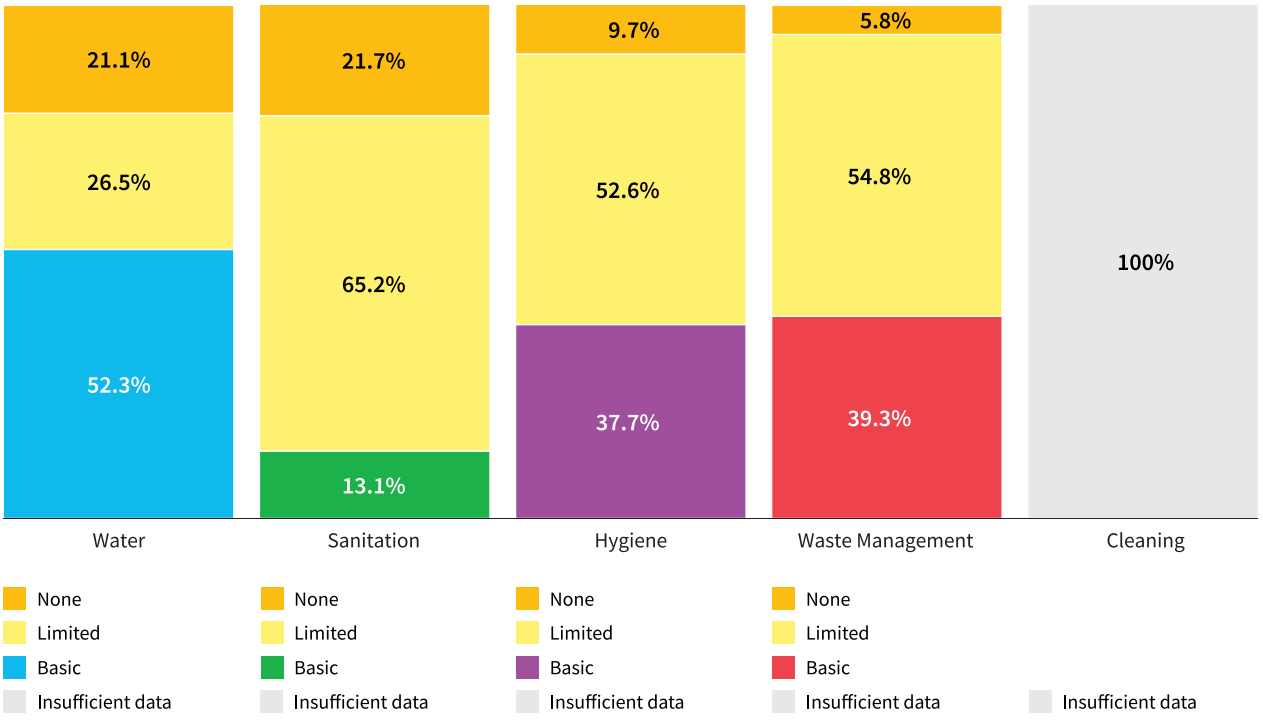
ities with direct support from WHO, while many more have adopted it with support from other partners.

In collaboration with the Sanitation and Hygiene Fund and UNICEF, WHO also supports countries to develop WASH accounts using the TrackFin methodology, to estimate related expenditure. This provides useful information for developing investment cases to advocate for increased budgets from domestic and external sources, and for improving data availability and quality for investment tracking. In 2015, Ghana was the only country in the Region to develop WASH accounts, but by 2024, this number had grown to 15.[269]

The evaluation of WHO's contribution in the African Region to the global WASH Strategy 2018–2025 is ongoing and is expected to identify strengths and gaps in regional and country capacity. Given the observed slow progress, and some setbacks in WASH coverage over the past decade, complementary evaluations are critical to understanding how to accelerate progress towards the SDG6 WASH indicators.

269 Benin, Burkina Faso, Chad, Ghana, Kenya, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Sierra Leone, Senegal and Uganda.

Figure 31: WASH assessments in health facilities in the WHO African Region, 2021



15% of facilities in the low- and lower-middle-income countries of sub-Saharan Africa lacked any access to energy whatsoever.

Source: WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP)


World Health
Organization

8.5

Preventing injuries, eliminating violence against women and children, reducing health inequities for people with disabilities and strengthening rehabilitation services

8.5.1 Road traffic accidents and deaths

As Africa undergoes rapid urbanization, with people relying primarily on private cars and motorcycles as their main means of transport, the unfortunate disadvantage is the concomitant increase in road traffic accidents, which are today the leading cause of injury-related death across the continent. Over the past decade, road traffic fatalities have increased significantly in the African Region, accounting for nearly one fifth of all road deaths worldwide, with almost 250 000 lives lost on the continent's roads in 2021 alone.[270]

"The findings of the [WHO Status report on road safety 2023 for the African Region] point to a serious public health concern for African countries, with hundreds of thousands of lives being lost unnecessarily."

Dr Matshidiso Moeti, WHO Regional Director for Africa

The increase is attributable to a number of factors, including inadequate road safety legislation and standards. In addition, road infrastructure safety ratings are remarkably low, with only a small percentage meeting acceptable standards for various road users.

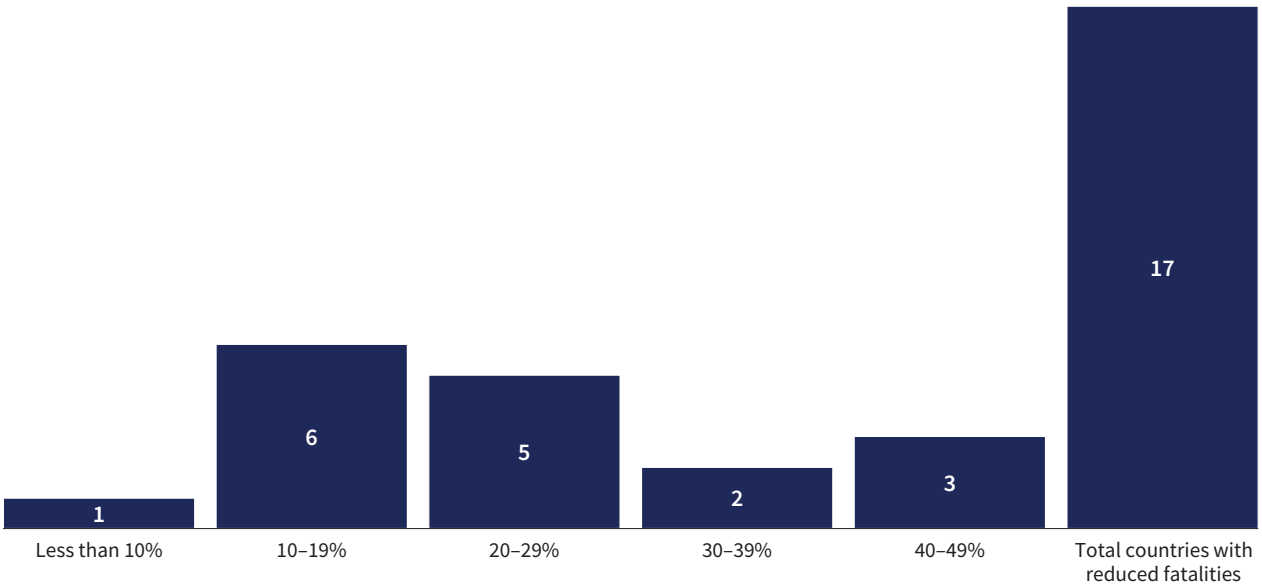
Despite this alarming trend, there are signs of progress, with Member States implementing several measures to tackle this growing public health burden. For example, the increase in road traffic fatalities is not uniform across the Region: the WHO status report on road safety 2023 for the African Region reveals that there have been reductions in more than one third of countries (see Figure 32).

270 https://www.afro.who.int/news/road-traffic-deaths-rise-african-region-down-globally-who-report

Of the 17 countries[271] with reductions, three[272] have achieved reductions of between 40% and 49%, and two[273] others of between 30% and 39%. When analysed by income level, the highest road traffic fatality rates are observed in low- and lower-middle income countries, which account for 91% of all estimated road traffic fatalities in the Region.

271 Burundi, Cabo Verde, Cameroon, Congo, Democratic Republic of the Congo, Eritrea, Gabon, Lesotho, Liberia, Mauritania, Mauritius, Rwanda, Sao Tome and Principe, Seychelles, Sierra Leone, South Africa and South Sudan.
272 Congo, Mauritania and Seychelles.
273 Burundi and Cameroon.

Figure 32: Proportion of countries with reductions in estimated road traffic fatalities in the WHO African Region, 2010–2021



These successes provide valuable lessons for the Region, demonstrating that robust, multisectoral evidence-based road safety interventions, together with effective implementation, can make a significant difference. Advocating for Region-specific research and strengthening research capacity are therefore critical for identifying and documenting successful Africa-focused interventions for broader replication.

A total of 35[274] countries in the Region have national road safety strategies, most of which are aligned with global targets, but only 21[275] of these have specific targets for reducing road traffic accident fatalities.

The WHO African Region response is guided by the WHO global action plans for the first (2011–2020) and second (2021–2030) decades of action for road safety, supporting countries through a "safe systems" approach. This places the safety of the individual at the centre of all components of road safety, from urban planning and alternative modes of transport to road infrastructure, vehicle safety, user behaviour and post-crash response.

Regional efforts over the past 10 years have included technical assistance to strengthen national legislation on road accident risk factors in Ethiopia, Ghana, Kenya, United Republic of Tanzania and Uganda, through the Bloomberg Initiative for Global Road Safety, and in Mozambique. Although no country in the Region currently has legislation that meets best-practice standards for the five[276] key road safety behavioural risk factors, there have been modest improvements in the enforcement of speed management, seat belt laws, drink-driving and child restraints.

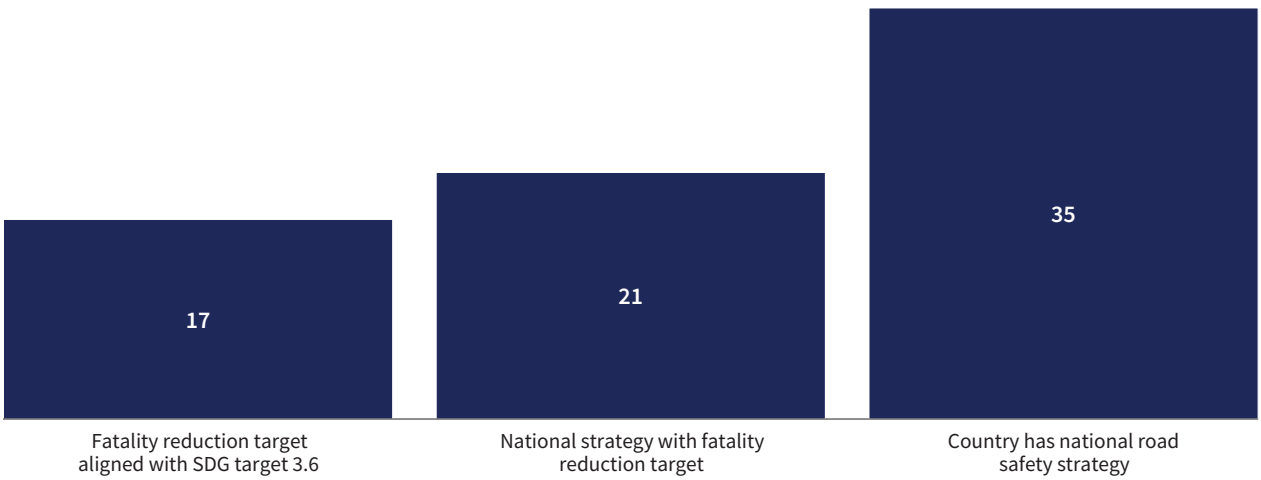
Dar es Salaam in United Republic of Tanzania, with its ambitious Bus Rapid Transit system, has adopted WHO's "safe systems" approach to become a model of synchronicity between urban planning and road safety reforms. Launched in 2016, the system has provided a safer and more efficient transport system for nearly 200 000

274 Algeria, Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Sierra Leone, South Africa, United Republic of Tanzania, Togo, Uganda and Zambia.

