The Work of the World Health Organization in the African Region

Report of the Regional Director:
1 July 2024 – 30 June 2025

World Health Organization
African Region

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Abbreviations

AAR	After-action reviews
ACT	Artemisinin-based combination therapy
AfDB	African Development Bank
Africa CDC	Africa Centres for Disease Control and Prevention
AIRA	Africa Infodemic Response Alliance
AHOP	African Health Observatory Platform on Health Systems and Policies
AMA	African Medicines Agency
AMRH	African Medicines Regulatory Harmonization
AMR	antimicrobial resistance
AMVIRA	Accelerating malaria vaccine introduction and rollout in Africa
AVAREF	African Vaccine Regulatory Forum
CHSSP	country health services and systems profile
cVDPV	circulating variant polio/circulating vaccine-derived polio
ENDISA	ending disease in Africa
EHSP	Essential Health Services Package
EOC	emergency operations centre
EPR	emergency preparedness and response
ESPEN	expanded special project for elimination of neglected tropical diseases
FCDO	Foreign Commonwealth and Development Office
GAP	Global Action Plan on Child Wasting
GBV	gender-based violence
GLASS	Global Antimicrobial Resistance and Use Surveillance System
HAT	human African trypanosomiasis
HBHI	high burden to high impact
HIV/AIDS	human immunodeficiency virus/ acquired immunodeficiency syndrome
IHR	International Health Regulations
IDSR	Integrated Disease Surveillance and Response
IMS	incident management system
IMST	Incident Management Support Team
IPC	infection prevention and control
JEE	Joint External Evaluation
Men5CV	pentavalent meningococcal ACWYX conjugate vaccine
MenACV	monovalent meningococcal A conjugate vaccine
NAP	National AMR action plan
NAPHS	National Action Plan for Health Security
NCD	noncommunicable disease
nOPV2	novel oral polio vaccine type 2
NTD	neglected tropical disease
PHC	primary health care
PHEOC	Public Health Emergency Operation Centres
PrEP	pre-exposure prophylaxis
RMNCAH	reproductive, maternal, newborn, child and adolescent health
SADC	Southern African Development Community
SDG	Sustainable Development Goal
SPAR	States Parties Self-Assessment Annual Report
SRMNCAH	sexual, reproductive, maternal, newborn, child and adolescent health
SVD	Sudan virus disease
TASS	Transforming African Surveillance Systems
TB	tuberculosis
UHC	universal health coverage
ULC	Universal Health Coverage – Life Course Cluster
UCN	Universal Health Coverage – Communicable and Noncommunicable Diseases Cluster
US CDC	United States Centers for Disease Control and Prevention
WASH	water, sanitation and hygiene
WICS	Women's Integrated Cancer Services
WHA	World Health Assembly
WHO	World Health Organization

Foreword

The period from July 2024 to June 2025 was marked by profound challenges – but also by remarkable resilience and unwavering purpose for the World Health Organization in the African Region. It was a year that tested our systems, stretched our resources, and demanded extraordinary resolve. Yet, through it all, our shared commitment to health shone through.

The Region faced one of the most severe financial crises in WHO AFRO's history, alongside an exceptionally high burden of health emergencies and three major leadership transitions. Despite these pressures, WHO remained steadfast – sustaining essential operations, advancing strategic priorities, and supporting countries to deliver for their people.

As I assume the role of Regional Director, I do so with deep respect for those who led during this pivotal year. I extend heartfelt appreciation to Dr Matshidiso Moeti, whose visionary leadership laid the foundation for this reporting period, and to Dr Chikwe Ihekweazu, who guided the Regional Office through transition with clarity and resolve. Their leadership ensured we never lost momentum.

Even amid resource constraints, our impact was undeniable. Together, we:

- Responded to over **160 public health emergencies**
- Rolled out **malaria vaccines in 19 countries**
- Protected millions of children through **immunization and nutrition programmes**
- Strengthened **health financing in over 80% of countries**
- Validated the **elimination of multiple neglected tropical diseases.**

We also made strategic strides:

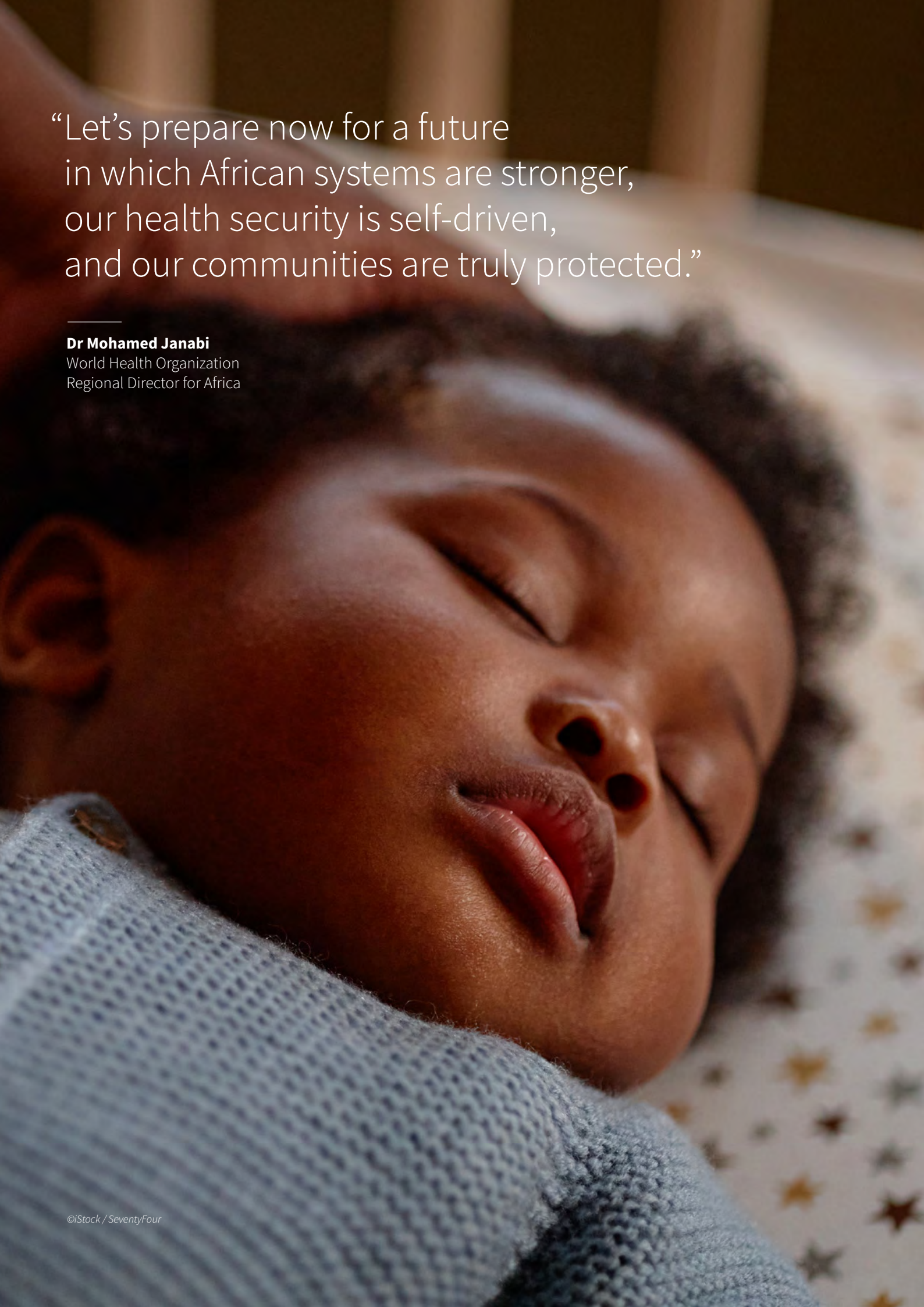
- The **Africa Investment Round** signalled a bold domestic commitment.
- Negotiations leading to the **Pandemic Agreement** affirmed Africa's rising influence on global health.

These achievements underscore a powerful truth: even in adversity, we can lead, innovate and deliver.

But we must also confront the road ahead. We need more predictable financing, stronger national systems and greater self-reliance. Reform and resilience must remain central to our mission.

As Regional Director, I am committed to building on this legacy – with a renewed focus on equity, innovation and measurable results. Let us accelerate the momentum. Let us prepare now for a future where African health systems are stronger, our health security is self-driven, and our communities are truly protected.

Dr Mohamed Janabi
World Health Organization
Regional Director for Africa



“Let’s prepare now for a future
in which African systems are stronger,
our health security is self-driven,
and our communities are truly protected.”

Dr Mohamed Janabi
World Health Organization
Regional Director for Africa

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Executive Summary

This report outlines the work of the WHO Regional Office for Africa from July 2024 to June 2025, a year marked by significant operational challenges and institutional transitions. Despite severe financial constraints, the Region maintained critical operations, supported Member States across key technical areas, and advanced regional and global health priorities.

Structured around four strategic pillars – universal health coverage, health emergencies, healthier populations and integrated action – the report highlights how WHO remained a reliable technical partner, adapted to shifting demands, and reinforced country-led efforts towards building resilient and equitable health systems.

Universal health coverage – expanding access to essential services

Progress towards universal health coverage (UHC) was supported in all 47 Member States, with a strong emphasis on primary health care (PHC). The District Health for All (DHFA) approach, which brings integrated services closer to communities, was implemented in 17 countries, leading to improved equity and district-level accountability.

In efforts to strengthen essential health services:

- 44 countries received support to develop and cost essential health service packages, aligned with national health strategies.
- 25 countries advanced immunization efforts by identifying and reaching zero-dose and under-immunized children.
- 19 countries rolled out the malaria vaccine, contributing to a reduction in child mortality.
- Digital innovations, including e-registries, AI-assisted diagnostics and telemedicine, were scaled up to enhance access and continuity of care.

Countries also integrated services for maternal and child health, mental health and noncommunicable diseases (NCDs) into PHC. Reforms in public financial management and health financing systems were implemented to ensure sustainability, while national regulatory capacities were strengthened to improve access to medicines and diagnostics.

Health emergencies – protecting populations from health threats

During the reporting period, the Region experienced 168 public health emergencies. WHO led and coordinated responses to cholera, mpox, yellow fever, measles and other threats, deploying technical expertise and emergency supplies to support national efforts.

Among key achievements:

- 36 countries improved emergency preparedness and response through risk assessments, simulation exercises and the development of response plans.
- Integrated disease surveillance and real-time data platforms were expanded, while genomic surveillance gained momentum.

- Essential services were maintained in fragile and conflict-affected settings through strengthened partner coordination.
- The Africa Investment Round and engagement in the Pandemic Agreement elevated regional leadership in health security.

WHO supported countries transitioning from emergency response to recovery, reinforcing resilience and system-wide preparedness.

Healthier populations – advancing well-being across the life course

WHO worked across the life course to reduce the disease burden and promote health in areas including NCDs, mental health, neglected tropical diseases (NTDs), malaria and nutrition.

Some highlights:

- Five countries validated the elimination of at least one NTD, and others expanded preventive chemotherapy and strengthened surveillance.
- 28 countries updated or implemented multisectoral nutrition action plans, while policies on tobacco, alcohol and sugary drinks gained traction.
- The mental health flagship programme progressed in 27 countries, integrating PHC-based services and workforce training.
- Adolescent health, digital engagement and sexual and reproductive health were integrated into national programmes.

Malaria control was reinforced through vaccine rollout, vector control and seasonal chemoprevention, particularly in high-burden areas. Additionally, technical guidance helped to improve food labelling and school health interventions.

Integrated action for better health – African leadership, innovation and systems resilience

Amid financial austerity and institutional transitions, WHO sustained operations by streamlining processes, aligning support with national priorities and driving results-based reforms.

Notable progress:

- 31 country offices finalized or updated country cooperation strategies to align with national development agendas.
- Institutional reforms improved procurement, supply chain management and accountability systems.
- Regional platforms and inter-country technical exchanges fostered African-led solutions and innovation.

WHO reinforced its zero-tolerance stance on misconduct and strengthened ethics and audit mechanisms. The Africa Investment Round convened high-level leaders to mobilize innovative health financing, while the Region's voice helped shape global preparedness through the Pandemic Agreement.

Conclusion and looking ahead

The 2024–2025 period tested the Region's agility and resilience. Despite constrained funding and institutional reforms, WHO sustained its technical leadership and supported Member States in delivering on both national and regional priorities.

WHO's actions contributed to stronger and more equitable health systems, improved emergency preparedness and promoted greater regional leadership in global health. Looking ahead, WHO will deepen its support for integrated, sustainable and people-centred health systems, anchored in primary health care, driven by innovation and led by African priorities.

Looking ahead, WHO will deepen its support for integrated, sustainable and people-centred health systems, anchored in primary health care, driven by innovation and led by African priorities.

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Our top 10 achievements 2024–2025

Responded to over 160 public health emergencies

Across 47 countries, WHO supported coordinated responses to cholera, mpox, Ebola, Marburg virus, floods and other crises, deploying over 400 surge staff and emergency supplies within days of outbreak detection.

Supported malaria vaccine rollout in 19 countries

Under the AMVIRA initiative, WHO provided technical support for the introduction of malaria vaccines, reaching over 600 000 children and contributing to sharp declines in child mortality in high-burden countries.

Protected over 221.6 million children in 24 countries through polio campaigns

WHO helped 24 countries plan and implement synchronized polio vaccination campaigns, contributing to a 44% reduction in type 2 detections.

Helped vaccinate over 7.5 million people against cholera, yellow fever and Ebola

Emergency campaigns were delivered with WHO support across multiple high-risk countries, limiting the spread of vaccine-preventable outbreaks and epidemics.

Validated elimination of three major NTDs

WHO officially validated the elimination of onchocerciasis in Niger, sleeping sickness in Guinea, and trachoma in Mauritania – milestones reflecting years of coordinated public health action.

Expanded mental health support in over 20 countries

WHO supported the integration of mental health into PHC and humanitarian response, training providers using mhGAP and launching new community-level care models.

Delivered measles and routine immunizations to 107 million children

WHO supported immunization campaigns in 21 countries, as part of the Big Catch-Up Initiative, helping close post-COVID coverage gaps and reach zero-dose children.

Strengthened health financing in over 80% of countries

WHO supported most Member States in advancing health financing reforms and reducing out-of-pocket spending through better budget alignment and expanded pooled funding.

Enabled NTD treatment for 16 million people

WHO supported mass drug administration campaigns in 27 countries with technical guidance, coordination and supply chain support for donated medicines.