275 Algeria, Benin, Cabo Verde, Cameroon, Chad, Côte d'Ivoire, Gabon, Gambia, Ghana, Guinea, Lesotho, Malawi, Mali, Mauritania, Mauritius, Namibia, Nigeria, Sierra Leone, South Africa, Uganda and Zambia.

276 Speeding, drink–driving, non-use of motorcycle helmets, seatbelts and child restraints.

Figure 33: Number of countries with national road safety strategies in the WHO African Region, 2021



people every day, addressing both traffic congestion and the resulting potential for road accidents.

The availability of reliable data on the road safety landscape and the burden of road traffic accidents is essential to inform policy and timely, life-saving interventions. WHO has therefore provided technical assistance to build capacity in road traffic data management, with notable improvements in Côte d'Ivoire, Senegal and Zambia. As a result, the 2023 road safety report recorded a significant 50% reduction in discrepancies between WHO estimates and country-reported data on fatalities.

8.5.2 Violence against women and children

Addressing violence against children is high on the agenda of the Namibian Government. As one of 38 Pathfinding[277] countries committed to ending this scourge, 13[278] of which are in the African Region, Namibia has a robust policy and legislative framework to protect children from violence and abuse, along with a 2022–2025 national plan of action to prevent and respond to violence against children.

One success story comes from Dodoma, capital of the United Republic of Tanzania, where a local school implemented the INSPIRE framework after witnessing several cases of child abuse in the community. Teachers were trained to recognize the signs of abuse and a reporting system was set up to ensure quick action when children were at risk. The number of reported cases of violence fell dramatically within the first year of implementation.

This multisectoral plan is aligned with the INSPIRE framework, which was developed by WHO and partners in 2016 as a guiding document with evidence-based interventions to reduce violence against children. In addition to Namibia, the framework has guided capacity-building and upscaling of interventions in Uganda and Zimbabwe, with United Republic of Tanzania leading the Region with comprehensive violence prevention strategies across the health, education and social service systems.

The framework, which includes interventions such as supporting parents and caregivers, enforcing laws and changing social norms, has been transformative in United Republic of Tanzania, where new programmes teach schoolchildren about their rights and how to protect themselves from abuse. Parents are being trained on positive parenting techniques that emphasize non-violent forms of discipline and WHO is helping to scale up these interventions throughout the country.

One success story comes from Dodoma, capital of the United Republic of Tanzania, where a local school implemented the INSPIRE framework after witnessing several cases of child abuse in the community. Teachers were trained to recognize the signs of abuse and a reporting system was set up to ensure quick action when children were at risk. The number of reported cases of violence fell dramatically within the first year of implementation.

WHO also worked with partners to develop the first comprehensive global status report on preventing violence against children 2020. Using the INSPIRE framework, it charted countries' progress towards achieving SDG 16.2 to end abuse, exploitation, trafficking and all forms of violence and

277 https://violenceagainstchildren.un.org/content/pathfinding-countries
278 Botswana, Burkina Faso, Côte d'Ivoire, Ethiopia, Guinea, Kenya, Namibia, Nigeria, South Africa, United Republic of Tanzania, Uganda, Zambia and Zimbabwe.

torture against children. The second edition of the report is being prepared.

In addition, WHO in the African Region established a strong partnership with UNICEF through the Global Initiative to Support Parents, which was launched during the COVID-19 pandemic when there was an increased need for support to parents and caregivers in the African Region.

Meanwhile, gender-based violence and sexual exploitation and abuse are a major public health threat. WHO has supported 20[279] countries in the Region to implement its guidelines for addressing the scourge through the RESPECT framework, which was launched in 2019 in collaboration with UN Women and other partners. The evidence-based framework supports policymakers to strengthen and scale up efforts to prevent violence against women.

In Rwanda in 2021, WHO, UN Women and other partners launched the RESPECT Women website, an online platform that aims to drive specific action to prevent and respond to violence against women and girls. It outlines a series of action-oriented steps to help policymakers and programme implementers design, plan, implement, monitor and evaluate programmes that use strategies to prevent violence against women.

Botswana and South Sudan have both adapted WHO recommendations to update their national guidelines for the prevention and management of gender-based violence through the health sector, including the RESPECT framework for frontline health workers. Ghana and South Africa now have national guidelines for operationalizing gender mainstreaming in health and health sector gender policies respectively.

In Nigeria, six zonal core teams on gender-based violence care and support were established following WHO-supported training, while Rwanda's 4x4[280] human resources for health reforms were reviewed to enhance their gender responsiveness.

8.5.3 Integrating rehabilitation into health systems

Rehabilitation has been recognized as a core component of the health care continuum since the Alma-Ata Declaration of 1978, but remains underprioritized in the African Region. It is most often framed as a service for people with disabilities in the context of community based rehabilitation frameworks, or as a post-conflict response for the injured. With the launch of the Rehabilitation 2030 initiative in 2017, WHO reaffirmed the importance of rehabilitation as a body of essential services within national health systems.

In the African Region and worldwide, Botswana was among the first countries to pilot the 2017 WHO rehabilitation guide for action, which recognizes the need for countries to identify their own rehabilitation needs and develop tailored response strategies. The tool guides governments through a four-phase process of assessment, planning and implementation.

As of 2024, 13[281] countries in the Region have been supported to develop national strategic plans for rehabilitation. Other technical packages implemented through the Rehabilitation 2030 initiative include the guide for rehabilitation workforce evaluation toolkit implemented in Rwanda; the integration of rehabilitation data in routine health information systems in Burkina Faso, Ethiopia and United Republic

279 Angola, Botswana, Burkina Faso, Democratic Republic of the Congo, Eswatini, Ghana, Guinea, Kenya, Lesotho, Mali, Malawi, Mauritania, Mozambique, Namibia, Nigeria, Senegal, South Africa, Uganda, Zambia and Zimbabwe.

280 The 4x4 strategy aims to quadruple the number of health care workers in the country by 2027 to meet the WHO recommendation of at least four health care professionals per 1000 population density.

281 Benin, Botswana, Burkina Faso, Burundi, Ethiopia, Guinea-Bissau, Mozambique, Namibia, Rwanda, Seychelles, South Africa, United Republic of Tanzania and Uganda.

"In the course of tackling violence, injuries and disability in the African Region, we have witnessed first-hand the pressing need for robust rehabilitation services. This need is not just a response to a growing public health concern; it is also a vehicle for achieving universal health coverage and the health-related targets of the Sustainable Development Goals."

Dr Adelheid Onyango, Director of the WHO Africa Region's Universal Health Coverage/Healthier Populations Cluster

of Tanzania; and the rehabilitation basic package of care-clinical modules in Ghana and Uganda, to expand the availability of rehabilitation in primary health care.

While rehabilitation services in the Region are making significant progress, much remains to be done. To further develop these services, it is crucial to integrate rehabilitation into primary health care and ensure that it becomes a fundamental part of the health system. The development of a skilled workforce dedicated to rehabilitation is essential, as is the promotion of innovative solutions for the effective delivery of these services, particularly in resource-limited settings.

Improving health security in Africa

9

9.1

From crisis to resilience

From the EVD crisis (2014–2016) in West Africa to the COVID-19 pandemic in 2020 and beyond, outbreaks and emergencies have repeatedly exposed the vulnerabilities of Africa's public health systems, leaving in their wake disruptions to essential services, economic hardship and communities grappling with disease and insecurity.

The WHO African Region bears the heaviest burden of public health crises in the world, with more than 100 outbreaks and emergencies triggered by disease, conflict and natural disasters every year. In addition to EVD and COVID-19, these include cholera, measles, yellow fever, polio, meningitis and, most recently mpox, severely testing health systems and affecting vulnerable populations the most.

Recognizing that health emergencies do not respect borders and therefore require a comprehensive and collaborative approach, Dr Moeti prioritized a strategy that emphasized not only the need to manage emergencies, but also to build stronger, more resilient health care systems capable of withstanding and mitigating the impact of future crises.

The Health Security and Emergencies Cluster was established in 2015 and in 2016 renamed the WHO Health Emergencies Programme (WHE), in line with the recommendations following the West African EVD outbreak. In 2019, the cluster was again renamed, becoming the Emergency Preparedness and Response (EPR) Cluster.

Despite the name changes, the cluster's focus has always been to strengthen the Region's defences against public health threats and humanitarian crises. For example, the Health Security and Emergencies Cluster consolidated experts and resources from separate programmes focused on outbreaks and humanitarian crises into three operational units.

With the establishment of the WHE in 2016, five programme areas were stand-

ardized across all regions and at WHO headquarters. These included Country Health Emergency Preparedness & International Health Regulations (IHR) (CPI), Emergency Operations (EMO), Health Emergency Information and Risk Assessment (HIR), Infectious Hazard Management and Management and Administration (MGA). The change to EPR in 2019, in alignment with restructuring at headquarters, reduced the number of programme areas to three: Health Emergency Information and Risk Assessment (HIR), Emergency Preparedness (EMP) and Emergency Response (EMR). A fourth unit, Operations Support and Logistics (OSL), was added in 2021 to ensure the rapid deployment of medical supplies in emergencies.

This visionary collaboration set the stage for partnerships that combined the strengths of stakeholders and ultimately changed the way epidemics and outbreaks are tackled.

Still in 2015, in response to the urgent need for an accountability framework for health security in Africa, WHO's Regional Office for Africa, the African Union Commission and other partners began laying the groundwork[282] for the establishment of the African Centres for Disease Control (Africa CDC). The memorandum of understanding (MoU) was signed in 2016, in what Dr Moeti described as one of her first major acts as Regional Director (see In Dr Moeti's own words: the journey of WHO's strategic partnership with Africa CDC later in this chapter).

Entitled the Framework for Collaboration between WHO and the African Union Commission on the Establishment and Operationalization of the Africa Centres for Disease Control and Prevention (to Improve Health Security in Africa, this visionary collaboration set the stage for partnerships that combined the strengths of stakeholders and ultimately changed the way epidemics and outbreaks are tackled.

Building on efforts to strengthen EPR systems in the Region, three flagship programmes were announced in early 2022 to help countries prepare for, detect and respond to public health emergencies. They were the outcome of extensive consultations with more than 30 African government ministers, technical stakeholders, partners across the continent and regional institutions such as Africa CDC. They are Promoting Resilience of Systems for Emergencies, Transforming African Surveillance Systems (TASS), and Strengthening and Utilizing Response Groups for Emergencies (SURGE).

Since its inception, the cluster has supported Member States in more than 200 public health emergencies, bringing hope to communities and establishing WHO as the leading emergency response agency in the African Region. Now, within 48 hours of an emergency, a series of coordinated responses are set into motion. Firstly, WHO grades the severity of the health threat, thereby activating an incident management system, which it uses to organize and manage each emergency response. Public health emergency operation centres are established in regional and country offices for emergency management personnel to coordinate operational information and resources.

Essential funding is released from WHO's Contingency Fund for Emergencies, to enable the rapid deployment of emergency responders and the activation of stockpiles of critical supplies, including personal protective equipment, medicines and vaccines. Communication networks are also quickly established, base camps are set up

282 https://www.afro.who.int/news/who-and-african-union-commission-are-working-establish-african-centre-disease-control-and

where necessary, and efforts begin to alert affected communities and neighbouring countries through official IHR procedures. This rapid and structured response has helped to ensure an effective response to outbreaks, even in hard-to-reach and challenging environments.

From the development of cutting-edge health information systems to the establishment of regional emergency hubs, progress towards health security has reflected determination and collaboration. The challenges are immense, even within this transformed approach, but so is the resolve.

9.2

Health information and risk assessment

9.2.1 Harnessing the power of data

Access to accurate, timely and high-quality health information for effective decision-making is the bedrock on which preparedness for public health emergencies is built. In the words of the late Kofi Annan, former UN Secretary-General: "Without good data, we're flying blind. If you can't see it, you can't solve it."

In the years following the 2014–2016 EVD outbreak, this has been one of the most important lessons learned, highlighting the importance of reliable data to enable health authorities to track the spread of disease, allocate resources and communicate effectively with the public. Reliance on paper records, telegraphs and word-of-mouth to report cases was slow and error-prone, contributing to life-threatening delays in response.

Within the EPR cluster, the Health Emergency Information and Risk Assessment programme has been a key player in the ambitious quest to revolutionize health information systems. The aim was to create a single platform for collecting, analysing and disseminating health data by integrating surveillance systems, adopting digital tools and training health workers in data management and analysis.

Over the past decade, the programme has grown and been adapted to become a reference point and source of validated information for all public health emergencies in the Region. Initially comprising three units (see Figure 34), its scope of work later expanded to include a fourth unit focused on genomics and laboratory diagnostics.

The most recent achievement in 2024 was the launch of a new Data Analytics and Innovation Centre, The Data Sphere, at the WHO Regional Emergency Hub in Dakar, Senegal. This is a supplementary tool to support countries in building national and subnational capacity in epidemiological surveillance, data analysis and innovation,

to improve detection and response to public health emergencies.

The combined impact is evident in the statistics. The 2014 EVD outbreak in three West African countries overwhelmed capacity, resulting in over 28 000 cases and over 11 000 deaths, largely due to weaknesses in surveillance systems that hindered early detection and response. In 2022, after these widespread efforts to strengthen African surveillance systems and streamline health information workers, a similar outbreak in the Democratic Republic of the Congo in 2022 took just 29 days to detect. It was brought under control in a remarkably short 37 days, with only one case and one death.[283]

9.2.2 Comprehensive implementation of the integrated disease surveillance and response framework

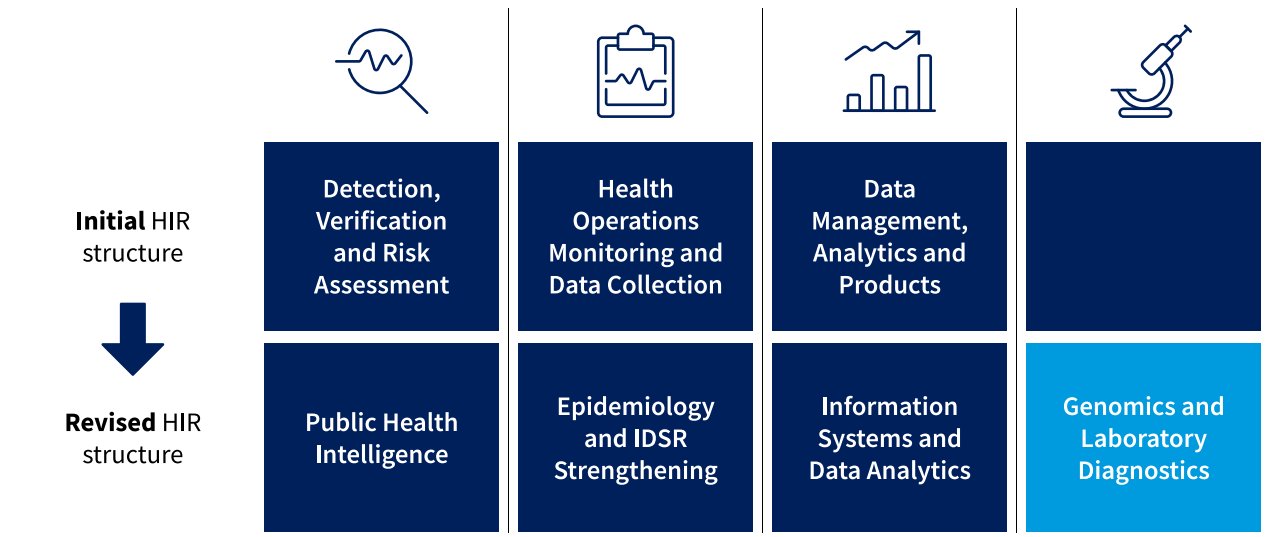
The integrated disease surveillance and response (IDSR) framework has been the blueprint for public health surveillance in the African Region since 1998. However, although it has attained several milestones during its first decade of implementation, Member States continued to struggle to prevent, detect and respond to health emergencies.

The Regional Office responded by setting clear milestones and targets in the regional strategy for IDSR 2020–2030, adopted by the Regional Committee for Africa in 2019. The TASS flagship programme was developed in 2022 to accelerate implementation of the regional strategy. It is an important platform for mobilizing stakeholders and resources to sustain progress, and has notably accelerated the online submission of weekly IDSR data from Member States through a centralized data platform.

There were challenges, such as health facilities in remote areas with limited access to electricity and the Internet, together with overburdened and under-resourced health workers adapting to new technologies and reporting protocols. Nonetheless, the tide began to turn.

283 https://www.who.int/emergencies/disease-outbreak-news/item/2022-DON411

Figure 34: Structure of the HIR Programme and adaptations during the Transformation Agenda



Key statistics highlighting impact:

28 Member States*

received critical catalytic funding of

US$ 14 783 860

to address challenges and enhance IDSR capacity.†

46‡ of 47 Member States

have adapted and updated their national surveillance guidelines to the third edition of the IDSR technical guidelines and training materials.

The coverage of weekly IDSR data reporting improved from

10 to 39§ Member States

(2022–2024), the data completeness rate improved from

21% to 83%

and timeliness improved from

11% to 66%

More than

47 000

copies of IDSR materials were distributed in

10 Member States.¶

More than

12 000

health workers in

17 Member States#

were trained on various aspects of IDSR to improve competence and skills in core surveillance functions.

As a result of TASS support,

only three

countries** still have challenges in IDSR reporting.

* Angola, Botswana, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gambia, Ghana, Guinea, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, South Africa, United Republic of Tanzania, Togo and Uganda.

† Data as of August 2023.

‡ Except for Algeria.

§ Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Eritrea, Eswatini, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, South Sudan, United Republic of Tanzania, Togo, Uganda and Zambia.

¶ Botswana, Chad, Congo, Côte d'Ivoire, Kenya, Madagascar, Mauritania, Namibia, Niger and Togo.

Botswana, Cameroon, Congo, Côte d'Ivoire, Gambia, Ghana, Guinea, Kenya, Madagascar, Mali, Mauritania, Mauritius, Namibia, Niger, South Africa, Togo and Uganda.

** Algeria (with no adoption of IDSR) plans to share surveillance data through system exchange; Comoros and Equatorial Guinea (where efforts are underway with WHO – supported consultants).

9.2.3 Enhancing public health intelligence through innovative technology

There has also been significant progress in the past decade in incorporating innovation and technology to enhance public health intelligence activities. An example is the Epidemic Intelligence from Open Sources (EIOS)[284] initiative.

Nearly four million articles were comprehensively reviewed between 2018 and 2023 in a mammoth effort to collect and analyse relevant information, to ensure timely and accurate responses to emerging health crises.

Since its introduction in the African Region in May 2018, EIOS has been utilized daily by trained public health intelligence officers as the primary system for conducting media monitoring. As a result, nearly four million articles were comprehensively reviewed between 2018 and 2023 in a mammoth effort to collect and analyse relevant information, to ensure timely and accurate responses to emerging health crises.

In addition to using EIOS as an internal tool, the HIR programme has supported its significant scale-up to enhance event-based surveillance activities at country level. The platform now contributes to the detection of more than a third of all public health events in the Region.

In particular, the number of Member States connected to EIOS increased from only two in 2019 to 38[285] in 2024; over 1200 EIOS users had been trained in 38[286] Member States, with remaining countries to be connected by the end of 2024; and EIOS has achieved an 84% timely detection rate (detection within seven days of onset) for most disease outbreaks in the Region.

9.2.4 Genomic sequencing capacity

Significant advances in laboratory and genomic surveillance have further strengthened the Region's preparedness for future outbreaks, with gains especially evident during the COVID-19 pandemic. In February 2020, when the first case was documented in the African Region, only four[287] countries had effective capacity to sequence SARS-CoV-2 and report sequencing data. By December 2020, only 5000 (1%) sequences had been reported from the Region.

The WHO Regional Office for Africa and Africa CDC established a network of genome-sequencing laboratories for COVID-19 and other emerging pathogens in September 2020.[288] In addition to increasing national sequencing capacity, WHO trained laboratory personnel on using rapid antigen diagnostic tests, supported the establishment of wastewater surveillance for pathogens with epidemic and pandemic potential, and provided bioinformatics training.

Additional tools were developed and piloted, including a genomic surveillance costing tool, and a monitoring and eval-

284 The world's leading initiative for open-source intelligence for public health decision-making and an important tool to enhance media monitoring activities.

285 Angola, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Cabo Verde, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, United Republic of Tanzania, Togo, Uganda, Zambia and Zimbabwe.

286 Angola, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Cabo Verde, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, United Republic of Tanzania, Togo, Uganda, Zambia and Zimbabwe.

287 Kenya, Nigeria, Senegal and South Africa.

288 https://www.afro.who.int/news/covid-19-genome-sequencing-laboratory-network-launches-africa

Key statistics highlighting impact:

Number of countries with in-house sequencing capacity increased from

12 to 42[*]

(2020–2022).

47 Member States

established national laboratories for polymerase chain reaction testing by 2021.

A total of

96

participants trained in bioinformatics[†].

Production of sequencing data increased from

5000 to > 150 000

(2020–2022), with a 30-fold increase following on-site visits to

44 Member States[‡]

(94%) to support upscaling of genomic surveillance.

Installation of sequencing platforms, on-site training and mapping of sequencing platforms in

46 Member States[§]

(98%).

* Except for Burundi, Comoros, Eritrea, Liberia and South Sudan.
† In collaboration with US Centers for Disease Control and the South African National Bioinformatics Institute.
‡ Except for Comoros, Eritrea and South Sudan.
§ Except for South Sudan.

uation tool to track the performance of country visits for scaling up genomic surveillance.

Key lessons have been learnt. Robust financial and human resources are necessary, including sustainable domestic funding, to ensure effective strengthening of surveillance systems and implementation of IDSR. Integration and interoperability of data systems are also essential for efficient disease surveillance, while the transition to electronic reporting systems significantly improves the accuracy and timeliness of data.

Community engagement is critical for the sustainability of surveillance activities, as is building strong relationships with local stakeholders to improve compliance and participation. Meanwhile, training health workers at all levels in information management and surveillance principles ensures a well-prepared workforce capable of managing health crises.

Finally, the use of advanced tools and platforms for data analysis and outbreak prediction has proven to be a game changer, highlighting the need for continuous innovation in surveillance technologies. Effective partnerships and continuous monitoring and evaluation are also essential to adapt strategies and improve health outcomes.


COVAX
CEPI
Gavi
unicef
World Health Organization
COVAX
EPI
Gavi
icef
Emirates

9.3

Operations Support and Logistics (OSL)

9.3.1 Breaking the logistical medical supply logjam

While there has been a significant leap forward in the development of health information systems, the critical challenge of logistics remained. The capacity to rapidly deploy medical supplies is a key pillar of emergency response but it had been one of the weakest areas of response in Africa, and for WHO in the African Region.

Many countries have their own stockpiles of medical supplies and channels for international procurement, but they are often overwhelmed by the increased needs of their populations in emergencies, and rely on WHO's support. Hard-to-reach areas, often the epicentre of outbreaks, are particularly vulnerable to isolation owing to poor infrastructure, limited transport and inadequate supply chains.

During the EVD outbreak (2014–2016), the logistical challenges of delivering medical supplies, transporting patients and coordinating field operations created bottlenecks that hampered the response, underscoring the urgent need for robust logistics and operational support systems and highlighting the need for a reset.