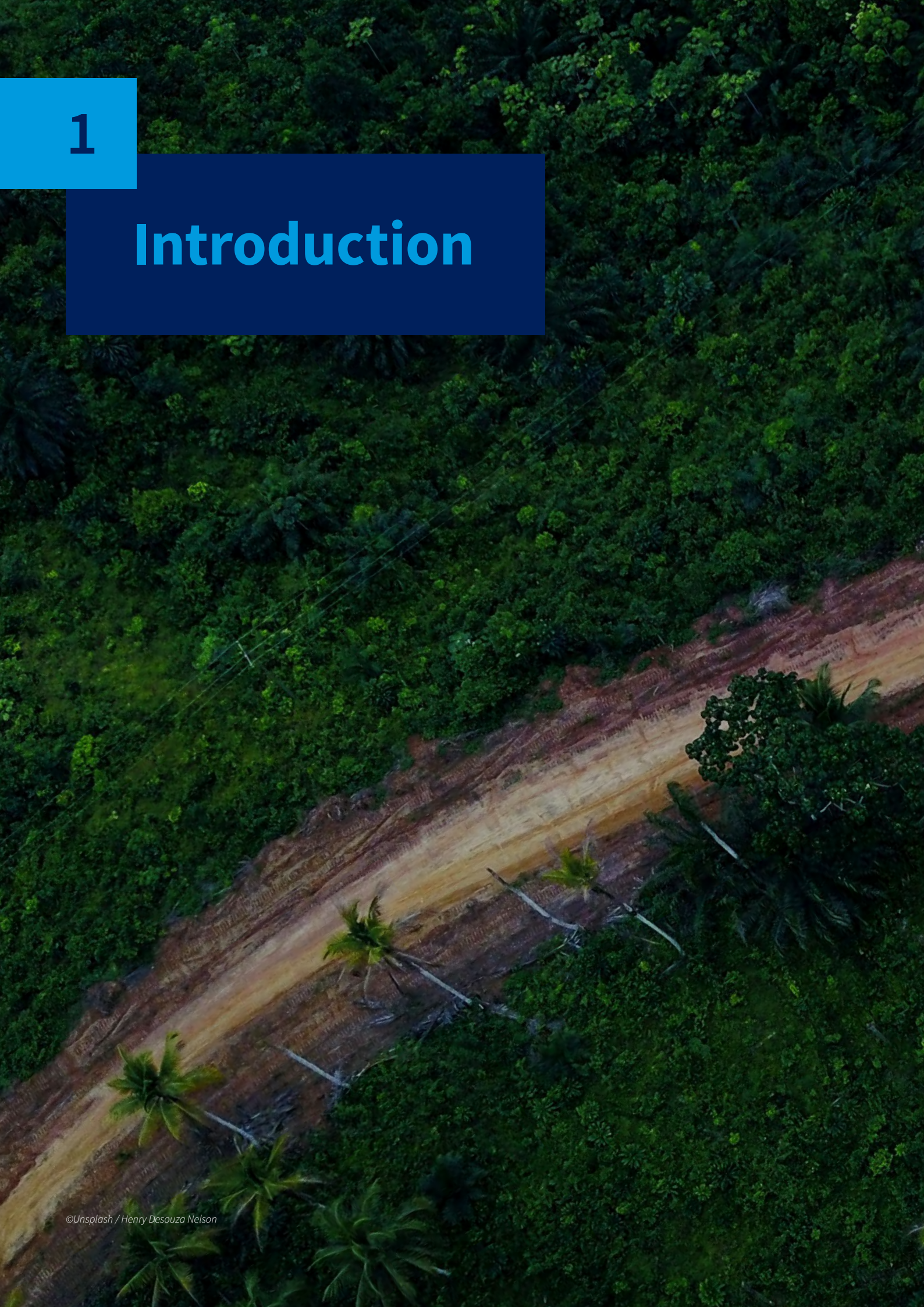
Improved real-time disease surveillance in 42 countries

Countries adopted digital IDSR, EIOS and DHIS2 platforms with WHO support, strengthening early detection and response to health threats.

All achievements reflect WHO's technical and coordination support under Member State leadership, in collaboration with national and international partners.

1

Introduction



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The period from July 2024 to June 2025 was one of the most difficult in the WHO African Region's history. Severe financial constraints, unprecedented leadership transitions at the highest levels and a high volume of public health emergencies placed immense pressure on WHO's operational capacity. This difficult year tested the limits of institutional resilience and exposed long-standing structural vulnerabilities within the Region's health systems.

(WHO) helped countries mount rapid emergency responses, sustain critical vaccination campaigns and navigate complex reform agendas.

The funding crisis, among the most acute the Region has ever faced, was driven by a combination of global economic headwinds, shifting donor priorities and prolonged underinvestment in core capacities. As a result, WHO was compelled to make hard choices about where and how to deliver, often amid considerable uncertainty. While essential programmes were maintained, some planned activities were scaled back or delayed, and technical support was stretched thin across multiple competing demands.

These strains were compounded by leadership transitions at both the regional and senior technical levels. Despite these disruptions, the Regional Office managed to maintain basic programmatic continuity through rapid onboarding, knowledge transfer systems and targeted strategic reprioritization. However, the cost of this stability should not be understated; it required extraordinary internal coordination, staff resilience and difficult resource trade-offs.

At the same time, Member States continued to rely heavily on WHO's normative and technical support. The Organization helped countries mount rapid emergency responses, sustain critical vaccination campaigns and navigate complex reform agendas. But this support often took place under conditions of financial stress, with a need for sharper prioritization and increased domestic commitment.

Amid these challenges, important developments unfolded: the first Africa Investment Round catalysed new dialogue on sustainable financing; regional positions on the Pandemic Agreement signalled Africa's rising voice in global health; and digital innovations were accelerated in key areas, including surveillance and data integration.

This report is both a record of achievements and a reflection on what it took to deliver under duress, as well as where the Region must go next to build more resilient, self-sustaining health systems.

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Chapter 1
Introduces the report and outlines the political, financial and institutional context in which WHO operated during the 2024–2025 period. It highlights the challenges that shaped delivery across the Region, and sets the stage for the technical and strategic priorities that follow.

Chapter 2
Presents WHO's work and progress towards universal health coverage across the African Region. Structured around seven pillars, the chapter outlines achievements in essential service delivery, health financing, human resources for health, disease control, and efforts to mainstream equity and rights-based approaches.

Chapter 3
Details WHO's support for Member States in preparing for and responding to health emergencies. It highlights improvements in risk assessment, emergency coordination and timely response to outbreaks, including cholera, mpox and Marburg virus, while noting remaining challenges in surge capacity and logistics.

Chapter 4
Explores WHO's efforts to promote healthier populations through multisectoral action and community engagement. The chapter focuses on climate and health, road safety, tobacco control, nutrition and food safety, and the role of community-led interventions in advancing well-being across the life course.

Chapter 5
Highlights cross-cutting priorities essential to building resilient health systems, including Africa's leadership role in health investment and governance, antimicrobial resistance, health research, digital innovation and data systems. The chapter reflects on how WHO supported Member States to drive reforms, strengthen accountability, and harness partnerships and technologies to advance sustainable, country-led health transformation.

Chapter 6
Presents the conclusion and proposes the way forward.

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"I am deeply committed to championing home-grown solutions and harnessing regional expertise. By fostering a vibrant culture of mentorship, empowering our youth, and upholding the highest standards of ethical governance, I aim to help build resilient communities and shape a future driven by local innovation and integrity."

A vision grounded in action – Dr Mohamed Janabi's commitment to a healthier Africa

For me, health is more than a service. It is a foundation for prosperity, stability and dignity. I am committed to advancing stronger domestic financing, deeper African engagement in global health governance, and a relentless focus on results that improve lives and strengthen systems.

As I assume the role of Regional Director at WHO AFRO, I bring with me a clear and pragmatic vision: a continent where access to essential health services is universal, and where resilient systems protect communities from both everyday threats and extraordinary crises.

Central to my agenda is the expansion of primary health care, which I see as the backbone of universal health coverage. I have long advocated for greater investment in maternal and child health, mental health, and the integrated response to both communicable and noncommunicable diseases. My approach prioritizes equity, sustainability and innovation, delivered through systems that are locally led, financially sustainable and equipped to meet evolving needs.

My background in clinical medicine, public health strategy and global health diplomacy, has shaped a systems-oriented perspective grounded in real-world experience. I have been privileged to contribute to national health reforms, help transform the Jakaya Kikwete Cardiac Institute into a regional centre of excellence, and collaborate with global partners to improve emergency preparedness and equitable access to medicines and vaccines.

My vision is also shaped by the urgent health risks posed by climate change. I believe our health systems must be resilient to environmental shocks, and responsive to the broader determinants of health. Strengthening early warning systems and building multisectoral collaboration are core to this approach.

Above all, I believe in investing in African capacity, including our research, our digital innovation and our public health leadership. I am deeply committed to championing home-grown solutions and harnessing regional expertise. By fostering a vibrant culture of mentorship, empowering our youth, and upholding the highest standards of ethical governance, I aim to help build resilient communities and shape a future driven by local innovation and integrity.

This is the vision that guides WHO AFRO today: to build stronger systems, deliver measurable results, and work hand in hand with Member States to achieve sustainable health for all.

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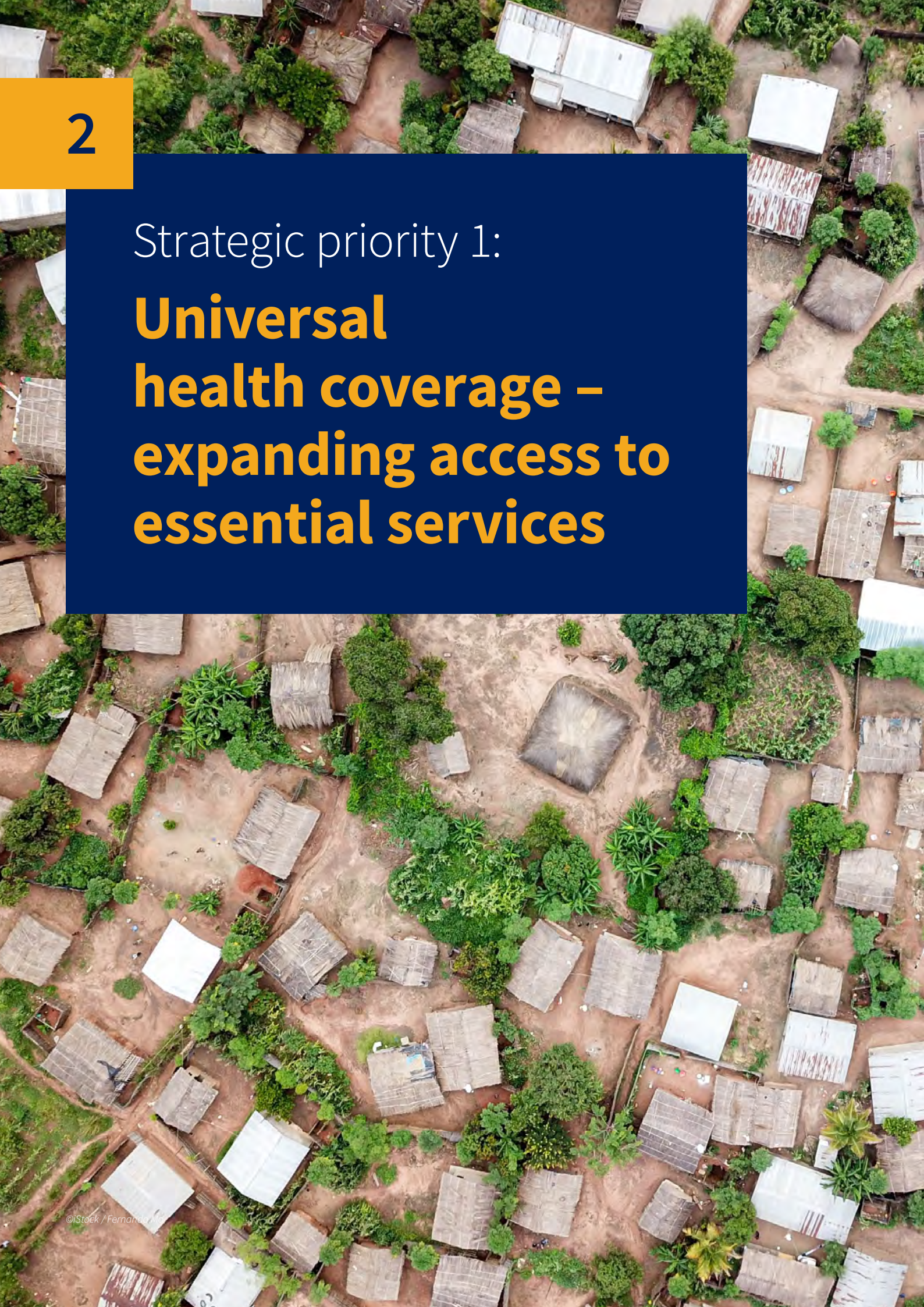
Strategic priority 1:

Universal health coverage – expanding access to essential services



Key achievements:

47 countries
supported to develop GPW13 country profiles

Niger verified for
onchocerciasis elimination

15+ countries
improve access to SRMNCAH services

Botswana upgraded to
HIV gold tier status

17 countries
implementing WHO-backed essential service packages*

107 million children
vaccinated against measles

National health workforce strategies and quality care standards scaled up in
36+ countries

Polio campaigns protected
221.6 million children
in 24 countries

40 countries
implement WHO's Family of International Classifications of Disease (ICD-11 and ICHI)

Regulatory systems improved access to essential medicines in
30+ countries

Malaria vaccine introduced in
19 countries

33 countries
supported to strengthen national regulatory systems for medicines and health technologies

* A defined set of health interventions considered vital for achieving UHC and improving population health outcomes

The 2024–2025 period was pivotal for accelerating progress towards universal health coverage (UHC) in the WHO African Region, even in the face of severe financial pressures and complex health demands.

The Universal Health Coverage/Life Course (UHC/LC) cluster played a central role in fostering multisectoral collaboration and translating health into tangible progress in service delivery, financing and equity.

WHO worked with countries to expand access, improve service quality and ensure financial protection.

Grounded in the life course approach and guided by principles of integration and people-centred care, WHO worked with countries to expand access, improve service quality and ensure financial protection.

These efforts supported emergency recovery and pandemic preparedness, but also helped build the foundations of long-term system resilience.

2.1 Improved access to quality essential services

Expanding access to essential health services remained a major focus, with WHO prioritizing the revitalization of primary health care and ensuring services reached the most underserved communities.

From 30 June 2024 to 1 July 2025:

Eswatini developed its national Essential Health Services Package (EHSP), bringing the total number of countries implementing or preparing EHSPs to 17.[1]

These packages help countries reorganize services to better meet community needs, improve service quality and support integration across health programmes.

To address critical gaps in surgical care, which is often overlooked in UHC strategies, WHO launched a regional programme on surgical care services. This initiative is helping countries expand access to safe, timely and affordable surgery, especially in rural and remote areas.

Together, these efforts contribute to strengthening PHC systems and expanding the range of essential services that people can access close to home.

1 Botswana, Burkina Faso, Eswatini, Ethiopia, Kenya, Lesotho, Malawi, Namibia, Niger, Rwanda, Seychelles, South Africa, South Sudan, Sierra Leone, United Republic of Tanzania, Uganda, Zimbabwe

2.2 Protecting people from impoverishing health spending

WHO supported Member States in strengthening their health financing systems, enabling people to access care without risking financial hardship.

Countries made progress in:

- Improving financial risk protection for vulnerable populations;
- Conducting public expenditure reviews and updating national health financing strategies;
- Designing benefit packages that ensure that service coverage aligns with population health needs.

Strategic purchasing improved through WHO's technical assistance, helping countries strengthen provider payment systems and expand pooled funding arrangements:

- Malawi and Nigeria introduced performance-based financing models in selected districts;
- Benin began aligning its health purchasing with essential services delivery.

At the same time, WHO helped countries explore domestic resource mobilization through:

- Fiscal space analyses and reviews of public spending (in Sierra Leone and Uganda, for example);
- National dialogues on sustainable health financing and reducing reliance on out-of-pocket payments.

WHO also strived to improve the legal and policy environments for UHC. In collaboration with the Inter-Parliamentary Union (IPU), the International Labour Organization (ILO) and O'Neill Institute:

- All 47 Member States conducted legal assessments of their health systems. Country-specific draft reports and a consolidated database of UHC-related laws were developed. These resources are now guiding national reform efforts to create legal foundations that support universal access, equity and social protection.

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2.3 Better health for women, children, adolescents and older people

WHO supported countries in expanding high-impact interventions for women, children, adolescents and, increasingly, older populations, using a life-course approach.