It was necessary to develop more sophisticated logistics and operational support systems, improve coordination mechanisms and enhance the capacity to stockpile and rapidly deploy medical supplies. Recognizing the need for a unit dedicated to managing the complex logistical and operational challenges of public health emergencies, WHO developed the Operations Support and Logistics (OSL) framework in 2021.

This was an improvement from the days when the OSL function had been embedded in the Emergency Response programme and chronically understaffed. At that time, Africa did not have its own stockpiles of emergency medical supplies and relied on the WHO warehouse in Dubai and the UN

Humanitarian Response Depot in Ghana. The reliance on other partners exacerbated inefficiencies, with shipment from Ghana to other parts of the continent taking up to 25 days.

For example, in early 2022, it took more than three months to deliver critical supplies to countries on the brink of famine in the Greater Horn of Africa, while countries waited 21 days for the first shipment of protective equipment such as masks following the COVID-19 pandemic outbreak in 2020.

9.3.2 From bottlenecks to breakthroughs

The devastating impact of COVID-19 was a wake-up call for African countries to prioritize efforts to build resilient health systems that could provide essential quality health services, while coping with health emergencies. At the same time, the need for African countries to work closely together in times of crisis had never been clearer.

In real terms, the new programme reduced the lead time for responding to Member State requests for emergency supplies, from an average of three weeks to less than three days.

The world watched as countries in Africa, even those willing to pay a premium in the private market, were unable to secure critical supplies, including personal protective equipment, ventilators and vaccines, to protect their citizens.

With its competitive advantage in terms of "boots on the ground", and decades of experience working in the African Region, WHO responded in 2021 with the launch of its ambitious Regional Strategy for Health Security and Emergencies (2022-2030), which aims to improve countries' preparedness, detection and response to health emergencies by 2030, through 12 targets. All 47 African health ministers endorsed the strategy in 2022.

Also in 2022, the three flagship initiatives referred to earlier in this chapter were launched to support the implementation of the regional strategy, in particular to promote a Member States-led, whole-of-government and whole-of-society approach. To support the flagship initiatives and the broader EPR mission, an additional fit-for-purpose programme was launched, including a new OSL programme to address gaps in operational support and strengthen logistics expertise.

The decision to create an independent OSL programme, led by a highly experienced logistician supported by experts in supply chain, operations, health logistics, customs and procurement, was a dramatic departure from the business-as-usual EPR operations, and a breakthrough for the Region. In real terms, the new programme reduced the lead time for responding to Member State requests for emergency supplies, from an average of three weeks to less than three days.

One of the key breakthroughs in the OSL framework was the establishment of regional emergency hubs, strategically located in regions prone to health crises, to act as command centres for emergency operations. An important and ambitious initiative, the locations of the hubs in Kenya (2022), Senegal (2023) and South Africa (ongoing) were chosen for their well-developed infrastructure, proximity to modern international airports and access to seaports.

Strategically located and stocked to maximize efficiency and effectiveness, the hubs in Kenya and Senegal are already accelerating the delivery of supplies during crises. To leverage economies of scale, they are also available for use by other UN agencies to provide training on emergency and humanitarian crises, including conflict management, food security, logistics and recovery.

Much more than just warehouses, the

hubs enhance subregional coordination, enabling close cooperation with governments to efficiently manage complex, multi-country emergencies, effectively decentralizing emergency response, while storing and rapidly deploying emergency supplies and equipment.

They also serve as centres of excellence for the Region, promoting cross-country learning and providing a vital training ground for 3000 multidisciplinary African responders. Each hub is specialized to leverage regional strengths. Thus, Senegal focuses on supply chain, data, innovation and intelligence, while Kenya focuses on supply chain and workforce development. Once operational, the hub in South Africa will focus on research and development, and genomic surveillance.

a) Early successes

Significant improvements in outbound lead-times

In line with the key objective of significantly reducing the time frame for responding to requests from Member States and delivering emergency supplies to communities within 24 hours, the operationalization of the temporary warehouse at the Kenya hub in September 2022 immediately reduced lead times from three weeks or more to an average of three days. For example, between January and July 2022, delivery took an average of 17 days (longest lead time of 67 days). Since September 2022, this has been reduced to an average of three and a half days (see Figure 35).

b) Improved emergency response

As improved emergency response is essential for effective crisis management and ensuring rapid action to save lives and reduce suffering, the Region has recorded improvements in response to several crises, including COVID-19, cholera in Malawi and Mozambique, the cyclone, floods and landslides in Madagascar, the Marburg virus disease (MVD) outbreak in Ghana and the EVD outbreak in Uganda (see Figure 35).

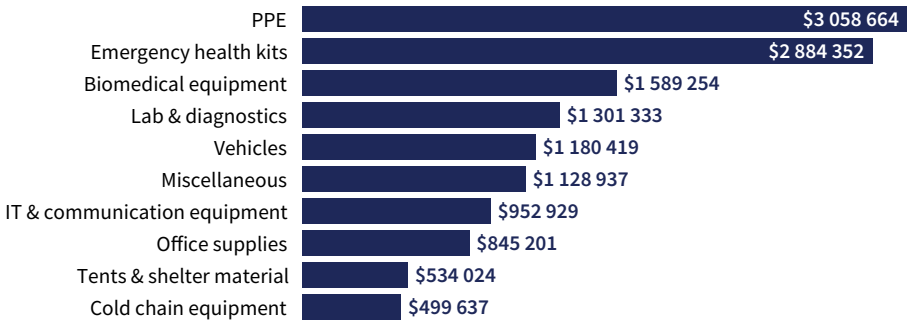
For example, between September 2022 and June 2024, the Kenya and Senegal warehouses collectively processed more than 280 outbound shipments valued at US$ 16 million to support emergency response in all 47 countries of the Region (see Figures 36 and 37).

Figure 35: WHO African Region outbound delivery lead-time before and after operationalization of the temporary warehouse at the Kenya regional emergency hub

Figure 36: Top 10 inbound/outbound activities with breakdown by response operation; Kenya warehouse (September 2022–June 2024)

Inbound activities (stockpiling)

Top 10 purchasing categories:

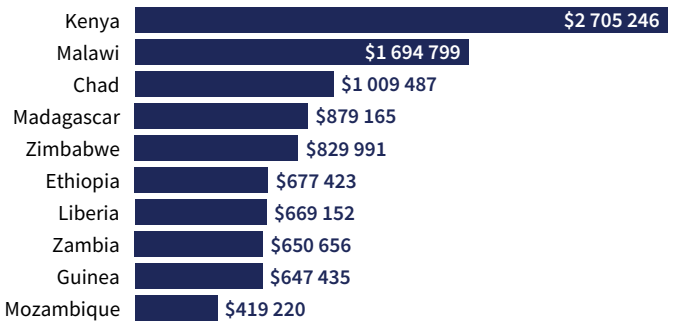


Purchase order:
275 inbound shipments

Item value:
$15 035 845

Outbound activities (emergency response)

Countries by stock release value:



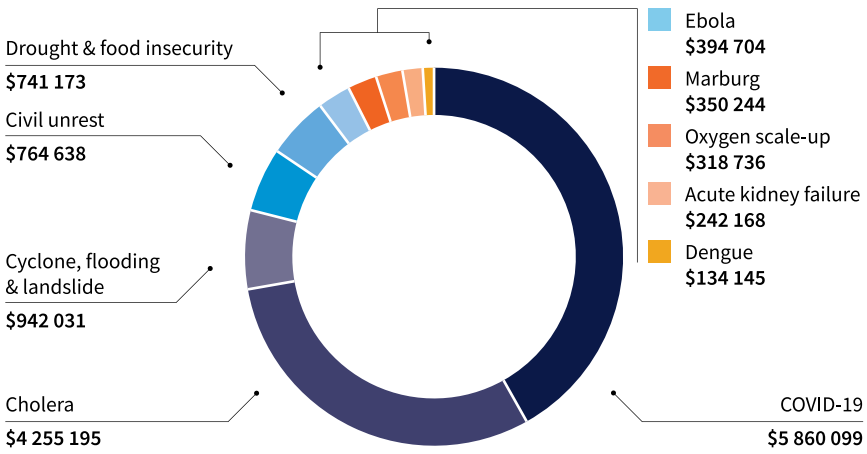
Stock release:
267 shipments, 5 direct supply to 45 countries

Item value:
$15 533 844

Weight:
1 090 346kg

Volume:
6469.48 CBM

Response operations



14 Emergencies:
Acute kidney failure, Accident & trauma, Cholera, Civil unrest, COVID-19, Cyclone, Flooding & landslide, Dengue, Drought & food insecurity, Ebola, Hub operations & capacity building, Marburg, Malaria, Mpox, Oxygen, Scale-up, SVT, Yellow fever, WHO regular support to Member States

Graded Emergencies:
Cholera, Dengue, Diphtheria, Cyclone, Flooding & landslide, Marburg, Yellow fever

c) Increased stockpile capacity

A robust stockpile helps mitigate the risk of supply chain disruptions. In times of crisis, logistical challenges can hinder the delivery of supplies, but a well-maintained stockpile ensures that essential items are available when needed, regardless of external factors. This reliability is critical for maintaining uninterrupted support during emergency operations.

By maintaining a larger stockpile of essential supplies, WHO in the African Region has ensured a rapid and effective response to crises, significantly reducing the time needed to deliver essential assistance to affected populations. For example, as of June 2024, the Kenya and Senegal warehouses had collectively stockpiled more than US$ 10 million worth of emergency supplies, by processing more than 330 inbound shipments.

For example, shipping 30 tonnes of supplies from Dubai to African countries costs about US$ 450 000, compared to US$ 75 000 from Nairobi to East and Southern Africa, a reduction of 83.3%.

The stockpiles included emergency supplies and equipment ranging from emergency health kits (cholera, trauma, interagency emergency health and malnutrition) and equipment (biomedical, laboratory and diagnostics, cold chain, field support, and IT and communication), to tents and shelter materials (see Figures 36 and 37).

d) Dramatic cost-savings in the procurement and delivery of emergency supplies

The operationalization of the temporary warehouses had a significant transformative impact on regional procurement, pre-positioning and movement of supplies. These include promoting a “by Africa” approach to procurement, thereby helping to strengthen local manufacturing, while significantly reducing costs, particularly for freight forwarding. It also reduces dependency on warehouses outside the African continent.

The Kenya hub has worked with WHO’s quality assurance teams to qualify regional manufacturers and suppliers who meet the required standards. This has resulted in savings through economies of scale and strategic procurement, improved response times and a smaller environmental footprint. Freight costs have also been significantly reduced owing to the proximity of stockpiles to emergency areas.

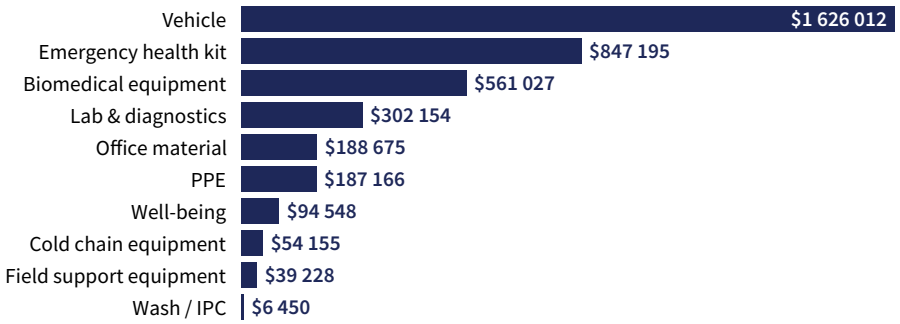
For example, shipping 30 tonnes of supplies from Dubai to African countries costs about US$ 450 000, compared to US$ 75 000 from Nairobi to East and Southern Africa, a reduction of 83.3%. Similar economies of scale have been observed in the Senegal hub, with the impact clearly demonstrating WHO’s improved ability to serve Member States more efficiently and effectively.

The early successes in regional procurement and cost reduction further demonstrate the value of a decentralized, Africa-centric approach to emergency health logistics. These advances not only address immediate logistical challenges, but also strengthen Africa’s preparedness to face future health crises, saving lives and ensuring faster, more effective responses.

Figure 37: Top 10 inbound/outbound activities breakdown by response operation; Senegal warehouse (January 2024–June 2024)

Inbound activities (stockpiling)

Top 10 purchasing categories:

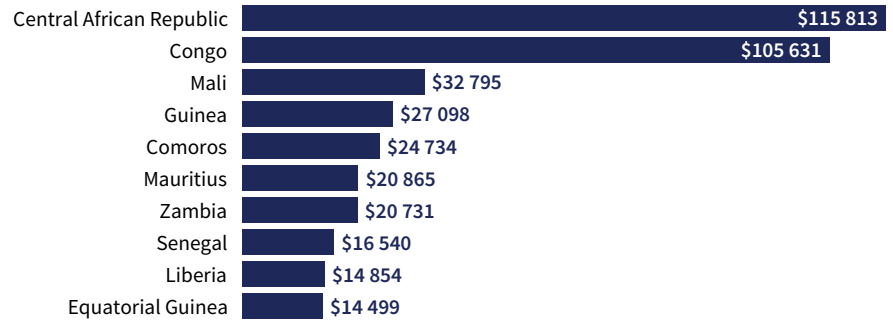


Purchase order: **61 inbound shipments**

Item value: **$4 851 910**

Outbound activities (emergency response)

Countries by stock release value:



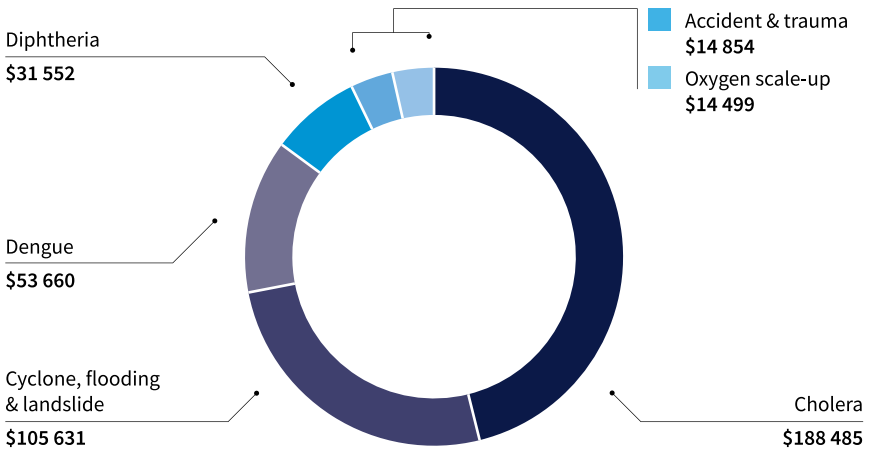
Stock release: **21 shipments to 16 countries**

Item value: **$457 996.13**

Weight: **20 205.12kg**

Volume: **3261.9 CBM**

Response operations



6 Emergencies: Cholera, Cyclone, Flooding & landslide, Dengue, Diptheria, Donation, Accident & trauma, Oxygen scale-up, WHO regular support to Member States

Graded Emergencies: Cholera, Dengue, Diphtheria, Cyclone, Flooding & landslide

9.4

Emergency preparedness: learning from the past, preparing for the future

Since the EVD outbreak in West Africa, the world has witnessed six other public health emergencies of international concern, four of which have had a significant impact on the WHO African Region. These are the 2014 polio resurgence, the 2018–2020 Kivu EVD epidemic in the Democratic Republic of the Congo, the COVID-19 pandemic, and most recently, the mpox outbreak (in 2022). Each has imposed a significant health and economic burden on African societies and each has provided a stark reminder of the need for countries to be optimally prepared for emergencies.

While the Region has recorded a marginal increase in average IHR 2005 core capacity scores – from 42 to 50 (2008–2023) – these have plateaued since 2020, and remain below the global average. This stagnation is primarily due to underinvestment in these capacities, as evidenced by the underfunded national action plans for health security.

Financing for preparedness remains a critical challenge, with WHO and the World Bank estimating an annual global funding gap of US$ 10 billion for effective national, regional and global health emergency preparedness. In addition, there have been significant obstacles to compliance with and implementation of the IHR, particularly in terms of travel restrictions and trade impact, which were very much in evidence during the COVID-19 pandemic.

WHO and the World Bank estimating an annual global funding gap of US$ 10 billion for effective national, regional and global health emergency preparedness.

Despite the challenges, the Emergency Preparedness (EMP) unit of the EPR cluster has evolved over the past decade to meet emerging needs, implementing 484 activities across all 47 Member States between 2016 and 2023 – more than any other WHO

Region. Evidence also shows that countries that undertake more preparedness activities are benefiting, with improvements in detection, notification and response times during outbreaks. However, more data is needed to accurately measure the impact of preparedness efforts and to inform better policy.

The transformation of the EMP reflects both changes in the public health threat landscape, and an unwavering commitment to improving health security. The past decade has been marked by remarkable progress and strategic shifts, underpinned by the tireless efforts of dedicated professionals working to protect the health of millions.

A key lesson from the COVID-19 pandemic and other regional outbreaks was the importance of a more holistic, integrated approach to health emergencies. The incorporation of primary health care as a fundamental pathway to preparedness and resilient health systems has been one of the most profound strategic shifts. This approach emphasizes the importance of multisectoral coordination beyond the health sector, as embodied in the One Health framework, which links human, animal and environmental health.

The EMP unit's commitment to strengthening preparedness capacities has led to several notable advances, including a focus on creating enabling legal and policy infrastructures to provide a solid foundation for emergency management. Innovative tools have also been developed to predict future hazards, harnessing the power of artificial intelligence and machine learning. These tools have revolutionized the way in which risks are assessed and managed, enabling more proactive and informed decision-making.

A major transformation within the EMP has been the shift from assessing hazards only after they have occurred, to actively predicting their likelihood, particularly through the adoption of the strategic toolkit for assessing risk. By 2023, 31[289] countries in the Region had used the toolkit to develop comprehensive risk profiles and multi-hazard plans. This proactive approach has played a crucial role in enhancing the Region's ability to prepare for, and respond to potential emergencies, ensuring that countries are better equipped to manage outbreaks before they occur.

289 Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Congo, Democratic Republic of the Congo, Equatorial Guinea, Gabon, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, South Sudan, United Republic of Tanzania, Togo and Zambia.

Governance and multilateral engagement have been central to the progress of the EMP. WHO in the African Region has played a leading role in global health diplomacy, supporting the Intergovernmental Negotiating Body and the Working Group on IHR amendments. New partnerships, such as with the Inter-Parliamentary Union, have strengthened the legal framework for health security across the continent. These collaborations have been instrumental in promoting a coherent and coordinated response to health emergencies, with the potential to protect millions of lives.

The development of normative guides and tools has been another area of achievement, notably the regional guide for viral haemorrhagic fevers and the preparedness and resilience for emerging threats initiative. These resources have provided Member States with clear, actionable frameworks to strengthen their preparedness efforts. By 2023, an impressive 200 000 health professionals had been trained through hybrid platforms, ensuring that the Region's health workforce is well equipped to respond to emergencies.

Meanwhile, preparedness assessments have been crucial in preventing the cross-border spread of infectious diseases. Prior to the COVID-19 pandemic, preparedness assessments during the EVD outbreak in the Democratic Republic of the Congo highlighted gaps and accelerated the development of effective contingency plans. During the pandemic, all 47 countries in the Region conducted preparedness assessments, resulting in improved preparedness scores and comprehensive contingency planning. In the post-pandemic period, similar assessments for outbreaks such as cholera, mpox and MVD have further strengthened preparedness, ensuring rapid and coordinated responses to emerging threats.

Vaccination campaigns have been another cornerstone of the EMP's success. Following the end of the EVD outbreak in West Africa, the introduction of the yellow fever vaccine in 25[290] at-risk countries protected 377 million people. Moreover, 145 690 doses of EVD vaccines were deployed to high-risk areas, providing essential protection to health workers and frontline staff.

Overall, in the past decade there has been an extraordinary evolution in emergency preparedness in the African Region. The EMP unit's strategic initiatives, innovative tools and unwavering commitment have significantly bolstered the Region's ability to predict, prepare for, and respond to health emergencies. While challenges remain, progress to date, including the shift towards using primary health care as a foundation for resilience, provides a solid foundation for future efforts.

Going forward, there is an urgent need to increase investment in strengthening core capacities, including integrating resilience-building measures into national health plans and emergency preparedness strategies. Increased investment in preparedness is also needed, particularly in capacity-building initiatives through regular training programmes, workshops and simulation exercises. Continued advocacy for sustainable financing mechanisms and adequate budgetary resources for health security is also essential.

The accessibility and distribution of vaccines, especially in remote and underserved areas, should be prioritized, along with support for research and development to identify new tools and methods to improve preparedness through disease surveillance and risk assessment.

290 Angola, Benin, Burkina Faso, Cameroon, Chad, Central African Republic, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, Sudan, Togo and Uganda.

9.5

Emergency response: rapid action, real impact

While preparedness is crucial, the ability to respond quickly and effectively to a crisis is the true test of a health system's resilience. The EVD outbreak of 2014–2016 provided harsh lessons and exposed the vulnerability of the Region to health emergencies, particularly the shortcomings of emergency response mechanisms, with delays, coordination failures and resource shortages having devastating consequences.

Determined to change the status quo, the EPR's Emergency Response Unit has taken steps to transform WHO's response to multiple health emergencies, making significant strides to support countries to better manage and respond to health crises, while also strengthening health systems.

Today, the reset has resulted in 17 out of 18 EVD and MVD outbreaks between 2015 and 2023 being brought under control, with no cross-border spread. There has also been a 50% improvement in the timeliness of outbreak detection, translating into diseases averted and lives saved.

Meanwhile, the overall time to contain outbreaks has been reduced by 60%, from 156 to 63 days (2017–2023). This includes notable reductions in the time to control outbreaks of vector-borne diseases such as yellow fever, dengue and leishmaniasis, from 234 to just 16 days; vaccine-preventable diseases such as cholera and diphtheria, from 308 to 56 days; and viral haemorrhagic fevers, from 106 to 48 days.

Underpinning the response to all outbreaks and emergencies is a standardized assessment that guides the level of response. WHO's emergency response framework provides a rapid assessment of the emergency, which is then graded.[291]

291 There are three WHO grades for emergencies, signifying the level of operational response by the Organization: Grade 1 (limited response), Grade 2 (moderate response), and Grade 3 (major/maximal response).

Based on a no-regrets policy, the ERF performance standards ensure that resources are provided in good time where required.

Between 2017 and 2023, incident management teams were activated within 24 hours in over 90% of all graded events, with additional African Health Volunteers Corps (AVoHC) emergency surge responders deployed within 72 hours in over 80% of these events. This has greatly improved operational efficiency and contributed to faster control of emergencies.

During the EVD outbreaks, for example, community resistance initially posed a major challenge. However, by engaging community leaders and harnessing local knowledge, the programme fostered greater compliance with public health measures, leading to successful outbreak containment.

The development of the SURGE health emergency workforce has been central to the improved response, addressing significant skills gaps and creating a more robust response. More than 1700 members have been trained in various emergency response modules, including coordination, prevention of sexual exploitation, abuse and harassment and gender-based violence. In addition, 134 WHO staff members have been trained on the emergency response framework and incident management system.

One of the key achievements of the EPR programme has been the establishment and operationalization of 42 public health emergency operations centres across the Region. Successfully managing outbreaks such as EVD, MVD, yellow fever, cholera and COVID-19, they have demonstrated their critical role in effectively managing multiple, concurrent emergencies, coordinating responses, streamlining communication and facilitating timely decision-making.