This support included:

- The 2gether4SRHR partnership (23 countries)[2] and the Every Woman Every Newborn initiative (27 countries)[3], which helped countries improve access to integrated sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) services;
- In fragile settings, such as Burundi and Chad, efforts focused on integrating family planning, maternal care and gender-based violence services into PHC;
- 13 countries[4] developed or strengthened RMNCAH scorecards and dashboards to guide local decision-making;
- Over 30 countries re-established and operationalized national RMNCAH technical working groups.

WHO also co-hosted the Strategic Leadership Forum, with UNFPA, UNICEF and UNAIDS. These platforms helped reinforce national leadership, multisectoral collaboration and accountability in RMNCAH programming.

Further achievements:

- More than 80% of countries now have maternal and perinatal death surveillance and response systems;
- 28 countries[5] have begun implementing WHO standards of care for maternal and newborn health;
- WHO led the development of the Regional Framework for Strengthening Integrated, Child-Centred Services for Ages 0–19 Years (2024–2030), supporting five countries[6] to adopt a transformative approach to child and adolescent well-being.

In adolescent health, WHO promoted:

- School health programmes;
- Adolescent-responsive care models;
- Collaborations with education ministries and youth networks.

2 Angola, Botswana, Burundi, Comoros, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, United Republic of Tanzania, Uganda, Zambia, Zimbabwe

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

4 Angola, Botswana, Democratic Republic of the Congo, Eswatini, Lesotho, Madagascar, Malawi, Mozambique, Namibia, South Africa, United Republic of Tanzania, Zambia, Zimbabwe

5 Algeria, Benin, Burkina Faso, Burundi, Congo, Comoros, Chad, Cote d'Ivoire, Eswatini, Ethiopia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Sierra Leone, South Africa, United Republic of Tanzania, Togo, Uganda, Zambia, Zimbabwe

6 Malawi, Mozambique, Rwanda, United Republic of Tanzania, Uganda

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In Namibia and Zambia, these initiatives increased access to mental health support, counselling and contraceptive services for young people.

Recognizing demographic shifts, WHO began scaling up support for healthy ageing. Two countries[7] initiated situational analyses to assess needs and guide future action, with WHO providing technical assistance.

2.4 Towards more health workers with the right skills in the right places

Addressing health workforce shortages remained essential to strengthening service delivery and ensuring UHC.

WHO provided support to:

- Seven countries[8] to implement or revise national health workforce strategies and investment plans;
- Key focus areas including workforce planning, recruitment, training and retention, particularly targeting underserved areas.

Zimbabwe, for example, launched a health workforce investment compact, with WHO support, successfully mobilizing partner alignment and national commitment to health workforce development.

To improve health workforce intelligence:

- Eight countries[9] conducted health labour market assessments;
- Mozambique and Seychelles developed staffing norms for more equitable distribution;
- Ghana and Nigeria developed migration policies to help retain staff.

7 Côte d'Ivoire, Mali
8 Central African Republic, Eritrea, Eswatini, Ethiopia, Ghana, Kenya, Zimbabwe
9 Central African Republic, Chad, Côte d'Ivoire, Eswatini, Madagascar, Mozambique, Uganda, Zambia

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This first-of-its-kind initiative has galvanized national momentum, attracting match funding and opening the door for scale-up.

COUNTRY SPOTLIGHT: LIBERIA

Tackling substance use among at-risk youth

In the aftermath of Liberia's civil war, the rising use and abuse of narcotic drugs among the country's youth signalled a troubling public health crisis. Economic hardship and the proliferation of drug trafficking networks left a devastating legacy, with over 40 000 at-risk youth estimated to be living with substance use disorders. Marijuana, cocaine, heroin and other emerging substances have taken hold, contributing to high levels of crime and social instability.

Recognizing the urgency of the crisis, Liberia's President declared substance use a national public health emergency in his first State of the nation address. However, the country lacked the necessary infrastructure, with few treatment centres, inadequate access to essential medicines, and limited health care worker capacity to provide specialized care.

To confront this challenge, WHO partnered with UNICEF and UNFPA to launch a joint response, securing more than US$ 800 000 to scale up treatment and rehabilitation services for substance use in Liberia. The partnership delivered a comprehensive package of interventions across the country's most affected areas.

A key milestone was the training of 44 health workers, including doctors, nurses and social workers, as certified addiction professionals. These specialists are now delivering services at 33 health facilities in two counties, already reaching over 1500 at-risk youth with life-changing support.

WHO also supported the refurbishment of key treatment centres, including a clinic and a major inpatient facility in Montserrado County, and helped establish two outpatient centres in partnership with the Ministry of Health. In a significant step toward sustainability, the initiative integrated Addiction Science into the University of Liberia's master's curriculum, ensuring a pipeline of trained professionals.

This first-of-its-kind initiative has galvanized national momentum, attracting matching financing and opening the door for scale-up. It represents a critical turning point for Liberia's health and social services, and offers a replicable model for addressing youth substance use in other fragile settings.

WHO also led the first Africa Health Professions Education dialogue in Zambia, to promote regional consensus on health worker competencies and curriculum transformation.[10]

Other efforts:

- Five countries[11] developed country health services and systems profiles (CHSSPs);
- At least 20 countries[12] have advanced national quality policies and strategies to strengthen continuous improvement in care delivery;
- Regional platforms supported regulatory strengthening in licensing, accreditation and continuing professional development.

Despite progress, countries continued to face high attrition rates, uneven workforce distribution and limited capacity to absorb new graduates. WHO is supporting efforts to address these challenges through enhanced planning frameworks, innovative retention strategies and long-term capacity-building approaches.

2.5 Improving access to quality medical products

WHO scaled up efforts to help countries strengthen regulatory systems and ensure access to safe, effective and affordable medical products.

WHO scaled up efforts to help countries strengthen regulatory systems and ensure access to safe, effective and affordable medical products.

Through the Organization's Global Benchmarking Tool (GBT), countries:

- Identified gaps in regulatory functions;
- Developed institutional improvement plans;
- Adopted regulatory reliance mechanisms;
- Strengthened pharmacovigilance.

Notably:

- Rwanda, Senegal and Zimbabwe achieved maturity level 3 (ML3), indicating stable and integrated regulatory systems;
- Benchmarking assessments were conducted in 16[13] additional countries;
- The Region is on track to reach its goal of 15 ML3 countries by 2035.

10 Proceedings of the Africa health professions education dialogue – https://iris.who.int/handle/10665/381384
11 Ethiopia, Kenya, Nigeria, Rwanda, Senegal
12 Botswana, Burkina Faso, Cameroon, Eswatini, Ethiopia, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mauritania, Mozambique, Namibia, Rwanda, Senegal, Seychelles, South Africa, United Republic of Tanzania, Uganda, Zimbabwe
13 Algeria, Angola, Benin, Botswana, Burundi, Cote d'Ivoire, Ethiopia, Ghana, Kenya, Mozambique, Namibia, Nigeria, South Africa, United Republic of Tanzania, Uganda, Zambia

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In 2022, Eswatini had 9741 health workers, just 48.1% of the 20 272 needed to achieve UHC.

COUNTRY SPOTLIGHT: ESWATINI

Aligning health workforce planning with UHC needs

Eswatini has long faced persistent health workforce challenges that threaten progress towards universal health coverage. Despite producing a growing number of health professionals, a disconnect remained between training output and service delivery needs. Many health workers were unemployed or underutilized, particularly in rural areas, while strategic workforce planning lacked comprehensive, current data.

A national recruitment freeze since 2018 (Circular No. 3) further exacerbated these issues, limiting the health system's ability to absorb available talent. In response, the Ministry of Health, with technical and financial support from WHO, undertook a groundbreaking health labour market analysis (HLMA) to provide a clear, evidence-based picture of the country's health workforce dynamics.

Using WHO's standardized HLMA methodology, the assessment analysed 51 health workforce occupations across the supply, demand and need spectrum. Stakeholder consultations and capacity-building were integral to the process, ensuring national ownership and policy relevance. The findings were sobering: in 2022, Eswatini had 9741 health workers, just 48.1% of the 20 272 needed to achieve UHC. Nearly 10% of trained workers, including 431 midwives and 300 doctors, were either unemployed or underemployed.

Geographic inequities were equally stark. While 77% of the population lived in rural areas, only 45% of the health workforce served these communities. Migration risk also loomed large, with 41% of health workers reporting their intention to emigrate, and 34% already taking active steps towards leaving the country.

In response, the Government approved the recruitment of 907 previously unemployed health workers and initiated the development of a new national human resources for health (HRH) strategic plan. HLMA findings are already informing distribution reforms and guiding donor alignment for resource mobilization. WHO continues to support the implementation, including the design of rural deployment incentives and retention strategies.

To sustain progress, Eswatini has also begun institutionalizing national health workforce accounts (NHWA) for ongoing monitoring and planning. By building a stronger evidence base, Eswatini is laying the foundation for a more balanced, resilient and responsive health workforce.

To address medicines shortages:

- Countries strengthened supply chain systems, improved storage and distribution practices, and expanded logistics management information systems;
- Particular attention was placed on maternal and child health commodities, emergency medicines and treatments for noncommunicable diseases.

In Small Island Developing States (SIDS), which face unique procurement challenges, WHO supported the operationalization of the SIDS Pooled Procurement Agreement. This initiative helps countries such as Comoros and Mauritius secure lower prices, achieving early cost savings of over 50% across 47 formulations.[14]

Blood safety was also prioritized:

- WHO assisted in developing national blood strategies, improving infrastructure and training staff;
- A campaign marking the twentieth anniversary of World Blood Donor Day culminated in a regional effort in Congo that collected 100 units of blood for local hospitals.

At the Seventy-fourth WHO Regional Committee for Africa, Member States endorsed the new "Framework for strengthening local production of medicines and other health technologies 2025–2035: report of the Secretariat", aimed at building regional manufacturing capacity.

2.6 Eradicating, eliminating, preventing and controlling diseases

WHO assisted Member States in making substantial progress on disease control and elimination through the Ending Disease in Africa (ENDISA) initiative.[15] This comprehensive effort covers malaria, NTDs, HIV, tuberculosis (TB), polio, immunization, noncommunicable diseases and mental health.

Malaria control and elimination

Malaria remains a major health threat, with the African Region responsible for 95% of global cases and deaths. In Africa, it accounts for 76% of all deaths in children under five years old.

Key progress:

- Cabo Verde was certified malaria-free, the second country in the Region to achieve this status;
- Rwanda and Sao Tome and Principe are on track to meet the 2025 targets for reduced malaria incidence and mortality;
- 19 countries[16] rolled out malaria vaccines;
- Seasonal malaria chemoprevention was implemented in Côte d'Ivoire and Mauritania.

14 Compared to baseline 2022 prices

15 The Universal Health Coverage/Communicable and Noncommunicable Diseases Cluster's strategic initiative supporting disease prevention, control, elimination and eradication

16 Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ghana, Guinea, Kenya, Liberia, Malawi, Mozambique, Niger, Nigeria, Sierra Leone, Uganda, South Sudan

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Reaching maturity level 3 signals that a national regulatory system is well-functioning, stable and integrated, a prerequisite for engaging in regional initiatives such as the African Medicines Agency (AMA).

Senegal and Rwanda achieve key milestone in medicines regulation

In a major step towards improving access to safe, effective medicines and vaccines, Senegal and Rwanda were recognized by WHO for reaching maturity level 3 (ML3) in the global classification of national regulatory authorities.

This designation places the two countries among only eight in the WHO African Region to have achieved this level, which is an important benchmark of regulatory strength and reliability. It reflects years of sustained efforts to strengthen systems that safeguard public health through the effective regulation of medical products.

The recognition follows comprehensive assessments conducted in October 2024 using WHO's Global Benchmarking Tool, which evaluates over 250 indicators of regulatory performance. These include essential functions such as product evaluation and registration, market surveillance, safety monitoring and post-market controls.

In Senegal, the milestone was achieved by the Agence Sénégalaise de Réglementation Pharmaceutique, and in Rwanda by the Rwanda Food and Drugs Authority. Both evaluations were carried out in close partnership with the WHO Regional Office for Africa and WHO country offices, highlighting the collaborative approach that underpins regulatory strengthening efforts.

Reaching maturity level 3 signals that a national regulatory system is well-functioning, stable and integrated, a prerequisite for engaging in regional initiatives such as the African Medicines Agency (AMA). It also marks the beginning of a new phase, as countries prepare to continue advancing toward maturity level 4, the highest level of regulatory excellence.

WHO supported:

- Cross-border coordination and regional elimination strategies under the Sahel and SADC malaria frameworks;
- Malaria outbreak responses in Botswana, Namibia and South Africa;
- Data-driven targeting using subnational stratification in countries such as Kenya and the United Republic of Tanzania.

In response to rising drug resistance:

- WHO promoted multiple first-line therapies and updated treatment guidelines in Burkina Faso, Rwanda and Uganda;
- Hosted a regional workshop in Djibouti and stakeholder coordination meetings held in March 2025 enhanced preparedness.

Through the high burden high impact (HBHI) and malaria accelerator initiatives, WHO facilitated catalytic investments and engaged parliamentarians, via the Coalition of Parliamentarians to End Malaria in Africa (COPEMA) to mobilize resources and drive action against malaria.

WHO facilitated catalytic investments to mobilize resources and drive action against malaria.

Neglected tropical diseases

The Region saw major milestones in NTD control. The N'Djamena Declaration committed Chad, Cameroon and the Central African Republic to cross-border Guinea-worm eradication. On the margins of the Seventy-eighth World Health Assembly, six African countries[17] signed a regional Memorandum of Understanding targeting visceral leishmaniasis (VL) as a public health problem.

Key country progress:

- Niger became the first African Region country to be verified for onchocerciasis elimination;
- Guinea eliminated human African trypanosomiasis (HAT), joining seven other countries[18] that have achieved this status;
- Mauritania became the seventh African country to eliminate trachoma as a public health problem[19], with support from Pfizer's azithromycin donation programme, partner collaboration and the WHO-recommended SAFE strategy.[20]

Women leaders involved in NTDS received support through the Mwele Malecela Mentorship Programme, dedicated to empowering women in the fight against NTDs. The programme launched its second cohort, welcoming five women leaders who will receive mentorship and training over the next two years.

17 Benin, Chad, Côte d'Ivoire, Equatorial Guinea, Ghana, Rwanda, Togo, Uganda
18 Benin, Chad, Cote d'Ivoire, Equatorial Guinea, Ghana, Togo, Uganda
19 The earlier six are: Benin, Gambia, Ghana, Malawi, Mali, Togo
20 The SAFE strategy consists of: surgery to treat the blinding stage (trachomatous trichiasis); antibiotics to clear the infection, particularly mass drug administration of the antibiotic azithromycin; facial cleanliness; and environmental improvement, particularly improving access to water and sanitation

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HIV, hepatitis and tuberculosis

WHO convened a regional meeting on HIV, hepatitis and NCD integration, resulting in a commitment to create a hepatitis community of practice. Uganda became the first African country to surpass the target of diagnosing 30% of people living with hepatitis B.

Botswana's HIV validation status was upgraded to gold tier in May 2025, supported by WHO. The country also showed progress in eliminating mother-to-child HIV transmission (EMTCT).

In tuberculosis control, all 47 Member States now use WHO-recommended molecular diagnostic tests, raising rapid testing rates. As of the end of the review period, 15 countries[21] are transitioning to implementing WHO's six-month drug-resistant TB regimens to tackle drug-resistant TB.

Through the Regional Green Light Committee, WHO supported 13 countries[22] in aligning their policies on diagnosis and treatment of drug-resistant tuberculosis.

Routine immunization and outbreak response

Progress on immunization:

- 107 million children vaccinated against measles in 21 countries;[23]
- Vaccination campaigns in Niger and Nigeria reached nearly 5 million people in response to meningitis outbreaks;
- Over 600 000 children received malaria vaccines through the Accelerating Malaria Vaccine Introduction and Rollout in Africa (AMVIRA) initiative.

21 Botswana, Burkina Faso, Chad, Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Ghana, Lesotho, Mali, Namibia, Nigeria, Sierra Leone, South Africa, Zimbabwe

22 Angola, Botswana, Chad, Eswatini, Ethiopia, Gabon, Kenya, Lesotho, Malawi, Mauritania, Niger, Rwanda, South Africa

23 Benin, Burkina Faso, Burundi, Cote d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Ghana, Guinea, Guinea Bissau, Liberia, Madagascar, Mali, Mauritania, Mozambique, Nigeria, Rwanda, Senegal, Sierra Leone, United Republic of Tanzania, Zambia

NCDs and mental health

Only four countries[24] are on track to meet the SDG target for reducing premature NCD mortality.

WHO addressed this through the:

- Women's Integrated Cancer Services (WICS) project, launched in Côte d'Ivoire, Kenya and Zimbabwe, reaching over 1700 women;
- PEN-Plus strategy for managing severe NCDs:
  - 20 countries[25] developed national operational plans
  - 17 countries[26] began service rollouts
  - 16 countries[27] launched specialized training
  - 13 countries[28] initiated PEN-Plus implementation into at least one district hospital.

WHO published strategic resources on breast cancer, PEN-Plus, oral health, hearing care and sickle cell disease. Additionally, the Diabetes and Cardiovascular Disease in Africa (D-Card Africa) initiative, in collaboration with the World Diabetes Foundation, strengthened diabetes and cardiovascular disease care in Ghana and Uganda.

Mental health programming focused on:

- Suicide prevention;
- Men's mental health;
- Workplace well-being.

Under WHO's SAFER initiative,[29] 15 countries[30] received support to reduce alcohol-related harm.

Polio eradication and cross-border coordination

Polio campaigns reached 221.6 million children with at least one dose of oral polio vaccine in 24 countries,[31] achieving a 45% reduction in variant poliovirus type 2 detections compared to the same period the previous year.

In a significant move to combat the ongoing challenge of variant poliovirus transmission in Central and West Africa, Ministers of Health from the Lake Chad Basin countries and the Sahel subregion published a comprehensive cross-border coordination plan for 2024–2025. As a direct result, a joint vaccination campaign was launched in the Lake Chad Basin subregion from 24 to 28 April 2025, aimed at protecting nearly 83 million under-five children.

24 Algeria, Gabon, Nigeria, South Africa
25 Benin, Burkina Faso, Cameroon, Congo, Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Lesotho, Liberia, Malawi, Mozambique, Niger, Nigeria, Rwanda, Sierra Leone, United Republic of Tanzania, Uganda, Zambia, Zimbabwe
26 Benin, Burkina Faso, Cameroon, Ethiopia, Ghana, Kenya, Lesotho, Liberia, Malawi, Mozambique, Nigeria, Rwanda, Sierra Leone, United Republic of Tanzania, Uganda, Zambia, Zimbabwe
27 Benin, Burkina Faso, Ghana, Ethiopia, Kenya, Lesotho, Liberia, Malawi, Mozambique, Nigeria, Rwanda, Sierra Leone, United Republic of Tanzania, Uganda, Zambia, Zimbabwe
28 Burkina Faso, Ethiopia, Kenya, Lesotho, Liberia, Mozambique, Niger, Rwanda, Sierra Leone, United Republic of Tanzania, Uganda, Zambia, Zimbabwe
29 The SAFER Initiative – https://www.who.int/initiatives/SAFER
30 Angola, Burkina Faso, Congo, Equatorial Guinea, Ethiopia, Gabon, Ghana, Kenya, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, Seychelles, Uganda
31 Angola, Burkina Faso, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Congo, Democratic Republic of the Congo, Ethiopia, Gambia, Ghana, Guinea, Kenya, Liberia, Madagascar, Mali, Mozambique, Niger, Nigeria, Sierra Leone, South Sudan, Uganda, Zambia, Zimbabwe

Table 1. **Polio vaccinations: children reached (1 July 2024 – 30 June 2025)**
Figures represent number of children vaccinated, in millions.

		2024						2025				
Country	Vaccine Type	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Apr	May	Jun
Congo	bOPV			1.3								
DRC	bOPV		4.3	0.8						1.2		
Guinea	bOPV										5.1	
Madagascar	bOPV	5.9										
Mozambique	bOPV	9.6										
Angola	nOPV2			6.7		0.4						
Burkina Faso	nOPV2			0.5		5.8						
Cameroon	nOPV2				7.0	3.6				7.8	7.9	
CAR	nOPV2				0.5		1.3			2.5		
Chad	nOPV2					10.9				5.6		5.5
Côte d'Ivoire	nOPV2			9.4					10.1		10.2	
DRC	nOPV2		4.6		32.8		26.9	1.7		9.3	0.2	
Ethiopia	nOPV2				5.4		6.3		15.3		16.3	
Gambia	nOPV2					0.4	0.4					
Ghana	nOPV2				6.9	7.8			0.8			
Guinea	nOPV2			0.6		3.2					5.1	
Kenya	nOPV2				3.8	3.0	0.1		0.9	0.9		
Liberia	nOPV2			0.9								
Mali	nOPV2			0.1		7.9						
Mozambique	nOPV2											21.6
Niger	nOPV2	7.8		7.7	7.9		8.1				8.3	8.4
Nigeria	nOPV2			20.6		77.6		8.2				
Sierra Leone	nOPV2			1.9								
South Sudan	nOPV2					3.5			3.6			
Uganda	nOPV2				3.3	3.4						
Zambia	nOPV2	2.3										
Zimbabwe	nOPV2					4.7						
Guinea	nOPV2 & bOPV					1.3			5.1			

Total children vaccinated by vaccine type:
bOPV: 28 111 738; nOPV2: 455 577 651; nOPV2 & bOPV: 6 341 300

Source: PEP SIA repository ©WHO AFRO

In addition, across the African Region, the infrastructure built to eradicate polio is proving invaluable in advancing broader public health priorities. In Madagascar, the polio programme played a pivotal role in declaring the cVDPV1 outbreak closed.

During a recent mass drug administration campaign, the infrastructure also helped health authorities reach an impressive 19 million people. Thanks to this integration, the campaign achieved its coverage targets, and saved US$ 1.4 million in operational costs.

Similarly, in Angola polio resources and personnel were swiftly repurposed to detect and respond to cholera and measles outbreaks. This same capacity for rapid deployment and coordination has supported the ongoing response to the measles outbreak in the Democratic Republic of the Congo.

Innovations included:

- GIS-based dashboards to improve microplanning and track vaccination activities in real time;
- Enhanced sequencing technologies and training in 15 countries;[32]
- A dedicated environmental surveillance unit to bolster early warning systems in Zimbabwe.

Polio transition:

- Malawi advanced national planning to embed capacity within the broader health system.

Laboratory and diagnostic systems

WHO also supported countries in strengthening diagnostics and laboratory systems, as core enablers of early detection and disease control. Six countries[33] established genomic surveillance laboratories for the first time, with WHO providing sequencing equipment, reagents and on-site training.

Through the Global Laboratory Leadership Programme (GLLP), 20 laboratory leaders across human, animal and environmental health sectors received strategic planning and management training.

Technical support was provided to Eritrea, Eswatini and Mauritius to develop national laboratory policies and strategies. In Eswatini, this included advancing medical imaging through the development of new policies, guidelines and standard operating procedures.

WHO also:

- Conducted two rounds of the microbiology external quality assessment (EQA) programme, involving 22 national laboratories;
- Engaged in collaborations with WHO Collaborating Centres and the Emerging and Dangerous Pathogens Laboratory Network (EDPLN).

WHO partnered with the International Atomic Energy Agency and other stakeholders to define a regional imaging agenda. A baseline survey involving 46 Member States[34] was completed, with results expected by the end of 2025.

32 Burkina Faso, Burundi, Central African Republic, Ghana, Comoros, Eritrea, Kenya, Liberia, Mali, Mauritius, Nigeria, South Africa, Togo, Uganda, Zambia

33 Burundi, Central African Republic, Comoros, Eritrea, Liberia, Togo

34 Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Central African Republic, 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, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, Togo, Uganda, Zanzibar (United Republic of Tanzania), Zambia, Zimbabwe

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2.7 Mainstreaming gender, equity and human rights

WHO worked with Member States to embed gender, equity and human rights into national health systems by identifying and addressing structural barriers to care.

All 47 countries in the Region received support to apply WHO's Rapid Assessment of Legal and Regulatory Frameworks (RALF) tool. This process helped identify laws and policies that influence equitable access to health services, especially for women, adolescents and people with disabilities. As a result, countries such as Ethiopia and Ghana have initiated legal reforms to better align their health systems with rights-based and equity-focused approaches.

WHO also helped countries integrate gender-sensitive elements into health policies and essential service packages.

Examples:

- Namibia and Uganda revised reproductive health and adolescent health policies to better support girls, survivors of gender-based violence and people living with disabilities.
- Health workers received training through the 2gether4SRHR platform and regional initiatives, promoting respectful and inclusive care.

These efforts were especially critical in humanitarian and fragile settings, where social exclusion often compounds health risks.

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Guinea received official WHO validation in January 2025 for eliminating gambiense human African trypanosomiasis (HAT), or sleeping sickness, as a public health problem.

COUNTRY SPOTLIGHT: GUINEA

Guinea eliminates sleeping sickness as a public health problem

In a remarkable public health victory, Guinea received official WHO validation in January 2025 for eliminating gambiense human African trypanosomiasis (HAT), or sleeping sickness, as a public health problem. The milestone marks the first time the country has succeeded in eliminating a neglected tropical disease, placing it among a small group of African nations to have accomplished this feat.

Once endemic in coastal regions like Boffa, Dubréka and Forécariah, the disease was a deadly threat in the early 2000s, with more than 100 confirmed cases annually. Communities of fishers, farmers and salt harvesters were particularly at risk, while poor access to remote villages and weak health infrastructure hindered case detection and treatment.

Over two decades, WHO provided sustained technical leadership and operational support to help Guinea reverse the trend. In 2002, the Organization supported the Ministry of Health in launching a national elimination programme (PNLTHA) and building an integrated, data-driven response. Mobile screening teams, laboratory staff and clinicians were trained and equipped to detect and treat patients using the latest tools, from field-friendly rapid diagnostic tests to new oral therapies such as fexinidazole.

At the same time, WHO helped pilot a vector control strategy using thousands of insecticide-treated "tiny targets" to reduce tsetse fly populations in high-risk zones. Research on animal reservoirs, asymptomatic carriers and spatial mapping refined the response, while community networks ensured strong local engagement.

By 2023, reported cases had fallen to just 24 nationwide, down from a peak of 140 in 2017. This decline brought cases below the WHO threshold of one case per 10 000 population in all endemic districts for six consecutive years. Passive detection through health facilities now accounts for more than half of new cases, reflecting a strengthened national surveillance system.

Going forward, Guinea plans to build on this momentum by integrating HAT into broader skin-NTD surveillance programmes, targeting micro hotspots through reactive strategies and expanding community-led vector control initiatives. With WHO's continued support, the country aims to reach zero transmission by 2030, providing a replicable model for regional elimination efforts across West Africa.

3

Strategic priority 2:

Health emergencies – protecting populations from health threats

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Key achievements:

All 47 countries
submitted IHR State Party reports for the eighth consecutive year

13 million+ people
reached with oral cholera vaccines in eight countries

34 countries
completed a second joint external evaluation (JEE)

100 000+ frontline health workers
vaccinated against Ebola

US$ 66 million+
pledged by African countries and partners for regional health security

26 countries
supported to develop or update infection control and prevention (IPC) plans

Three viral haemorrhagic fever outbreaks
successfully contained
with no cross-border spread

39 countries
received US$ 5 million worth of emergency supplies within three days

2300 (77% of target)
AVoHC-SURGE responders trained and ready to deploy in 24–48 hours

400+ experts
deployed to support response to emergencies

88 public health events monitored
including five Level 3 emergencies

The WHO African Region continued to contend with a high volume and diversity of public health emergencies, as both acute outbreaks and protracted crises shaped the response landscape.

Events, ranging from cholera and mpox, to conflict-driven humanitarian crises, placed immense pressure on already overstretched health systems, highlighting the critical need for robust preparedness, effective coordination and rapid deployment capabilities.

WHO and Member States made considerable gains in preparedness, surveillance, response coordination and integrated service delivery.

These challenges notwithstanding, WHO and Member States made considerable gains in preparedness, surveillance, response coordination and integrated service delivery, underlining the need for sustained investment in preparedness and integrated risk management.

3.1 Preparing for all hazards

Significant progress was made across the Region in strengthening health emergency preparedness. All Member States completed their State Parties Self-Assessment Annual Reporting (eSPAR), with 30[35] now having completed second-round Joint External Evaluations (JEEs). Twelve countries[36] also updated their national action plans for health security (NAPHS), signalling stronger national leadership in risk management and strategic planning.

To ensure readiness for future pandemics, WHO supported simulation exercises in 12 countries[37]. These exercises helped to test cross-border coordination mechanisms and identify gaps in multisectoral preparedness. WHO also facilitated intra-action reviews in nine countries[38] and after-action reviews in five[39], helping to translate outbreak response experiences into long-term improvements.

In a significant step forward, 10 countries[40] adopted WHO's Preparedness and Readiness for Emerging Threats (PRET) framework, with Cameroon and the United Republic of Tanzania revising their preparedness plans by incorporating scenario-based modelling and surge planning tools.

35 Angola, Botswana, Benin, Burkina Faso, Burundi, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Gambia, Ghana, Guinea, Kenya, Liberia, Mali, Mauritania, Malawi, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, South Sudan, United Republic of Tanzania (including Zanzibar), Togo, Uganda, Zambia

36 Benin, Burkina Faso, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Guinea, Ethiopia, United Republic of Tanzania, Uganda

37 Burundi, Central African Republic, Côte d'Ivoire, Eritrea, Ethiopia, Ghana, Guinea Bissau, Namibia, Senegal, Togo, Uganda, Zimbabwe

38 Burundi, Central African Republic, Côte d'Ivoire, Eritrea, Ethiopia, Guinea Bissau, Senegal, Togo, Uganda

39 Kenya, Nigeria, Uganda, Zambia, Zimbabwe

40 Angola, Botswana, Côte d'Ivoire, Guinea, Guinea Bissau, Mozambique, Sao Tome and Principe, South Sudan, Zambia, Zimbabwe

©WHO

By mid-2025, however, the outbreak had been contained to just two regions, and the national case fatality rate had fallen from 1.47% the previous year to 1.00%.

COUNTRY SPOTLIGHT: ETHIOPIA

Turning the tide on a complex cholera outbreak

At the start of the review period, Ethiopia was facing its worst cholera outbreak in years, affecting 11 regions. The health system, already under pressure from conflict, displacement and other emergencies was struggling to cope.

By mid-2025, however, the outbreak had been contained to just two regions, and the national case fatality rate had fallen from 1.47% the previous year to 1.00%. This remarkable turnaround reflects effective preparedness, swift action and strong coordination.

With technical and financial support from WHO, Ethiopia launched a new five-year National Action Plan for Health Security (NAPHS 2024–2028). Aligned with the International Health Regulations (IHR 2005), the plan outlined national priorities for risk mapping, workforce development and emergency coordination. The country also submitted its annual IHR self-assessment using the SPAR tool, an important milestone in global accountability.