Effective community engagement and risk communication strategies are also key. By implementing tailored communication strategies that take account of cultural contexts, the programme has ensured that communities are well-informed and actively involved in preparedness activities. Accurate information dissemination has countered misinformation and built public trust, which is crucial in health emergencies.

During the EVD outbreaks, for example, community resistance initially posed a major challenge. However, by engaging community leaders and harnessing local knowledge, the programme fostered greater compliance with public health measures, leading to successful outbreak containment. Similarly, during the COVID-19 pandemic, the EPR programme worked with the communication unit to use various media platforms to disseminate timely and accurate information, combat misinformation and ensure that the public was well-informed.

Finally, efficient logistics and supply chain management improved the procurement, storage and distribution of essential medical supplies and equipment. The establishment of regional stockpiles, as discussed earlier in this chapter, along with robust supply chain networks, continues to mitigate supply shortages and ensure timely delivery of critical resources during emergencies.

Key achievements in the COVID-19 response (2022–2024):

More than

30 000

health and care workers trained in emergency response.

ICUs in

10 countries*

strengthened with personal protective equipment, biomedical equipment, emergency kits and medicines.

Oxygen production plants installed in

nine countries,†

increasing oxygen production by about

7.9 million

litres per day, which is sufficient to treat

1130

patients with critical conditions per day.

In

46‡ out of 47 Member States, 413 million

people were reached with at least one dose of COVID-19 vaccine;

365 million

completed the primary series.

Strengthened laboratory capacity in all

47 countries,

supported by three dedicated and nine regional reference laboratories.

* Cameroon, Congo, Democratic Republic of the Congo, Ghana, Lesotho, Malawi, Mali, South Sudan, Tanzania (Zanzibar), Togo.
† Chad, Democratic Republic of the Congo, Gambia, Ghana, Lesotho, Mauritania, Mozambique, Niger, South Sudan.
‡ Except for Eritrea.

In Dr Moeti's own words:

The journey of WHO's strategic partnership with Africa CDC

As I sit down to reflect on the journey we have embarked upon together, I am filled with a deep sense of pride and hope for the future of public health in Africa. Our Region faces no shortage of challenges, with more than 100 public health emergencies occurring every year. Yet, in the face of these daunting odds, we have also seen remarkable progress. This progress, however, has not come without the realization that we must continually evolve and strengthen our systems to better protect the lives of our most vulnerable populations.

One of the first significant actions I took as Regional Director was to sign a Memorandum of Understanding (MoU) in 2016. This MoU, entitled Framework for Collaboration between The World Health Organization and the African Union Commission on the Establishment and Operationalization of the Africa Centre for Disease Control and Prevention (Africa CDC) to Improve Health Security in Africa, was a forward-looking agreement. It was established even before the official creation of Africa CDC in January 2017, highlighting the visionary nature of our collaboration. This MoU laid the groundwork for our joint efforts to build a robust public health infrastructure across the Region.

The creation of the Africa CDC was indeed a pivotal moment for the continent. It was born out of a vision to empower African states to respond to disease threats and outbreaks with greater efficiency and coordination. The collaboration between Africa CDC and WHO was not just a strategic decision, but a necessary evolution to meet the growing demands of our Region. Our initial joint efforts, particularly during the COVID-19 pandemic, were a testament to what we could achieve together. But we knew that this was only the beginning.

In 2023, we solidified our collaboration with the creation of the Africa CDC & WHO Joint Emergency Action Plan (JEAP). The JEAP, which I have championed with all my heart, is not just a blueprint—it is a beacon

of hope for a future where Africa is better equipped to prepare for, detect and respond to public health emergencies. The support from the Bill & Melinda Gates Foundation was instrumental in bringing us together and developing this plan, providing the resources and encouragement needed to take the first steps towards a shared goal.

> "The JEAP, which I have championed with all my heart, is not just a blueprint – it is a beacon of hope for a future where Africa is better equipped to prepare for, detect and respond to public health emergencies."

In its first year, JEAP established a robust foundation through comprehensive governance and management structures under the Africa CDC-WHO MoU. A high-functioning steering committee, secretariat and technical working groups were set up, ensuring strong oversight and effective day-to-day management. Despite challenges to participation in some areas, continuous feedback and the implementation of standard operating procedures have enhanced operational efficiency.

Reflecting on these accomplishments, it is particularly noteworthy that in just one year, JEAP has directly served more than 36 countries in critical areas such as workforce development, surveillance, laboratory enhancement and response coordination. The support provided to countries and regional entities in submitting 57 proposals to the second Pandemic Fund call highlights the remarkable regional consensus and collaboration, and underscores the shared vision for a healthier, safer Africa.

The vision that JEAP embodies is one that I hold dear. It is a vision that I believe will transform the way we approach public health on the continent. But more than that, it is a vision that I hope will be carried forward with the same passion and dedication by those who come after me.

In addition to launching and operationalizing JEAP, in 2022 I established an emergency preparedness and response technical advisory group. This independent body is the WHO's principal advisory group in the African Region for strategic guidance on public health emergencies.

Following a call for applications in July 2022 that drew nearly 600 submissions, 16 members were selected, representing diverse organizations, nationalities and expertise. The group convened for the first time in person in Senegal in July 2024, which was a pivotal moment to discuss key issues in emergencies and generate practical recommendations. As of August 2024, implementation of the recommendations is underway, and the technical advisory group is positioned to be a key tool for the next Regional Director.

I believe in the power of collaboration, and I have seen first-hand the incredible things that can be achieved when we work together towards a common goal, and seek advice/guidance from external experts. The partnership between Africa CDC and WHO is more than just an agreement – it is a commitment to the people of Africa.

The future of public health in Africa depends on our ability to work together, to innovate and to remain steadfast in our mission. The journey is long, but the destination is one worth striving for – a healthier, safer Africa for all.

Challenges and lessons learnt

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Challenges and lessons learnt

Over the past decade, WHO in the African Region has faced a multitude of public health challenges, reflecting the complexity and scale of health problems across the continent, all compounded by limited financial resources, under-resourced health systems and underdeveloped health infrastructure. Despite facing around 100 emergencies every year, ranging from health outbreaks to natural disasters, the Region has demonstrated remarkable resilience, ingenuity and adaptability over the past decade. Reliance on key lessons learned has led to important progress, paving the way for longer-term sustainable solutions.

A Region at the epicentre of global health crises

Every year, the Region finds itself at the epicentre of a wide range of outbreaks and emergencies that test its health systems. From infectious diseases such as Ebola, COVID-19 and mpox, to the increasing impact of natural disasters, the Region faces a relentless barrage of health crises. These occur in a context of limited funding, with resource constraints often negatively impacting prevention, preparedness, identification and response capabilities.

Yet, in the midst of these challenges, important progress is being made. The Region has seen a modest improvement in core IHR capacity, with the median States parties self-assessment annual report capacity score rising from 42 to 51 (2018–2023). While these figures remain below the global average, they represent an undeniable step in the right direction. The stagnation of recent years is not owing to a lack of will, but rather a reflection of funding limitations and weak health infrastructure, which WHO is working hard to overcome in collaboration with its Member States and partners.

The lesson is that incremental progress is still progress, and has a positive impact

on the lives and livelihoods of African populations. With continued focus on building stronger health systems, the goal of achieving UHC is within reach.

Climate change: a growing public health threat

Climate change poses a complex and multi-dimensional threat to health and environmental stability in the Region. Increasingly erratic weather patterns have led to more frequent and severe natural disasters, including floods and droughts, which threaten food security and create conditions conducive to disease outbreaks. One of the consequences of climate change is the surge of zoonotic diseases – diseases transmitted from animals to humans, as urbanization and the destruction of natural habitats increase contact between humans and wildlife.

However, countries in the Region are taking decisive steps to develop more robust health systems that can better withstand climate-related health threats, with advances in innovation providing new ways to work smarter and more strategically.

An important area of growth has been the adoption and use of digital health tools for tracking and managing outbreaks across the Region, transforming the way governments anticipate, monitor and respond to health emergencies, while strengthening national preparedness and response strategies.

In effect, these digital tracking systems and artificial intelligence-based models are enabling governments to anticipate risks, prepare more effectively for future disasters, and allocate resources more strategically, demonstrating the key lesson that technology can help bridge the gap between limited resources and increased need. This approach not only provides countries with immediate solutions to address the immediate impacts of climate change, but also builds a culture of preparedness that will be critical to addressing future climate-related health threats.

Strengthening health systems: a vital and ongoing investment

Chronic underfunding of national health systems remains a major barrier to progress across the Region, which also faces a staggering shortfall of 61 million health workers. This hampers the implementation of vital health programmes, and weakens

the response to both routine health care needs and the frequent health emergencies.

Despite this daunting reality, progress is being made: the number of health workers in the Region tripled between 2013 and 2022. Countries across the Region are making progress in addressing the human resources challenge by expanding training capacity, particularly for health workers at the primary care level.

There is also a growing recognition of the need to retain health professionals in their home countries. It has become a priority for most governments to tackle the “brain drain” phenomenon, where trained health workers seek better opportunities abroad.

Programmes such as the Global Laboratory Leadership Programme have helped countries build and sustain national laboratory capacity, demonstrating the power of strategic investment in local talent, and enabling swifter and more effective responses to outbreaks and emergencies.

Partnerships with academic institutions and international health organizations are also strengthening health workforce training programmes, equipping professionals with the skills needed to meet the Region’s evolving health care needs. By equipping health workers with the skills and tools they need, the Region is laying the foundation for a more resilient and self-reliant health workforce.

There is also a growing recognition of the need to retain health professionals in their home countries. It has become a priority for most governments to tackle the “brain drain” phenomenon, where trained health workers seek better opportunities abroad. The lesson here is that sustained investment in the health workforce is not only necessary to meet immediate needs, but is also a long-term strategy for building self-sustaining and robust health systems.

Local manufacturing: towards greater self-sufficiency

Another major challenge facing the Region, which was disturbingly highlighted during the COVID-19 pandemic and more recently during the mpox outbreaks, is its dependence on imported medical products and vaccines. This is exacerbated by suboptimal procurement systems and limited regula-

tory capacity, which drive up prices but leave countries vulnerable to supply chain disruptions and an influx of substandard and counterfeit medical products.

However, WHO is cooperating with high-level African partners to support Member States to take bold steps to address these vulnerabilities. Countries such as Ghana, Senegal and South Africa are making important progress in local vaccine production, reducing their dependence on external suppliers and increasing their capacity to respond rapidly to health crises. While this is a long-term solution that requires significant investment and coordination, these efforts are part of a broader strategy to promote self-reliance and resilience in the health sector.

Countries such as Ghana, Senegal and South Africa are making important progress in local vaccine production, reducing their dependence on external suppliers and increasing their capacity to respond rapidly to health crises.

In addition, national regulatory authorities in the Region are receiving technical assistance to strengthen their oversight capacity and ensure that local medical products meet international standards for safety and efficacy. So far, national regulatory authorities in four countries in the Region have achieved level 3 maturity and this number is expected to rise to at least seven by 2025.

These efforts are strengthening the future capacity of African countries not only to ensure access to essential medical products, but also to reduce their vulnerability to global supply chain disruptions, and improve their ability to meet the health needs of their populations.

Maternal health: addressing a persistent challenge

Despite significant achievements, maternal mortality rates remain alarmingly high in the Region, and among the highest in the world, with many countries unlikely to meet the relevant SDG 3 target. Significant changes are still needed to address, among other things, persistent delays in access to care, poor medical practices, and limited availability of evidence-based interventions, including management of obstetric complications.

However, there is reason for optimism. Seven countries have met the relevant SDG 3 target, while 13 reduced their maternal death rates by more than half in the two years to 2020. A growing number of countries are also making a difference by adopting innovative digital tools that track women throughout pregnancy, labour and the postnatal period. These tools help ensure that women receive timely care, and that health professionals are alerted in real time to potential complications.