As outbreaks surged, from cholera and measles to mpox, anthrax and malaria, Ethiopia's emergency response mechanisms were quickly activated. WHO helped deploy over 155 national and international experts to support the response to 107 disease alerts, all of which were investigated within 48 hours. In the hardest-hit areas, mobile teams coordinated surveillance, case management and community engagement efforts.

The cholera response proved to be a defining moment in Ethiopia's outbreak management. WHO supported the activation of a full incident management system (IMS), enabling real-time coordination between Federal and regional authorities. Targeted oral cholera vaccination, improved water and sanitation interventions, and enhanced logistics support helped bring the outbreak under control. The reduction in fatalities reflected not only better case management, but also stronger surveillance and supply systems.

At the same time, Ethiopia managed several other emergencies, including the Sudan refugee crisis, a circulating vaccine-derived poliovirus type 2 (cVDPV2) outbreak, and two protracted emergencies (dengue fever and relapsing fever), alongside non-graded events such as earthquakes and meningitis. WHO worked closely with the Ministry of Health and the Ethiopian Public Health Institute to maintain essential services and coordinate partner support in these complex settings.

Ethiopia's experience during the review period underscores the value of sustained preparedness, strong local leadership and rapid response. With WHO's continued support, the country not only confronted multiple emergencies head-on, but also strengthened the systems needed for long-term health security.

Vaccination preparedness also gained momentum:

- Over 101 000 frontline health workers were vaccinated against Ebola in two countries;[41]
- In eight high-risk countries,[42] more than 13 million people were reached with oral cholera vaccines (OCV), through innovative campaigns, including mobile outreach and integration with routine immunization in Malawi and Mozambique.

The link between health emergencies and climate risk became more apparent.

WHO helped 26 countries[43] to strengthen their national IPC plans, aligning efforts with the new global IPC strategy. In South Sudan, WHO provided tailored support to adapt IPC protocols to the country's fragile and conflict-affected setting.

The link between health emergencies and climate risk became more apparent. Five countries[44] received WHO support to incorporate epidemic preparedness into climate adaptation strategies, including early warning for floods, vector-borne diseases and environmental hazards.

41 Democratic Republic of the Congo, Sierra Leone
42 Angola, Ghana, Malawi, Mozambique, Nigeria, South Sudan, Zambia, Zimbabwe
43 Angola, Benin, Cameroon, Central African Republic, Chad, Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Ethiopia, Ghana, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritius, Namibia, Niger, Nigeria, Rwanda, Sierra Leone, South Sudan, Togo, Uganda, Zambia
44 Ethiopia, Kenya, Madagascar, Mozambique, Niger

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3.2 Assessing risk and sharing information

Between 2024 and 2025, WHO scaled up support to help countries map hazards, assess vulnerabilities and improve real-time alert systems.

Nine countries[45] completed subnational risk mapping exercises, enabling targeted contingency planning and more effective pre-positioning of supplies. With backing from WHO and Quadripartite partners, 20 countries[46] conducted One Health risk assessments. Uganda and the United Republic of Tanzania swiftly operationalized joint frameworks for managing zoonotic threats such as anthrax and avian influenza.

Nine countries[47] also advanced National Bridging Workshop roadmaps, establishing formal mechanisms for joint surveillance and coordinated rapid response.

Digital innovation played a central role:

- WHO supported 15 countries[48] to expand their real-time digital alert systems, many of which were integrated into existing integrated disease surveillance and response (IDSR) platforms;
- Nigeria and Senegal enhanced their data dashboards with geo-tagging features to track events and ensure faster reporting at the district-level.

Social listening emerged as an important tool. Ten countries[49] monitored social media and call centre data to detect and respond to community concerns and misinformation during outbreaks. These insights were then used to design more effective risk communication campaigns.

Across the African Region, high-level engagements reinforced shared priorities. Ministerial dialogues focused on strengthening national public health authorities, while a strategic meeting brought together 35 representatives from the African Group to coordinate regional positions on the Pandemic Agreement.

Meanwhile, Cameroon, Congo and the United Republic of Tanzania completed peer-led universal health and preparedness reviews, helping to extend national preparedness agendas beyond the health sector to encompass finance, security and public infrastructure.

45 Burundi, Central African Republic, Côte d'Ivoire, Eritrea, Ethiopia, Guinea Bissau, Senegal, Togo, Uganda
46 Benin, Burkina Faso, Cabo Verde, Central African Republic, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, South Africa, Togo
47 Cameroon, Guinea, Kenya, Liberia, Nigeria, Senegal, Sierra Leone, United Republic of Tanzania, Uganda
48 Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Cote d'Ivoire, Equatorial Guinea, Gabon, Ghana, Guinea Bissau, Lesotho, Madagascar, Sao Tome and Principe, Senegal, Zambia
49 Ethiopia, Gabon, Ghana, Madagascar, Namibia, Rwanda, South Africa, South Sudan, Togo, Zimbabwe

3.3 Timely and effective response to health emergencies

Table 2. Summary table of key active health emergencies in the WHO African Region (July 2024–June 2025)

#	Health emergency	Brief description (as of 30 June 2025)	Key public health actions
1	Humanitarian crisis in eastern Democratic Republic of the Congo regional spillover	Since January 2025, armed conflict in eastern Democratic Republic of the Congo has intensified, triggering a deepening humanitarian crisis. Nearly 4 million people have been internally displaced, with over 500 000 refugees seeking refuge in neighbouring countries. Cholera and mpox outbreaks further strain resources, complicating humanitarian access.	– Deployed an international incident manager and set up an effective integrated incident management team with rapid response teams – Supported care for 8000 patients with cholera – Administered 150 000 vaccines to protect vulnerable populations against preventable diseases – Distributed 50 000 water purification tablets
2	South Sudan Humanitarian Crisis	South Sudan is grappling with a cholera outbreak that has generated 70 000 cases, with a mortality rate of 1.8%, alongside severe malnutrition affecting 1.3 million children. Over 7 million people urgently need humanitarian assistance.	– Vaccinated 6.9 million people against cholera – Supported the treatment of 2000 children suffering from malnutrition – Established 10 cholera treatment centres, reducing mortality by 20%.
3	Cyclone Jude in Mozambique	Cyclone Jude displaced approximately 200 000 people and damaged 150 health facilities, severely disrupting health care delivery. As of June 2025, urgent efforts are needed to restore health services and reach affected communities.	– Distributed 2000 emergency health kits to restore access to care – Established 5 temporary clinics that served 10 000 patients.
4	Sudan Virus Disease (SVD) in Uganda	In Uganda, the Sudan virus disease outbreak lasted from 30 January to 26 April 2025, with 14 cases (12 confirmed and two probable) and four deaths (two confirmed and two probable). With no new infections reported in 42 consecutive days, the Ministry of Health (MoH) officially declared the outbreak over on 26 April 2025.	– Disbursed US$ 2.5 million from the CFE to cover critical areas of the response – Deployed 38 national and international experts and supported the MOH to deploy eight emergency medical technicians – Clinical trial of candidate vaccine rolled out within three days of outbreak declaration
5	Marburg virus disease outbreak in the United Republic of Tanzania	From 14 January to 13 March 2025, a Marburg virus outbreak in Tanzania's Kagera region caused 10 deaths from two confirmed and eight probable cases (100% CFR). Swift public health interventions helped prevent further spread, and the outbreak was officially declared over after 42 days without new infections.	– Disbursed US$ 1.5 million from the CFE to facilitate early action – Deployed 20 national and international experts to support fundamental pillars of the response – WHO shipped over 1.4 tonnes of essential medical supplies including diagnostic kits and personal protective equipment (PPE)
6	Cyclone Chido in Southern Africa (multiple countries)	Cyclone Chido made landfall in Mozambique on 15 December 2024, impacting 453 971 people, causing 120 fatalities. The storm damaged critical infrastructure, disrupted health care services and triggered urgent humanitarian needs across neighbouring countries (Comoros, Malawi, Mayotte and Mozambique, with the most severe impact reported in Comoros, Mayotte, Mozambique).	– Deployed mobile medical and laboratory teams with equipment and test – Donated medical supplies, including essential medicines, kits and tents to affected districts – Catalytic funding from APHEF US$ 992 056 to Mozambique (US$ 492 093) and Malawi (US$ 499 963) for critical lifesaving interventions
7	Humanitarian crisis in Cabo Delgado, Mozambique	In February 2025, the Cabo Delgado conflict in Mozambique displaced over 10 140 people. At least 32 reported incidents resulted in at least 25 deaths and 20 abductions, further disrupting humanitarian operations amid ongoing insecurity.	– Provision of interagency emergency health kits, including essential medicines, diagnostic tools, and supplies tailored for specific health emergencies, such as outbreaks or pandemics – Delivered 50 tonnes of nutritional assistance

#	Health emergency	Brief description (as of 30 June 2025)	Key public health actions
8	Regional spillover of the Sudan refugee crisis	The crisis in Sudan has displaced over 12.1 million people, including 7.7 million internally displaced persons (and 4.1 million refugees and returnees in neighbouring countries such as Chad, the Central African Republic, Ethiopia and South Sudan). This situation has triggered a severe humanitarian emergency, exacerbated by health challenges leading to outbreaks of cholera and hepatitis, while host countries struggle to provide adequate healthcare resources.	– Delivered over 280 tonnes of medical supplies, including cholera kits, emergency health kits, and trauma care materials – Central African Republic: WHO reopened 5 health centres for 30 000 people, managed 571 emergencies, deployed 10 outbreak kits and strengthened disease surveillance – Chad: WHO supported mobile clinics, mass measles immunization, and 1197 surgeries, distributing cholera and hepatitis E virus kits and training local IPC workers – Ethiopia: WHO deployed mobile teams for health and nutrition services, enhancing outbreak response and providing psychosocial support and sexual and reproductive health kits – South Sudan: WHO delivered 175 metric tonnes of cholera kits, installed water bladders, constructed latrines, coordinated cross-border surveillance, and established referral pathways for gender-based violence, with the United Nations Fund for Population Activities
9	Response to humanitarian crisis in northern Ethiopia	Ethiopia's humanitarian response targets 16 million people in need, amid ongoing conflict-related challenges. The health sector faces multiple outbreaks, including 58 508 cholera cases, increased malaria cases exceeding 360 000 weekly in 2024, and the hosting of 942 000 refugees.	– Delivered 672 metric tonnes of medical supplies valued at US$ 7.75 million to 30 implementing partners in 2024 – Deployed over 155 experts to address 107 disease alerts, investigating all within 48 hours – Cholera and immunization: Provided US$ 613 360 in cholera response supplies and led five rounds of oral cholera vaccination campaigns, vaccinating 4.58 million people (99% coverage)
10	Mpox (Public Health Emergency of International Concern)	As of 30 June 2025, 25 countries (Angola, Burundi, Cameroon, the Central African Republic, Congo, Côte d'Ivoire, the Democratic Republic of the Congo, Ethiopia, Gabon, Ghana, Guinea, Kenya, Liberia, Malawi, Mauritius, Nigeria, Rwanda, Sierra Leone, South Africa, South Sudan, the United Republic of Tanzania, Togo, Uganda, Zambia and Zimbabwe) had reported cases since January 2024, with 43 768 confirmed cases and 143 confirmed deaths (CFR=0.3%).	– Jointly with Africa Centres for Disease Control (CDC), WHO established the continental Incident Management Support Team and co-coordinated the response on the African continent – Trained 1500 health workers to strengthen detection and management of mpox – Shipped 12 tonnes of treatment kits, laboratory supplies and PPE to high-risk areas; and supported several health care facilities in managing and isolating cases – Enhanced vaccination campaigns reaching 500 000 people – Funding of US$ 5 million for rapid response and strengthened supply chain for mpox-related medical supplies
11	Marburg virus disease outbreak in Rwanda	Rwanda reported its first Marburg case in September 2024, implementing strict isolation measures that effectively curtailed further spread. The Marburg virus disease outbreak, officially declared on 27 September 2024, concluded on 20 December 2024, after recording 66 cases and 15 deaths, with no new cases reported over the subsequent 42 days. Notably, nearly 80% of the cases involved health workers. Rapid confirmation and isolation of cases underscored the effectiveness of Rwanda's public health response.	– Deployed 11 WHO experts and facilitated additional 39 teams of African Volunteers Health Corps – Strengthening and Utilizing Response Groups for Emergencies from Uganda, Liberia and Sierra Leone to ensure continuity of essential services – Procured and dispatched PPE, viral haemorrhagic fever kits and test kits worth US$ 650 000 to support diagnosis care and infection prevention and control – Catalytic funding of US$ 550 000 from the CFE to enable early action and further mobilized additional funding from the Foreign, Commonwealth & Development Office (GBP 486 127), European Civil Protection and Humanitarian Aid Operations (EUR 850 000), and United States Agency for International Development (US$ 1.7 million)

#	Health emergency	Brief description (as of 30 June 2025)	Key public health actions
12	Multi-country dengue outbreak	As of 31 March, 2025, the WHO African Region reported 13 508 dengue cases in 18 countries, with 1248 confirmed cases and 126 deaths. Peak transmission occurred in January with 6000 cases. Burkina Faso accounted for 66% of total cases.	– Held a five-day capacity-building webinar series on dengue preparedness and response for more than 500 professionals, featuring 20 international experts – Delivered 6.44 tonnes of supplies for diagnosis and case management to affected countries from Nairobi and Dakar hubs – Mobilized and secured US$ 2 million for dengue response – Deployed four senior entomologists and an epidemiologist to strengthen entomological surveillance
13	El Niño flooding in Southern Africa	Southern Africa faced the lowest mid-season rainfall in 40 years. Six countries (Botswana, Lesotho, Malawi, Namibia, Zambia and Zimbabwe) are under a state of emergency due to El Niño, impacting health services for 8 million people and increasing food insecurity and disease rates. More than 1.1 million children face severe malnutrition, with threats from cholera and mpox. Urgent coordinated responses are critical to address health needs in the sub-region.	– Distributed 10 000 health supplies to vulnerable families – Activated emergency operations centres and health clusters to ensure effective coordination with local partners – Performed rapid health assessments and deployed multidisciplinary rapid response teams – Performed risk communication and community engagement to enhance early detection and prevent outbreaks
14	Cyclone Gamane in Madagascar	Cyclone Gamane struck Madagascar on 27 March 2024, impacting over 200 000 and causing extensive disruptions to health services and food supply chains. More than 100 000 people in 15 districts required urgent aid. Diarrhoea incidence rose among children (26.5 cases/100 000) and malaria cases reached 80 387, a 50% increase.	– Mobilized US$ 300 000 from the CFE and US$ 300 000 from the Central Emergency Response Fund – Established 17 mobile clinics and deployed 40 trained health workers – Distributed five interagency emergency health kits, including essential medicines and cholera and malaria kits – Continued the distribution of more than 500 long-lasting insecticide-treated nets, 2000 rapid diagnostic test kits, 10 investigation kits and two laboratory kits
15	Multi-country cholera	There have been 142 895 cases and 2861 deaths from the cholera outbreak in the African Region, which has affected 20 countries and necessitated immediate public health interventions to mitigate the spread and promote sanitation practices.	– Vaccinated more than 6.9 million individuals against cholera in six countries to improve protection – Facilitated rapid containment in Angola by deploying six experts to strengthen the response – Deployed critical supplies worth US$ 214 801 from the Dakar hub to affected countries in the sub-region – Established 1000 rapid diagnostic testing locations
16	Multiple country anthrax	An anthrax outbreak in several African countries resulted in 300 reported cases, requiring urgent public health interventions to avert further spread and ensure effective management of affected individuals.	– Enhanced laboratory capacities with 50 new test kits – Conducted joint investigation and response in close collaboration with One Health partners under the leadership of host country governments
17	Cerebrospinal meningitis in Nigeria	In Nigeria, an outbreak of *Neisseria meningitidis* (meningococcus) serogroup C caused more than 1700 suspected meningitis cases, including 101 confirmed cases and 153 deaths in seven of 36 Nigerian states (Adamawa, Bauchi, Gombe, Jigawa, Katsina, Yobe and Zamfara) in 2024.	– To quell the deadly outbreak, a vaccination campaign was initiated in 2024 to initially reach more than 1 million people aged 1–29 years – Improved diagnostic testing, resulting in timely treatment for 750 individuals – Effective implementation of the WHO global roadmap to defeat meningitis by 2030
18	COVID-19	COVID-19 continues to impact public health systems globally, with over 200 million vaccine doses administered in Africa. Variants pose ongoing challenges for containment and healthcare delivery.	– Administered 200 million vaccines to over 100 million individuals – Strengthened health care systems through the provision of 10 million PPE kits – Integration of COVID-19 into routine primary health care. The transition led to the expansion of molecular testing platforms (e.g. Genexpert and polymerase chain reaction) and these are currently used in the mpox and outbreaks response – The response to and transition from COVID-19 facilitated the deployment of DHIS2, Go.Data and mobile reporting apps, enabling quicker testing, triage and referrals

The Region experienced 88 public health events , including 68 outbreaks and 20 humanitarian crises. Fifteen of these were formally graded by WHO, including five Grade 3 emergencies, which is the most severe classification.

Cholera remained the most common threat, with 22 countries[50] affected, particularly following floods or mass displacements. WHO provided technical guidance, supported rapid risk assessments and coordinated targeted outbreak responses.

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Building on past experience and capacities developed in countries, WHO supported Rwanda, Uganda and the United Republic of Tanzania in effectively responding to Marburg and Ebola outbreaks. All three were contained within 90 days, with no cross-border spread.

Mpox re-emerged in 18 countries[51], with human-to-human transmission documented in Burundi, the Democratic Republic of the Congo and Uganda. WHO worked closely with national authorities to strengthen case investigation, update isolation protocols and reinforce public health messaging.

In response to these and other threats, WHO:

- Activated its incident management system in multiple countries, deploying field teams and establishing country-level coordination hubs;
- Launched a new joint continental Incident Management Support Team with the Africa CDC;
- Deployed more than 400 surge experts, with over 60% mobilized within 72 hours of event grading;
- These experts included epidemiologists, IPC and water, sanitation and hygiene specialists, case managers, logistics coordinators and risk communicators.

WHO also worked closely with MoHs to train and equip Rapid Response Teams (RRTs). Recent rollouts in Burkina Faso, Kenya and Niger enabled faster outbreak containment at the district-level.

50 Angola, Burundi, Cameroon, Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Namibia, Niger, Nigeria, Rwanda, South Africa, South Sudan, United Republic of Tanzania, Togo, Uganda, Zambia, Zimbabwe

51 Burundi, Côte d'Ivoire, Congo, Democratic Republic of the Congo, Ethiopia, Ghana, Guinea, Kenya, Liberia, Malawi, Nigeria, Rwanda, Sierra Leone, South Sudan, United Republic of Tanzania, Togo, Uganda, Zambia

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Emergency kits, laboratory reagents, protective equipment and intravenous fluids were dispatched from WHO hubs, reaching crisis-affected countries within an average of three days.

WHO's regional supply chain system played a pivotal role in supporting these operations. Emergency kits, laboratory reagents, protective equipment and intravenous fluids were dispatched from WHO hubs in Nairobi, Dakar and Dubai, reaching crisis-affected countries within an average of three days – a significant improvement.

Mental health and psychosocial support (MHPSS) have become an integral part of emergency responses. WHO trained community workers in Burkina Faso, the Central African Republic and Mozambique in psychological first aid and distributed tools for managing acute stress, grief and trauma.

Integrated responses were prioritized. In Malawi and Zambia, WHO supported the delivery of cholera control measures alongside the restoration of immunization, maternal health and nutrition services. In Ituri, in the Democratic Republic of the Congo, similar models helped maintain health service delivery amidst displacement and conflict.

Public Health Emergency Operations Centres (PHEOCs) enabled real-time coordination and decision-making. WHO supported the activation and strengthening of PHEOCs in Malawi, Mozambique and Rwanda. In Mozambique, for example, the PHEOC became operational within 48 hours of a cholera alert, significantly reducing response times and improving multisectoral coordination.

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Uganda's rapid, coordinated response enabled it to end its sixth Ebola outbreak in record time, just 87 days after the Sudan virus was confirmed in the capital, Kampala.

COUNTRY SPOTLIGHT: UGANDA

Uganda shuts down Ebola outbreak in just 87 days

Uganda's rapid, coordinated response enabled it to end its sixth Ebola outbreak in record time, just 87 days after the Sudan virus was confirmed in the capital, Kampala.

The outbreak affected seven districts and three cities, including Mbale, Jinja and Fort Portal. A total of 14 cases were recorded; 12 confirmed and two probable. There were four deaths and 10 recoveries. More than 500 contacts were monitored and active surveillance was scaled up within hours of confirmation on 29 January 2025.

National emergency mechanisms were immediately activated. With support from WHO and partners, the Ministry of Health deployed 165 rapid response personnel to the affected areas. Isolation and treatment centres were established, surveillance and contact tracing were intensified, and screening was reinforced at 13 points of entry, including Entebbe Airport. Case management was supported by Emergency Medical Teams, while laboratory services were coordinated by Uganda's Central Public Health Laboratories and the Uganda Virus Research Institute. These institutions tested over 1500 samples.

Community engagement was pivotal. WHO deployed anthropologists, risk communication specialists and community health teams to address stigma, dispel misinformation and promote safe behaviours. These teams reached thousands of people with real-time, trusted information.

Despite the absence of a licensed vaccine for the Sudan strain, Uganda launched a clinical trial within four days of the outbreak being declared. The emergency use of remdesivir was approved, and patients were cared for using the best available supportive treatments.

WHO deployed 129 staff members and mobilized over US$ 7.3 million for the response. Supplies, emergency logistics and technical support were delivered rapidly to maintain momentum.

On 26 April 2025, after 42 days with no new cases, the Minister of Health, Dr Jane Ruth Aceng, declared the outbreak over.

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The result was a swift and effective response: just 84 days after the first case, Rwanda declared the outbreak over.

COUNTRY SPOTLIGHT: RWANDA

AVoHC-SURGE: Regional frontline expertise helps Rwanda halt Marburg

When Rwanda reported its first-ever case of Marburg virus disease in September 2024, WHO immediately activated its African Volunteer Health Corps– Strengthening and Utilizing Response Groups for Emergencies (AVoHC-SURGE) programme to support the national response.

A total of 39 seasoned public health professionals from Liberia, Sierra Leone and Uganda – countries with first-hand experience of tackling deadly filovirus outbreaks – were rapidly deployed to join Rwandan response teams on the ground. Their contributions were especially critical, as several local health workers had fallen ill or died in the early stages of the outbreak.

These AVoHC-SURGE experts brought a wide range of skills to the response, including IPC, case management, surveillance, logistics and community engagement. Working alongside WHO technical staff and national responders, they helped stabilize affected health facilities, support safe burials and improve coordination across response pillars.

Their presence filled urgent human resource gaps and ensured that life-saving interventions could continue uninterrupted. Beyond their technical expertise, the volunteers also fostered regional solidarity and peer-level trust, facilitating more effective collaboration with local teams in high-pressure situations.

The result was a swift and effective response: just 84 days after the first case, Rwanda declared the outbreak over. Only four cases were confirmed in total, and the spread was halted before the virus could gain a foothold.

The number of countries utilizing the regional IDSR platform for data-sharing increased to 37[52], enhancing regional collaboration and strengthening the timeliness and quality of public health information exchange. WHO also helped to strengthen laboratory linkages by improving sample transport and cold chain systems.

Cross-border coordination was essential. WHO facilitated joint planning among countries surrounding Lake Tanganyika and the Sahel, while bilateral coordination was reinforced between Burundi, the Democratic Republic of the Congo, Rwanda and the United Republic of Tanzania to coordinate surveillance for Ebola, Marburg and cholera.

Although 2024–2025 was a period of critical progress in health emergency preparedness and response, major challenges remain. Insecurity, logistical bottlenecks and underfunded response operations continue to limit reach and impact in some of the most vulnerable settings.

52 Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Central African Republic, Comoros, Equatorial Guinea, Eswatini, Gabon, The Gambia, Ghana, Guinea, Guinea-Bissau, Côte d'Ivoire, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Seychelles, Sierra Leone, South Africa, South Sudan, United Republic of Tanzania, Uganda, Zambia


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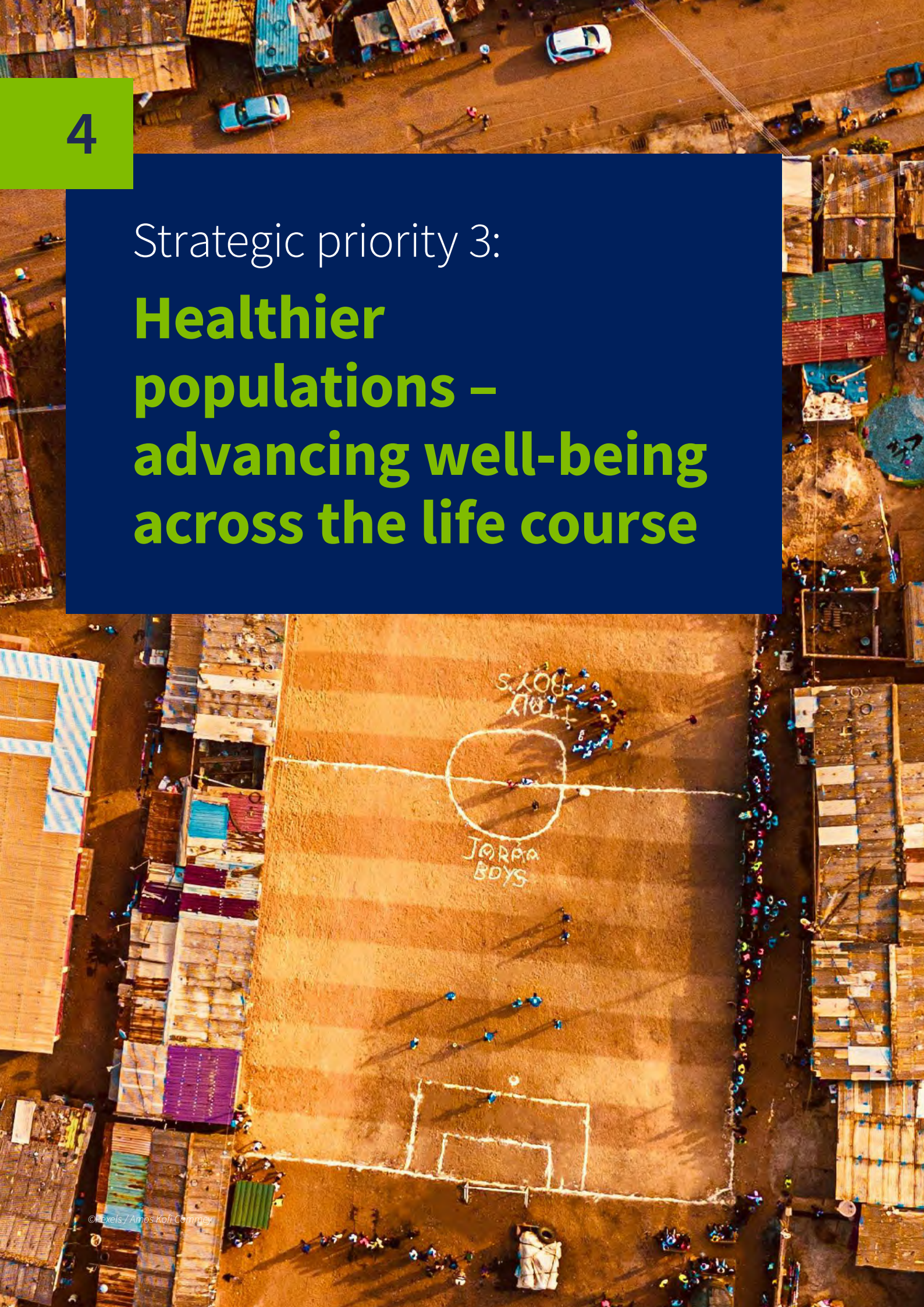
4

Strategic priority 3:

Healthier populations – advancing well-being across the life course



Key achievements:

200 000+ community health workers

were supported in 18 countries, expanding their roles in maternal care, the prevention of noncommunicable diseases and climate-smart health promotion

18 countries

updated national adolescent health strategies with youth input, expanding mental health services, digital access and school-based services

29 Ministers of Health

officially committed to build climate-resilient health systems

WHO built the capacities of

50 climate change and health experts

in the Region

29 countries

implemented at least four MPOWER measures, and

50 000 smokers

accessed cessation services

26 countries

updated their national nutrition strategies, and

15 countries

improved their national food control and surveillance systems

WHO supported

16 countries

in strengthening national coordination and trained more than

3000 health and emergency workers

in trauma and post-crash care

As the African Region continues to make progress towards UHC and health security, Member States are also increasingly turning their focus to addressing the broader social, environmental and behavioural conditions that influence people's health.

The healthier populations agenda promotes well-being across the life course, from infancy to older age, through prevention, behavioural change and healthier environments.

From July 2024 to 30 June 2025, WHO supported Member States in five priority areas: community engagement, climate and health, tobacco control, road safety, and nutrition and food safety.

4.1 Engaging communities

Communities are central to delivering lasting health outcomes. During the review period, WHO supported the implementation of the Regional Strategy for Community Engagement in the WHO African Region.

By mid-2025, 20 countries[53] had begun implementing the strategy, embedding behavioural insights, risk communication and community participation into health service delivery and emergency preparedness.

WHO placed a strong emphasis on developing and expanding the community health workforce, in line with the Yaounde Declaration. National strategies were scaled up to recruit and train community health workers (CHWs), with an expanded scope of practice in several countries.

Key achievements:

- In Ethiopia, Liberia and Malawi, community health workers were supported to take on new responsibilities, including:
  - Maternal health counselling.
  - Chronic disease screening.
  - Climate-smart health promotion.

53 Burkina Faso, Cameroon, Côte d'Ivoire, Chad, Ethiopia, Eswatini, The Gambia, Ghana, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mozambique, Rwanda, Senegal, Sierra Leone, South Africa, United Republic of Tanzania, Uganda

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Youth and adolescent engagement gained momentum through collaboration with the United Nations Fund for Population Activities, the United Nations Children's Fund and the Joint United Nations Programme on HIV/AIDS. This contributed to the revision of adolescent health strategies in Kenya, Madagascar and Sierra Leone.

WHO promoted community health scorecards to encourage local accountability. These tools were used to:

– improve immunization outreach

– reduce medicine stockouts

– support respectful maternity care.

In fragile and conflict-affected regions, WHO helped establish community health committees to maintain services and build trust.

In fragile and conflict-affected regions such as the east of the Democratic Republic of the Congo and Cabo Delgado, Mozambique, WHO helped establish community health committees to maintain services and build trust. These committees coordinated mobile outreach and engagement with displaced populations.

The "Big Catch-Up" immunization campaign demonstrated the effectiveness of community-driven health promotion. By partnering with faith-based organizations, traditional leaders and grassroots groups, Member States increased vaccination uptake and reached children who had not received any vaccines.