In addition, many Member States have adopted the WHO framework for enhancing the quality of care for maternal, newborn and child health, focusing anew on improving the quality of care for mothers and infants. This shift from simply increasing access, to improving the quality of care, is already yielding positive results.

Another critical factor in improving maternal health is the increased focus on the education and training of health workers. By equipping midwives, nurses and doctors with the tools and knowledge to manage obstetric emergencies, countries are taking proactive steps to reduce maternal mortality rates. These efforts demonstrate that targeted interventions, supported by technology, education and evidence-based practices, can have a profound impact on even the most intractable health challenges.

The growing burden of noncommunicable diseases

While much attention has historically been paid to communicable diseases, the Region is now grappling with the growing burden of NCDs such as diabetes, heart disease and cancer. These diseases have various causes, including changing lifestyles, poor diet, physical inactivity and the increasing prevalence of risk factors such as tobacco and alcohol use.

One of the main challenges in addressing NCDs is the lack of awareness among communities of the risk factors and the related preventive measures. However, public health campaigns are now being launched across the Region to raise awareness of the dangers of NCDs and to encourage healthier lifestyles. Countries are integrating NCD prevention and care into primary health care systems, ensuring that communities can access the necessary services without incurring catastrophic out-of-pocket payments.

Road safety and tobacco use are both areas where good results have been achieved. Over the past 10 years, 17 countries in the Region have halved the number of road traffic deaths. In addition, of the 56 countries worldwide that are likely to reduce tobacco use by 30% before 2025, 22 are in Africa.

This critical shift towards empowering communities with knowledge is the first step to improving health outcomes. By educating communities about the risks and promoting healthier lifestyle choices, countries can reduce the long-term burden of these diseases. Early interventions and community engagement are both key to tackling the silent epidemic of NCDs.

HIV and tuberculosis: a fight on two fronts with shared solutions

The WHO African Region has the highest burden of HIV in the world and tuberculosis (TB) remains a major public health challenge. The dual epidemics of HIV and TB often overlap, and people living with HIV are particularly vulnerable to contracting TB. Notwithstanding these daunting challenges, countries are increasingly adopting innovative approaches to tackle both diseases.

For example, the co-management of HIV and TB services, where resources and health care services are streamlined to provide comprehensive care, has improved patient outcomes. Shared diagnostic tools, integrated care pathways and joint patient tracking systems are helping to ensure that people receive the efficient and timely treatment they need. The introduction of WHO-recommended rapid diagnostics such as GeneXpert has revolutionized TB diagnosis, allowing for faster and more accurate detection of the disease. This enables early treatment, which significantly improves the chances of cure.

By improving coordination and reducing response times, they have ensured that life-saving supplies reach affected areas more quickly. The drastic reduction in outbound lead times – from three weeks to just three days – is a testament to the impact of effective collaboration.

In addition, high-level political commitment, as demonstrated by initiatives such as the African TB scorecard and the second historic political declaration on TB at the 2023 United Nations high-level meeting on TB, has galvanized regional efforts to eliminate the disease.

This approach clearly demonstrates the value of integration and collaboration, with significantly improved outcomes when health systems pool resources to optimize the use of limited resources, and adopt a holistic approach.

Partnerships: the power of collective action

Perhaps one of the most valuable lessons learnt from interventions to address the Region's health challenges is the power of partnerships. National governments, international organizations, local communities and the private sector all have a role to play in strengthening health care systems and responding to public health crises, particularly between WHO in the African Region, the African Union, Africa CDC and national governments.

For example, the creation of the OSL programme and the establishment of WHO's regional emergency hubs in Kenya and Senegal have transformed the Region's response to health emergencies. By improving coordination and reducing response times, they have ensured that life-saving supplies reach affected areas more quickly. The drastic reduction in outbound lead times – from three weeks to just three days – is a testament to the impact of effective collaboration.

Partnerships are not limited to emergency response, and have also been key to strengthening disease surveillance systems. By integrating digital health tools and interoperable data systems, countries can now detect and respond to outbreaks more quickly, reducing the spread of disease and saving lives. For example, in the fight against polio, collaboration with international donors, regional bodies and local communities has facilitated resource-sharing, technical support and coordinated responses.

The lesson here is that collective action amplifies individual efforts. When countries and organizations come together with a

common goal, the results are far greater than what could be achieved alone.

Community engagement: the key to health security

Another striking lesson from recent health emergencies, including EVD and COVID-19, is the critical role of community engagement. Health interventions are only as effective as the level of community trust and cooperation they inspire. During the EVD outbreak, for example, initial efforts were hampered by community distrust and resistance to health interventions. However, engaging local leaders and implementing culturally-appropriate communication strategies made communities far more receptive to public health interventions.

Tailored messaging that respects local customs and traditions has been crucial in gaining community buy-in and compliance with health interventions, demonstrating that health care cannot simply be imposed on people. Instead, it must be co-created with the target communities.

Building trust through engagement, transparency and respect for cultural contexts is essential to the success of any public health initiative. When communities are empowered and involved, they become the Region's strongest allies in the fight for public health.

A healthier future for all

Despite the numerous challenges facing the African Region, there are many reasons for optimism. The lessons learnt from managing emergencies, strengthening health systems, promoting local production and engaging communities provide a roadmap for future success. By continuing to build partnerships, integrate care and invest in innovation, the Region can overcome its challenges and build a health care system that serves all its people.

The African Region's journey is one of resilience, determination and growth. The road ahead is long, but the steps being taken today are laying the groundwork for a healthier future. With every challenge comes an opportunity to learn, adapt and move closer to the goal of health security and equity for all.

"I anticipate ... that there will be continued growth in our regional partnership with global health players, including the diaspora; that innovation and use of technology in health will increase and result in more efficient delivery of services; that the private sector's role in health on the continent will expand and supplement that of governments; and that more investment and financing for UHC will continue to grow for our Member States to fully attain UHC by 2030."

Dr Matshidiso Moeti

Conclusions and future perspectives

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Conclusions and future perspectives

Over the past decade, the work of WHO in the African Region has reflected a concerted effort to drive impactful health transformation on the continent. Guided by the Transformation Agenda that was launched in 2015, the African Region embarked on a mission to address the deep-seated inequities and disparities that hinder the potential advancement towards universal health coverage, and attainment of the highest standard of health for all.

Targeting strategic goals such as improving health security, strengthening health systems, tackling social determinants of health, and fostering a culture of accountability within the Organization, the Region has recorded substantial progress. Indeed, the 2021 Global WHO Transformation evaluation validated positive change in the organizational culture of WHO in the African Region, and the United Nations Joint Inspection Unit recognized the Transformation Agenda as a model for workplace culture reform.

The changes in organizational culture have led to improvements in donor reporting, compliance and enhanced transparency in the utilization of funds, significant increases in resource allocation for WHO country offices, and an increase in mobilized resources. These have, in turn, contributed to public health achievements such as improved outbreak detection and response times, containment of acute outbreaks, and progress in polio eradication, maternal mortality rates, and the elimination of neglected tropical diseases.

While it is clear that much work still remains, the accomplishments, coupled with the valuable lessons learnt from both the successes and challenges, have left a lasting legacy.

A transformation rooted in health systems resilience

One of the key pillars of the Transformation

Agenda was strengthening the Region's capacity to manage health emergencies and epidemic-prone diseases, and significant strides have been made to enhance health security across the Region. The WHO Secretariat in the Region has further cemented its relationship with Member States, supporting the development of core capacities for responding to outbreaks, improving detection, and ensuring rapid containment of diseases. Progress has been particularly evident in polio eradication efforts, with rapid action preventing the wild poliovirus from regaining a foothold in the Region following the outbreak in 2022, and in the improved surveillance and response times for other infectious diseases.

The COVID-19 pandemic presented an unprecedented challenge, threatening to reverse many of the gains made under the Transformation Agenda. Yet, rather than succumbing to these challenges, the African Region displayed unwavering resilience.

The COVID-19 pandemic presented an unprecedented challenge, threatening to reverse many of the gains made under the Transformation Agenda. Yet, rather than succumbing to these challenges, the African Region displayed unwavering resilience. By leveraging the lessons learnt from previous health crises and adapting quickly, WHO, in collaboration with governments and partners, mounted a robust response to the pandemic. This resulted in a far less severe pandemic landscape than predicted.

While the pandemic highlighted worrying vulnerabilities across African health systems, it also presented key opportunities for further strengthening of health security infrastructure. As such, the consolidation phase of the Transformation Agenda, which began in the wake of the pandemic, was a road map to a stronger, agile, more accountable and resilient WHO in the African Region, which is better equipped to support Member States' recovery efforts, and make health for all a reality on the continent.

However, resilience is not automatically achieved through improved investment in the health sector, building more health care facilities or developing epidemiological capacities. For countries to effectively prevent, prepare for, detect, adapt to, respond to and recover from public health threats, while maintaining optimal routine health services, even in fragile, conflict-affected and vulnerable contexts, WHO specifies six building blocks that must work in synergy. These are: human resources; information and research; service delivery; medicines and technologies; financing; and governance.

With demonstrated links to better health outcomes, improved equity, increased health security and cost-efficiency, enhanced primary health care is also key. Its significance has long been emphasized by WHO as the bedrock of health systems, evidenced by landmark declarations such as the Declaration of Alma-Ata in 1978, and subsequent initiatives such as the Declaration of Astana in 2018. The latter saw Member States reaffirm their commitment to PHC as a cornerstone of sustainable health systems for the achievement of UHC and the Sustainable Development Goals.

Health equity and UHC: a commitment to leave no one behind

Moving the Region closer to achieving UHC lay at the heart of the Transformation Agenda, and while important progress has been made, the journey is far from complete. The UHC service coverage index in the African Region nearly doubled between 2000 and 2021, rising from 23 to 44, showing a clear upward trajectory. Despite this progress, however, by 2021 a significant proportion of the Region's population still did not have

access to the health services they needed, remaining underserved.

Expanding access to health services is not a simple solution to the achievement of UHC. Beyond that, health services need to meet set minimum standards and be accessible to all, regardless of where people live, without causing financial hardship. Unfortunately, out-of-pocket expenditure is still a significant health care barrier for many. While the percentage of households facing catastrophic health expenditures has declined, the number of people spending at least 10% or more of their income on health has increased, pushing many deeper into poverty.

Poverty, lack of education, poor housing conditions and environmental factors all play a key role in determining health outcomes. Without concomitantly addressing these underlying issues, any progress made in health services delivery will ultimately be limited in scope and impact.

The disparity between those who can and cannot afford health services is a stark reminder that equity must remain at the forefront of the Region's health agenda. Health should not be a privilege reserved for those with financial means, but rather a fundamental human right enjoyed by all, regardless of their socioeconomic status.

Looking ahead, health financing reforms are essential to achieve UHC. Countries need to commit to increasing domestic health financing and reducing reliance on out-of-pocket payments. WHO's support to help countries implement health insurance reforms and other prepayment mechanisms will be critical to ensure protection for vulnerable populations, while collaborative initiatives such as the Africa Scorecard on Domestic Financing for Health and the African Union's Domestic Health Financing Tracker offer promising frameworks to help countries monitor and increase domestic investment in health.

By increasing the efficiency of health financing systems, countries will be able to direct more resources toward UHC, and ensure that health care is accessible to all, especially the poorest and most vulnerable of their populations. Much work has been done in the past decade to accelerate the gains made by the African Region following the transition from the MDGs to the SDGs, including significant if variable progress towards improving maternal health, reducing child mortality, and combating HIV, malaria and other diseases. However, the number of on-track targets is still too low.[292]

If Africa is to achieve the SDGs by 2030, much more work still lies ahead, with the realization of UHC requiring even greater political will, strategic planning and careful targeting of resources to ensure that no one is left behind.