4.2 Climate change and health

Climate change is already reshaping health outcomes across Africa. Rising temperatures, extreme weather events and shifting ecosystems are fuelling disease outbreaks, displacing communities and putting pressure on health systems.

Key actions and outcomes:

- 29 countries[54] received technical support to draft or implement Health National Adaptation Plans (HNAPs) following their commitment to the Climate and Health Initiative launched at COP26;
- Regional training workshops strengthened the capacity of ministries and 50 technical experts to use climate data for public health planning.

Countries developed early warning systems linking weather forecasts to public health responses.

Countries such as Ethiopia, Malawi and Zimbabwe developed early warning systems linking weather forecasts to public health responses. These systems aim to help predict outbreaks of cholera, malaria and heat-related illness.

In Botswana, Liberia, Mauritania, Mozambique and Rwanda, WHO supported vulnerability assessments of health systems in regard to climate change, and helped to prioritize investments to build resilience. In Guinea, Nigeria and Uganda, national assessments informed the development of roadmaps for transitioning to low-carbon health systems.

WHO worked closely with the Africa Centres for Disease Control and Prevention (Africa CDC) and the African Union on the Africa Climate and Health Strategy, which was endorsed in 2024. This provides a regional framework for coordinated action and elevates health in climate policy negotiations.

Additionally, the Framework for Building Climate-Resilient and Sustainable Health Systems in the WHO African Region (2024–2033) was approved by the 74th WHO Regional Committee for Africa. It aims to:

- Strengthen national capacities to build sustainable, resilient health systems;
- Promote integration through tools like Vulnerability and Adaptation assessments, national action plans (NAPs) and health national adaptation action plans (HNAPs);
- Mobilize leadership, governance and resources for implementation.

WHO also supported Member States to prepare funding proposals. In 2024:

- Mauritius successfully secured funding through the Green Climate Fund;
- Four additional proposals covering up to 10 Member States were submitted to the Adaptation Fund.

54 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, Zimbabwe

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The need for a health system capable of responding to climate variability has never been more urgent.

COUNTRY SPOTLIGHT: MAURITIUS

Mauritius tackles health risks from climate change

As one of the world's most exposed countries to disasters, Mauritius faces an increasing number of health threats from climate change, including a rising number of climate-sensitive diseases and worsening chronic health conditions. With more than 9000 cases of dengue reported in 2024 – the first such outbreak ever recorded in the country – and the re-emergence of chikungunya in 2025 after nearly two decades, the need for a health system capable of responding to climate variability has never been more urgent.

However, the health sector lacked a robust evidence base until recently, to guide climate adaptation and early warning efforts. Recognizing this, WHO supported Mauritius in undertaking its first comprehensive climate and health vulnerability and adaptation assessment, based on the methodology of the Fifth and Sixth Reports of the Intergovernmental Panel on Climate Change and WHO's six health system building blocks.

The assessment analysed four categories of climate-sensitive health threats: vector-borne diseases (such as dengue, chikungunya and lymphatic filariasis), water-borne illnesses, respiratory diseases and nutrition-related risks. It also evaluated the sensitivity, exposure, adaptive capacity and hazards of the heath system in Mauritius's five health regions. This work yielded a climate-health risk map offering clear guidance on priority action.

The assessment also laid the groundwork for an early warning alert and response system (EWARS) tailored to climate-sensitive diseases. The EWARS is designed to predict disease outbreaks using weather-based triggers, enabling timely vector control and preventive action. Roadmaps are under way, and a pilot is planned for April 2026.

In addition, the project has catalysed the development of a health national adaptation plan to ensure that health is fully integrated into the country's broader national climate strategies. Capacity-building efforts have also strengthened the ability of health planners and policy-makers to consider climate risks when planning programmes.

These efforts represent a significant shift in how Mauritius approaches the intersection of health and climate. With support from WHO, the country is developing the tools, strategies and institutional frameworks to protect its population from the health effects of climate change, both now and in the future.

4.3 Tobacco control

Tobacco remains one of the leading preventable causes of death in the African Region, with increasing marketing targeting young people and new users. WHO has supported 34 countries[55] to implement the WHO Framework Convention on Tobacco Control and its MPOWER[56] strategies.

Major milestones:

- 29 countries[57] implemented at least four of the six MPOWER measures at the national level;
- 22 countries[58] are on track to reduce tobacco use by 30% by 2025 (compared to 2010 levels).

WHO worked with several countries to strengthen their legislation and services:

- Angola, Comoros and Côte d'Ivoire adopted new laws on smoke-free environments, advertising bans and graphic health warnings;
- Ghana and Senegal introduced digital cessation tools and national quitlines, enabling over 50 000 smokers to access free counselling and treatment.

Taxation remained a key policy lever. In 2024, 12 countries[59] raised tobacco excise taxes, with the support of WHO. These efforts are expected to:

- Reduce tobacco use;
- Increase domestic revenue for health systems.

To address the emerging threats posed by e-cigarettes and heated tobacco products, 17 countries[60] received regulatory guidance. Over 375 multi-agency law enforcement officers were trained to enhance compliance at national and subnational levels.

WHO also promoted alternative livelihoods for tobacco farmers. In Kenya and Zambia, more than 13 000 people were assisted to transition to healthier and economically-viable crops, enhancing income, nutrition and environmental sustainability.

In Kenya and Zambia, more than 13 000 people were assisted to transition to healthier and economically-viable crops.

Tobacco control was integrated into broader health promotion:

- Workplace wellness, school health and media literacy programmes were enhanced in countries such as Ethiopia and Eswatini;
- In Cameroon, Mozambique and the United Republic of Tanzania, WHO helped strengthen enforcement through multisectoral task forces and mobile reporting tools.

55 Algeria, Benin, Botswana, Burkina Faso, Burundi, Cabo Verde, Cameroon, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Ethiopia, Gabon, Gambia, Ghana, Kenya, Liberia, Madagascar, Mali, Mauritius, Mauritania, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, South Africa, United Republic of Tanzania, Togo, Uganda, Zambia

56 MPOWER (Monitor tobacco use and prevention policies, Protect people from tobacco smoke, Offer help to quit tobacco use, Warn about the dangers of tobacco, Enforce bans on tobacco advertising, promotion, and sponsorship, and Raise taxes on tobacco)

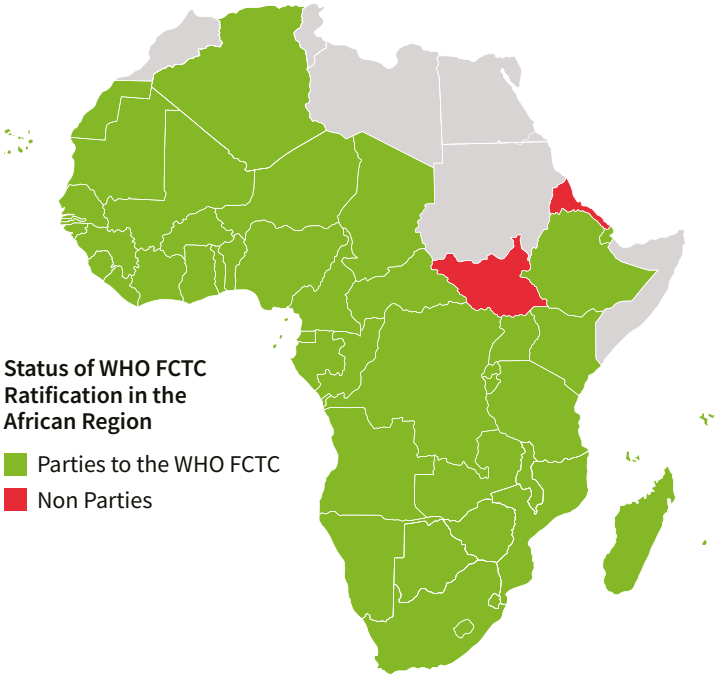
57 Algeria, Benin, Botswana, Burkina Faso, Cabo Verde, Cameroon, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gabon, Gambia, Ghana, Kenya, Liberia, Madagascar, Mauritius, Mauritania, Namibia, Niger, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, Togo, Uganda, Zambia

58 Burkina Faso, Benin, Burundi, Cameroon, Cabo Verde, Comoros, Côte d'Ivoire, Gambia, Ghana, Guinea-Bissau, Kenya, Liberia, Mali, Malawi, Mauritania, Nigeria, Senegal, Sierra Leone, United Republic of Tanzania, Togo, Zimbabwe, Uganda

59 Cabo Verde, Côte d'Ivoire, Ethiopia, Gabon, Gambia, Kenya, Mauritius, Senegal, Sierra Leone, South Africa, Zambia, Uganda

60 Algeria, Benin, Botswana, Burundi, Cabo Verde, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gabon, Gambia, Mauritius, Mauritania, Nigeria, Senegal, Sierra Leone, Uganda

Fig. 1. **Status of ratification of the WHO Framework Convention on Tobacco Control in the WHO Africa Region, 2025**



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4.4 Road safety

Road traffic injuries are among the top five causes of death in the Region, particularly affecting young people, pedestrians and cyclists. WHO supported evidence-based strategies aligned with the Decade of Action for Road Safety 2021–2030.

The key results are:

- Fifteen countries[61] reviewed their alcohol control policies, including drink-driving prevention;
- Burkina Faso and Ghana updated their road safety policies using WHO's Save LIVES road safety technical package.

Improvements in data and trauma care included:

- Establishing trauma registries and crash surveillance systems in Benin, Sierra Leone and Uganda to inform speed control and emergency response;
- Training of over 3000 emergency responders and health workers in Ethiopia, Namibia and Nigeria in triage, referral and psychological first aid.

Several countries incorporated road safety modules into primary health care emergency preparedness.

WHO also supported:

- Infrastructure safety upgrades in Mozambique and Togo, including speed humps, school zones and pedestrian crossings;
- Public awareness campaigns targeting seat belt, helmet use and responsible driving behaviour.

4.5 Nutrition and food safety

Malnutrition in all its forms continues to affect populations in the Region. WHO supported Member States in addressing undernutrition, obesity and food safety risks through multisectoral action.

Nutrition-specific highlights:

- 26 countries[62] updated or implemented national nutrition strategies focused on maternal, infant and young child nutrition;
- 12 countries[63] expanded services for managing acute malnutrition at the primary care level
  - Recovery rates reached 85% in Ethiopia and 92% in South Sudan.

61 Angola, Burkina Faso, Congo, Equatorial Guinea, Ethiopia, Gabon, Ghana, Kenya, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, Seychelles, Uganda

62 Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Guinea, Kenya, Madagascar, Malawi, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, South Africa, South Sudan, United Republic of Tanzania, Togo, Uganda, Zambia, Zimbabwe

63 Burkina Faso, Chad, Democratic Republic of the Congo, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Niger, Nigeria, Sierra Leone, South Sudan

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To address obesity and unhealthy diets:

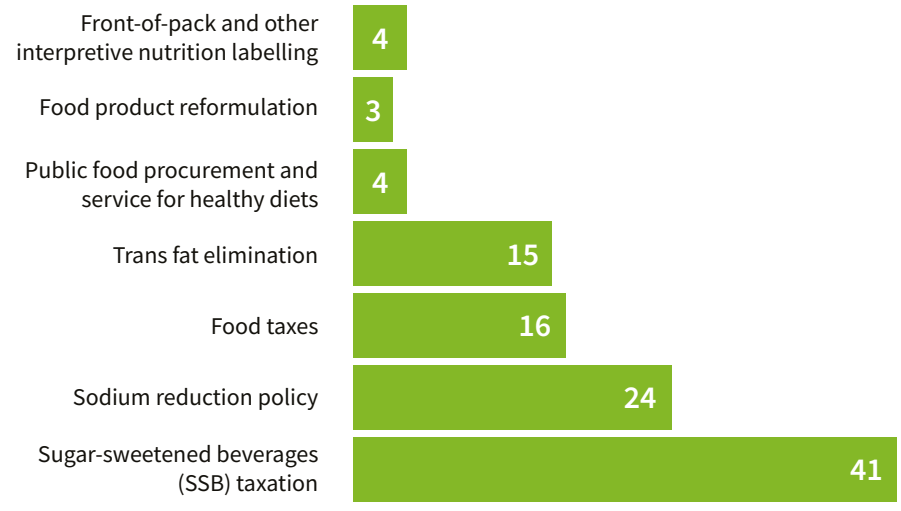
18 countries[64] developed food policies that included:

– front-of-pack labelling;

– regulation of unhealthy food marketing;

– nutrition in school health programmes.

Fig. 2. Number of countries in the WHO African Region implementing recommended policies to promote healthy diets



Source: The Global Database on the Implementation of Food and Nutrition Action (GIFNA), WHO

64 Botswana, Cameroon, Comoros, Democratic Republic of the Congo, Eswatini, Ghana, Kenya, Lesotho, Mauritius, Namibia, Nigeria, Rwanda, Seychelles, South Africa, United Republic of Tanzania, Uganda, Zambia, Zimbabwe

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Burkina Faso's progress demonstrates how targeted technical support and multisectoral collaboration can help maintain essential services in humanitarian settings.

COUNTRY SPOTLIGHT: BURKINA FASO

Improving nutrition access in crisis-affected areas

Escalating violence and insecurity in Burkina Faso have severely limited humanitarian access and disrupted essential health services, particularly in regions hosting large numbers of internally displaced persons. In this fragile context, addressing nutrition gaps has become a priority in order to prevent a further deterioration in health outcomes, particularly among children and women.

WHO supported the Ministry of Health in strengthening nutrition governance and service delivery at both national and community levels. A key achievement was revising the national protocol for managing cases of severe acute malnutrition, ensuring that it aligned with global standards and could be adapted to the country's evolving crisis settings.

To support informed planning, WHO helped to conduct a comprehensive review of nutrition data and needs in three of the worst-affected regions. These findings directly contributed to the development of Burkina Faso's new 2025–2029 National Nutrition Strategy. Meanwhile, over 350 national and regional decision-makers received training on integrating nutrition into crisis response and long-term health planning.

WHO also supported the expansion of community-based nutrition services to 120 sites in underserved areas. These services now provide screening, therapeutic care and education on infant and young child feeding, while addressing maternal undernutrition and food insecurity among displaced populations.

More than 250 health facilities now offer integrated nutrition and gender-based violence services, providing psychosocial and medical care to more than 50 000 survivors and thousands of other vulnerable individuals. The strengthened nutrition response complements wider health interventions, including immunization and malaria prevention.

Burkina Faso's progress demonstrates how targeted technical support and multisectoral collaboration can help maintain essential services in humanitarian settings.

Progress in food safety included strengthening food control systems, training food inspectors and improving laboratory testing capacity.

In Botswana and Mauritius, WHO supported the development of school meal standards and promoted healthy food environments. Eswatini and Mauritius developed integrated obesity prevention roadmaps through multisectoral consultations.

Progress in food safety included:

- Strengthening food control systems in 15 countries;[65]
- Training food inspectors and improving laboratory testing capacity;
- Enhancing surveillance systems, in partnership with Africa CDC.

Data systems and policy integration:

- WHO helped upgrade national nutrition information systems in four countries;[66]
- Nutrition indicators were incorporated into national health information systems and digital platforms such as DHIS2 were upgraded;
- Dashboards and monitoring frameworks were developed.

WHO also supported:

- Development of country profiles to track 2025 targets and plan for the 2030 global nutrition targets;
- Policy dialogue on issues including sugar-sweetened beverage taxation, breastfeeding protections and school feeding expansion.