Social determinants of health: addressing the root causes of inequities

The Transformation Agenda also placed significant emphasis on addressing the social determinants of health. Poverty, lack of education, poor housing conditions and environmental factors all play a key role in determining health outcomes. Without concomitantly addressing these underlying issues, any progress made in health services delivery will ultimately be limited in scope and impact.

One of the most profound social determinants of health in the African Region is malnutrition, which remains a persistent challenge. Inadequate nutrition during childhood can lead to stunted growth, weakened immune systems, and an in-

292 https://www.undp.org/africa/publications/2023-africa-sustainable-development-report

creased risk of illness throughout life. Recognizing this, WHO has supported countries to implement life-cycle approaches to improve maternal, newborn and child health services, integrating nutrition programmes into broader health plans.

Efforts to improve food safety and prevent foodborne diseases have also gained momentum. The adoption of the One Health approach, an integrated strategy that addresses foodborne diseases and zoonotic outbreaks by aligning human, animal and environmental health, has been particularly successful. Countries have worked to align national food safety standards with international guidelines, and training programmes across the food supply chain have improved public health outcomes.

Tackling noncommunicable diseases such as diabetes and heart disease is another crucial element of addressing the social determinants of health. As highlighted in previous chapters, these diseases, often driven by lifestyle factors such as poor diet and physical inactivity, have become a growing concern in the Region. Public health campaigns to raise awareness about the risk factors associated with NCDs, alongside efforts to strengthen community engagement, have shown some promising results in shifting behaviours toward healthier lifestyles.

Climate change, also addressed in previous chapters, disproportionately affects the African Region and is emerging as a new and significant determinant of health. The African Region contributes only 2% to 4% of global greenhouse gas emissions, yet it bears the brunt of the adverse effects of climate change. In response, WHO has been working with countries to implement climate-resilient health systems, improve early warning systems for climate-sensitive


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diseases, and promote the inclusion of climate change in health investment plans.

Going forward, continued attention to the social and economic determinants of health will be essential if the health equity gap is to be successfully closed. Governments must work across sectors to address the root causes of poor health outcomes, ensuring that policies in education, housing, agriculture and the environment are all aligned with health objectives.

Health emergencies: a test of health systems preparedness

Health emergencies have always been a defining challenge for the African Region, and previous chapters have dealt in detail with crises, from the resurgence of EVD to the devastating COVID-19 pandemic, which have tested the resilience and preparedness of the Region's health systems.

Thanks in large part to the Transformation Agenda, the response to these emergencies has improved significantly. WHO, in collaboration with Member States and international partners, has worked to build stronger early warning systems and improve outbreak response capabilities. The creation of the Operations Support and Logistics (OSL) programme, which significantly reduced response times during emergencies, and the establishment of regional emergency hubs, have been game changers in managing health crises on the continent.

The Ebola outbreak of 2014–2016 served as a critical turning point in how health emergencies are managed, and it was these lessons that were ultimately instrumental in shaping the response to the COVID-19 pandemic and many other subsequent outbreaks and emergencies. The African Region's coordinated response to the pandemic, despite its many challenges, was evidence of the strides made in health security over the past decade.

Into the future, the need to continue strengthening preparedness and response

systems is paramount. Investments in disease surveillance, laboratory capacities and the health workforce are essential to ensure that the Region can swiftly and effectively respond to future outbreaks. It is not a question of if, but rather when the next global health crisis will occur, and the African Region must be ready to respond.

Innovating for a healthier future: embracing new technologies and approaches

Over the past decade, a quiet yet transformative revolution has been taking place across the African Region, as the Secretariat and Member States have come together to pave the way for the adoption of groundbreaking approaches and technologies. These innovations, driven by the combined efforts of WHO and key partners, have set the stage for more efficient, responsive and equitable health systems. The commitment to this transformation is evident in the progress made, with 37 Member States developing comprehensive digital health strategies designed to harness the power of technology, and improve health outcomes for millions of people.

Over the past decade, a quiet yet transformative revolution has been taking place across the African Region, as the Secretariat and Member States have come together to pave the way for the adoption of groundbreaking approaches and technologies.

These strategies are much more than abstract policies, and are being translated into tangible actions. The introduction of cutting-edge technologies has revolutionized how health services are delivered and managed, not only streamlining operations, but also significantly improving service delivery, data management, and decision-making processes.

Across 19 countries, innovative interventions have been implemented to raise digital health literacy among populations, empowering people to engage with digital tools and health care services in new ways. Whether it is accessing medical information through mobile applications or understanding how to utilize digital platforms for consultations, these efforts are helping to bridge the knowledge gap between populations and modern health care technologies.

Meanwhile, the use of digital geospatial surveillance is proving to be a powerful tool that allows health systems to monitor and respond to health crises more efficiently. This technology has played a crucial role in strengthening health systems across the Region, ensuring more rapid responses to disease outbreaks and better overall health outcomes.

To continue this momentum, ongoing support to Member States is needed to generate and expand access to new evidence and knowledge. Understanding the challenges, both existing and emerging, is crucial for crafting effective interventions. Countries need to identify and nurture innovations with the potential to enhance health outcomes, ensuring that these technologies are scaled up in ways that benefit all, especially the most vulnerable populations.

In this endeavour, WHO's role as a partner is critical. It will be important for the Organization to work with countries to also strengthen priority national institutions and capabilities, helping to build scientific health infrastructure in the Region. This will empower countries to implement innovations based on solid evidence, and ensure that national research policies drive meaningful change.

Additionally, WHO must assist countries to develop the digital tools and policies necessary to create an environment that

fosters digital health transformation. This includes providing guidance and developing technical specifications that help countries assess, select and govern the appropriate digital health solutions for their contexts. Artificial intelligence (AI) has enormous potential to support health-related decision-making, diagnostics, and even predict health trends. However, as AI becomes more integrated into health care, it must be used responsibly, with strong governance and ethical considerations to protect patient data and privacy.

As Dr Moeti's tenure comes to an end, it is clear that the Transformation Agenda has precipitated remarkable progress in the African Region over the past decade. Life expectancy has increased, maternal and child mortality rates have declined, and the Region is making headway toward achieving UHC.

The responsible use of AI, combating cybersecurity threats, and addressing misinformation and disinformation are emerging issues that all require immediate attention. As health systems are increasingly digitized, they must also become more resilient to these threats. WHO will have a key role to play in fostering multisectoral, public and private partnerships to build this resilience, and ensure that the Region's health systems remain robust in the face of new challenges.

Consolidating the gains: a future of sustainable progress

As Dr Moeti's tenure comes to an end, it is clear that the Transformation Agenda has precipitated remarkable progress in the African Region over the past decade. Life expectancy has increased, maternal and child mortality rates have declined, and the Region is making headway toward achieving UHC.

To sustain the hard-won gains, continued investment in health systems strengthening, robust partnerships and active community engagement will be critical. The Region must also maintain its focus on addressing the social and economic determinants of health, ensuring that policies across sectors contribute to better health outcomes.

Looking ahead, WHO in the African Region must remain committed to driving progress towards UHC, health security and sustainable development, making every effort to ensure that all actions are consistently aligned with the health priorities of countries, as well as the Sustainable Development Goals. This will require prioritizing key areas such as primary health care, health financing and health equity. WHO must also continue to support countries to build resilient health systems that can withstand the pressures of future health emergencies.

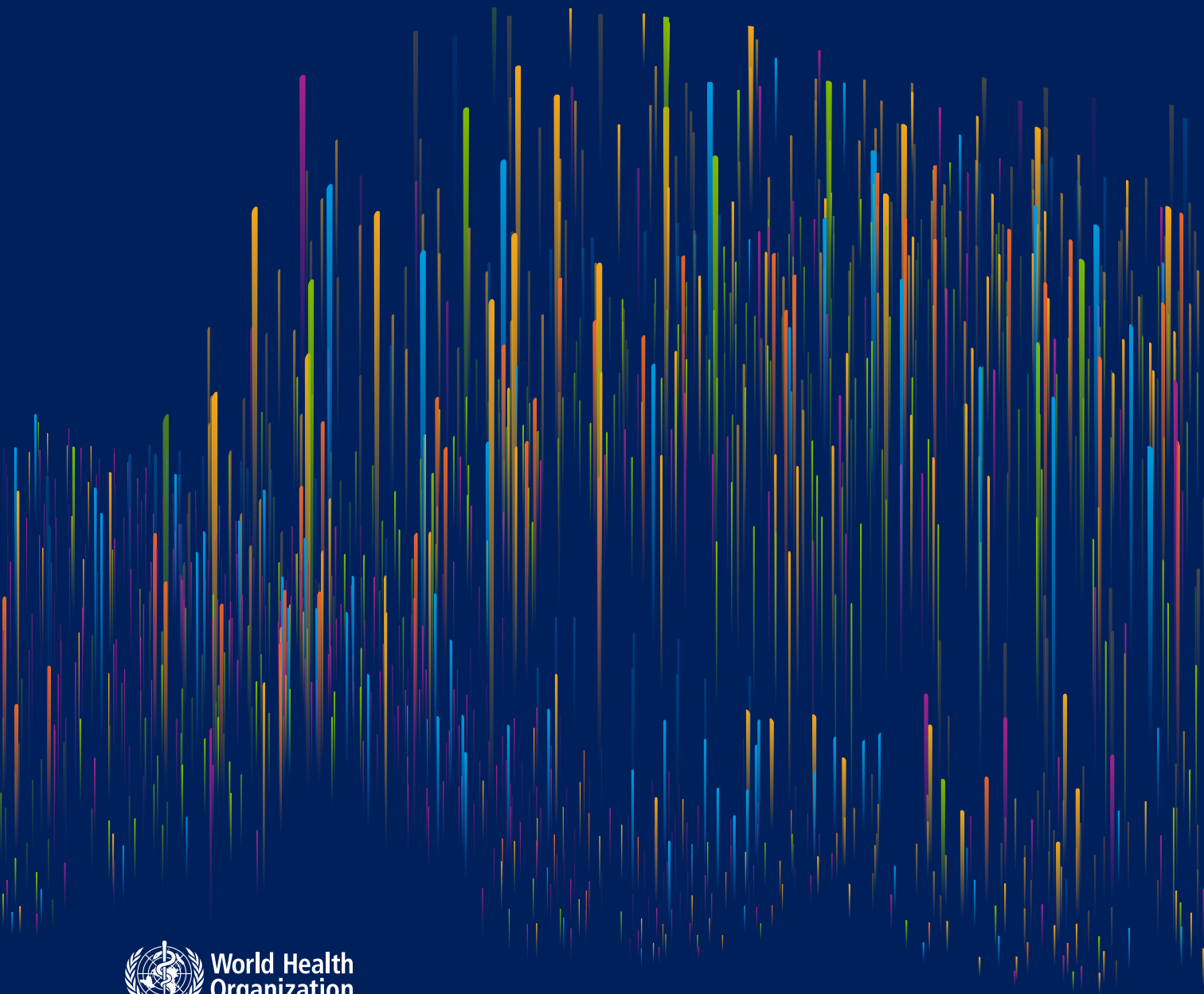
In effect, the transformation of the African Region's health systems has only just begun. The foundations laid over the past decade provide a road map for continued progress. By embracing the lessons learnt and building on the successes achieved, the Region is well-positioned to drive meaningful and sustainable change in the years to come. The legacy of the Transformation Agenda will undoubtedly inspire and inform the ongoing work of WHO, its partners and Member States far into the future as they strive to make health a reality for all people in the African Region.

“Thank you to every one of you who helped set the Transformation Agenda 10 years ago, and who have worked tirelessly alongside me to fulfil our fundamental goal of empowering Member States to deliver optimal health care to all Africans.”

Dr Matshidiso Moeti

“Together, we can build on our successes and ensure that the progress we’ve made is not only sustained, but accelerated.”

Dr Matshidiso Moeti, WHO Regional Director for Africa



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