65 Angola, Benin, Botswana, Burkina Faso, Cabo Verde, Central African Republic, Chad, Congo, Democratic Republic of the Congo, Gabon, Guinea-Bissau, Liberia, Malawi, Mauritania, Senegal

66 Côte d'Ivoire, Ethiopia, Uganda, Zambia

5

Integrated action for better health – African leadership, innovation and systems resilience

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Key achievements:

21 African Member States

pledge over US$ 21 million to WHO's Investment Round

20+ countries

advanced digital health strategies, with WHO support

US$ 113 million

mobilized through WHO AFRO's Crisis Response Resource Mobilization Plan

All 47 countries

completed GPW13 performance profiles

All 47 countries

adopted national AMR action plans

27 countries

submitted AMR data to WHO's global surveillance system

New partnerships struck

with UNITAID, the Children's Investment Fund and the Theophilus Yakubu Danjuma Foundation

Transformation of health in the African Region demands bold, African-led investment in the structural enablers of progress, including leadership, governance, financing, innovation, data, legal frameworks and partnerships. These cross-cutting domains are foundational to health outcomes. They determine how quickly innovations are adopted, how inclusively data is used, and how effectively systems respond to shifting needs and crises.

In 2024–2025, Member States reaffirmed their commitment to shaping the Region's health future, through significant financial investments, enhanced governance and decisive action in key areas. These included AMR, health research, digital transformation and data use. WHO's work across these enablers has bolstered the long-term agility, accountability and sustainability of national health systems.

5.1 African-led investment

"We are not just participating in global health transformation – we are leading it."

Dr Matshidiso Moeti,
WHO Regional Director Emeritus for Africa

A transformative shift in health leadership and ownership is underway across the Region. Since the launch of WHO's Investment Round in May 2024, 21 African Member States have pledged more than US$ 21 million towards shared regional priorities.

At the Seventy-fourth WHO Regional Committee for Africa (RC74) in August 2024, an additional US$ 45 million was committed, along with a further US$ 210 million at the Seventy-eighth World Health Assembly in May 2025.

Highlights:

New pledges came from Angola and Gabon for the first time and the United Republic of Tanzania doubled its previous contribution;

The pledges reflect strong trust in WHO's leadership and the value of flexible, predictable funding;

Countries prioritized investments in UHC, health systems resilience and pandemic preparedness, in a show of regional solidarity.

The following Member States of the WHO African Region made pledges:

Angola, Botswana, Cabo Verde, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Ethiopia, Gabon, Gambia, Ghana, Liberia, Mauritius, Namibia, Niger, Rwanda, Senegal, Seychelles, South Africa and the United Republic of Tanzania.

Africa played a leading role in shaping the Pandemic Agreement, which was adopted at WHA78.

The WHO Regional Office for Africa also launched a Crisis Response Resource Mobilization Plan (March 2025) to address funding shortfalls, with the following results:

- US$ 113 million was mobilized by June 2025;
- US$ 23 million was recovered through internal reprogramming;
- New partnerships established with the CIFF, UNITAID, TY Danjuma, WHO Foundation and the Susan Thompson Buffett Foundation.

Strategic private sector engagement was deepened in Côte d'Ivoire, Ethiopia and Ghana through high-level policy dialogues and technical missions. Advances in governance included the revision of the Rules of Procedure of the Regional Committee and the introduction of live, virtual forums for nominations of candidates for the position of Regional Director. Africa also played a leading role in shaping the Pandemic Agreement, which was adopted at the Seventy-eighth World Health Assembly.

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The result is Sao Tome and Principe's first National Health Financing Strategy (2025–2032), a landmark framework that has now been validated nationally and is moving towards legal endorsement.

COUNTRY SPOTLIGHT: SAO TOME & PRINCIPE

Financing health for the future

Until recently, Sao Tome and Principe faced a major obstacle on the road to UHC: the absence of a coherent and sustainable health financing system. Health funding was fragmented and heavily reliant on external sources. There was also a lack of a unified, evidence-based framework to guide investments.

Efforts to strengthen domestic resource mobilization were limited, and the country had no formal mechanisms to align financing decisions with national development priorities or fiscal realities.

Recognizing the need for reform, Sao Tome and Principe, with support from WHO and the UHC Partnership, embarked on a groundbreaking journey to reshape its health financing landscape. WHO led the country's first-ever Health Financing Progress Matrix assessment, providing technical expertise to analyse national health accounts, catastrophic expenditure patterns, and inefficiencies in resource allocation.

Building on these insights, WHO guided the establishment of a national health financing taskforce and facilitated strategic discussions between the Ministries of Health and Finance. These consultations helped shape a financing strategy reflecting the country's fiscal conditions, public health priorities and commitment to the Lusaka Agenda.

The result is Sao Tome and Principe's first National Health Financing Strategy (2025–2032), a landmark framework that has now been validated nationally and is moving towards legal endorsement. The strategy sets out a plan to increase domestic investment in health, particularly in primary health care, while protecting households from catastrophic out-of-pocket expenses.

The process also strengthened governance. For the first time, regular collaboration between health and finance authorities has been formalized, and a shared accountability framework is being developed. WHO's support extended to the public launch of the strategy, thereby boosting national ownership and state-level commitment to sustainable UHC.

Looking ahead, Sao Tome and Principe will focus on implementing the strategy, with WHO continuing to provide technical support. Key priorities include integrating health financing into budget cycles, increasing domestic resource mobilization, and maintaining cross-sector engagement to ensure long-term coherence and accountability.

5.2 Antimicrobial resistance (AMR)

AMR threatens decades of progress against infectious diseases and undermines health security. WHO has intensified its support in the areas of governance, surveillance, stewardship and public awareness.

Key achievements:

- All 47 Member States had developed and adopted national AMR action plans (NAPs);
- 27 countries[67] submitted data to the WHO Global Antimicrobial Resistance and Use Surveillance System (GLASS) platform, representing a 35% increase;
- WHO training and mentorship programmes have expanded laboratory surveillance in Cameroon, Ghana, Malawi and Uganda;
- 27 countries[68] strengthened laboratories with external quality assurance, in partnership with the National Institute for Communicable Diseases of South Africa.

One Health platforms were operationalized in Ethiopia, Nigeria and the United Republic of Tanzania, linking AMR action across the human, animal and environmental health sectors.

Behavioural change was a central focus:

- More than 40 countries hosted events to mark AMR Awareness Week 2024;
- AMR champions were launched in French-speaking countries to promote stewardship.

Antimicrobial stewardship (AMS) initiatives advanced in hospitals in Côte d'Ivoire, Senegal and Zambia. WHO helped to institutionalize prescription audits and promote digital tools for monitoring antibiotic use.

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67 Algeria, Benin, Burkina Faso, Burundi, Cameroon, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Eswatini, Ethiopia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritius, Mozambique, Namibia, Niger, Nigeria, South Africa, United Republic of Tanzania, Togo, Uganda, Zambia

68 Algeria, Angola, Burkina Faso, Cameroon, Cabo Verde, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, Ghana, Guinea Bissau, Kenya, Liberia, Malawi, Mali, Mauritania, Mauritius, Mozambique, Rwanda, Senegal, Seychelles, United Republic of Tanzania, Togo, Uganda, Zimbabwe

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5.3 Health research

Evidence-driven systems rely on robust, locally owned research ecosystems. WHO supported countries in strengthening governance, ethics and access to global knowledge.

Key results are:

- Survey of national research ethics committees completed in all 47 Member States;
- Legal reviews of ethics frameworks initiated in Mozambique and Rwanda;
- Over 30 countries expanded access to global databases (such as Hinari and Research4Life);
- Ghana and Malawi launched national research repositories.

WHO also helped to operationalize bio-risk management frameworks in Kenya and Uganda, aligning them with global standards for responsible life sciences research.

Continental collaboration advanced through the African Health Observatory Platform, which finalized a Country Health System Profile for Nigeria, with four more underway in Ethiopia, Kenya, Rwanda and Senegal.

5.4 Digital health and innovation

Digital transformation is enabling better diagnostics, data flow and service delivery. WHO supported 12 countries[69] to implement eHealth strategies and telemedicine initiatives.

Notable achievements include:

- Ghana, Kenya, Malawi and Rwanda expanded eHealth platforms to support electronic medical records, patient referrals, supply chain monitoring and COVID-19 after-action reviews of the response to the pandemic;
- Liberia and Sierra Leone piloted teleconsultation systems in rural districts;
- Senegal and Zambia conducted risk assessments on artificial intelligence;
- A regional guide on health data architecture and interoperability was launched;
- Over 400 health staff were trained in cybersecurity, telemedicine and data governance.

In the United Republic of Tanzania, community health workers were provided with mobile apps to improve the tracking of maternal health, while Uganda expanded its digital community-based surveillance platform.

> "Africa isn't just participating in the tech revolution – it's shaping it."
>
> Ngozi Okonjo-Iweala, Director-General, World Trade Organization

69 Botswana, Cabo Verde, Cameroon, Ethiopia, Guinea Bissau, Lesotho, Malawi, Mozambique, Nigeria, Rwanda, United Republic of Tanzania, Zambia

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Namibia is becoming a regional model for the sustainable control of AMR and for building a stronger, more resilient health system that aligns with the goals of UHC.

COUNTRY SPOTLIGHT: NAMIBIA

Namibia steps up fight against antimicrobial resistance

In June 2024, a 66-year-old patient in Windhoek presented with pneumonia that was resistant to all antibiotics except tigecycline. This served as a stark warning of the growing threat of AMR in Namibia. Determined to prevent such cases from becoming the norm, the Government of Namibia, with support from WHO's UHC Partnership, intensified its multisectoral AMR response over the following year.

Key actions during the review period included the national coordination workshop in October 2024, which brought together Ministries of Health, Agriculture, Environment and Water to reinforce the country's governance mechanisms and drive implementation of the National AMR Action Plan. This followed the submission of Namibia's first AMR surveillance data to WHO's GLASS platform in December 2023, after national teams had been successfully trained in the use of WHONET software.

Further operationalization of Namibia's Tripartite One Health Strategy (2024–2028) also occurred during this period. This strategy links AMR control to environmental and animal health alongside human health, ensuring a coordinated, cross-sectoral approach to health security and medicine stewardship.

These advances built on earlier investments. Namibia's first World Antimicrobial Awareness Week in 2021 marked a shift towards public engagement, followed by a national campaign in 2023 under the slogan "Antimicrobials: handle with care". This included school outreach, public marches and media engagement to raise awareness across sectors.

To strengthen clinical practices, Namibia launched its national infection prevention and control (IPC) action plan and guidelines in late 2023. WHO supported the rollout by providing hygiene training, distributing communication materials and integrating IPC into quality improvement systems.

Together, these efforts demonstrate Namibia's increasing leadership in addressing AMR through an integrated approach, encompassing governance, public engagement, clinical practice and surveillance. With continued support from WHO, Namibia is becoming a regional model for the sustainable control of AMR and for building a stronger, more resilient health system that aligns with the goals of UHC.

Emergency response innovations included:

- Real-time outbreak dashboards in the Democratic Republic of the Congo and Mozambique;
- Piloting of drone-supported medicine delivery in Madagascar.

Despite this progress, systems remain siloed. WHO is now supporting the development of integrated digital public health infrastructure and long-term investment roadmaps aligned with UHC.

5.5 Data analytics and knowledge management

WHO focused on strengthening data systems, equity analysis and regional knowledge platforms.

Data is a strategic asset for health systems. WHO focused on strengthening data systems, equity analysis and regional knowledge platforms.

Key developments:

- Country profiles for the Thirteenth General Programme of Work were produced for all 47 Member States;
- Countries used the profiles for policy dialogue and investment planning (for example, Ghana, Namibia, Togo);
- A regional data hub (RDHUB) is under development to enable real-time data aggregation and analytics.

Capacity-building in data analysis reached more than 250 planners and analysts, including in fragile states such as the Central African Republic and Chad. Standardization progressed with the broader adoption of international classifications and death certification protocols.

The deployment of the Health Equity Assessment Toolkit (HEAT) in more than 10 countries enabled disaggregated analysis of health indicators by income, geography, age, gender and disability. Countries such as Kenya and Zambia used HEAT outputs to refine service delivery plans and target investments more equitably.

Meanwhile, the African Health Observatory continued to evolve as the Region's leading health information platform. It published regional syntheses on maternal health, financing and the health care workforce, while also hosting dashboards and portals on neglected tropical diseases, emergency response and climate-sensitive diseases. Member States increasingly relied on the Observatory for peer benchmarking and research translation.

WHO also facilitated the digital transformation of health systems by providing multilingual online training tools. This enabled over 40 countries to implement the Family of International Classifications, thereby standardizing mortality and health data. Targeted support advanced verbal autopsy and medical certificate of cause of death protocols, thereby improving the accuracy of community and facility based death reporting.

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To close this gap, Ghana conducted its first nationwide WHO STEPS survey in 2024, marking a significant milestone in public health surveillance.

COUNTRY SPOTLIGHT: GHANA

Measuring what matters

In Ghana, noncommunicable diseases such as heart disease, diabetes and stroke account for nearly 45% of all deaths. However, until recently, the country lacked a complete and nationally representative picture of the risk factors driving this growing health burden.

To close this gap, Ghana conducted its first nationwide WHO STEPS survey in 2024, marking a significant milestone in public health surveillance. With technical and financial support from WHO, and support from the UK Foreign, Commonwealth & Development Office, the survey brought together key national stakeholders, including the Ministry of Health, the Ghana Health Service and the Ghana Statistical Services. WHO provided standardized tools, training and logistical support, including 168 glucometers, blood pressure monitors and tablets. This enabled real-time, quality-assured data collection in all 16 regions.

More than 160 field officers were trained in the STEPS methodology, biomarker collection and electronic data capture. In parallel, journalists received briefings to ensure the accurate public communication of results.

The survey gathered responses and biomarker data from 5438 adults aged 18–69. The findings, which were launched at a high-level event attended by over 400 people, revealed stark realities:

– 21.7% of adults had hypertension;

– 5.2% had elevated blood glucose;

– 23.1% had high cholesterol;

– 76% ate fewer than five servings of fruits and vegetables per day;

– 9.9% were physically inactive, with higher rates among women.

The survey also broke new ground in mental health and cancer screening surveillance. It found that 8% of Ghanaians experience depression and that 3.8% had considered suicide in the past year. For the first time, national data was also collected on oral health and cervical cancer screening.

The survey's findings are already informing policy dialogue, regional planning and academic research. Ten manuscripts are currently under peer review and tailored fact sheets have been developed for advocacy and public education.

6

Conclusion and looking ahead

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Despite one of the most severe funding crises in its history, WHO in the African Region continued to deliver impactful results in all 47 Member States. Between July 2024 and June 2025, Member States, with WHO's support, expanded access to essential services, launched new vaccination campaigns and responded to more than 160 public health emergencies.

These achievements, realized under significant operational and financial strain, are a testament to robust national leadership, resilient partnerships and WHO's steadfast dedication to country-driven priorities. They also affirm the Region's collective determination to protect lives and deliver on the promise of health for all.

Progress towards UHC and health security accelerated in key areas, including the elimination of neglected tropical diseases, the rollout of malaria vaccines and the expansion of community-based care. However, these gains remain fragile.

Health service coverage is uneven at subnational levels, the health workforce is under strain and foundational public health capacities remain chronically underfunded. The global funding crisis has exacerbated these issues, exposing systemic vulnerabilities and forcing difficult trade-offs.

Nevertheless, countries have adapted with agility and innovation. Digital tools have enhanced surveillance and response. Community structures have played a pivotal role in reaching vulnerable populations. Gender and equity frameworks have gained traction in national policy planning. These shifts signal a growing capacity for homegrown transformation.

Donors and global partners are urged to invest in African-led solutions that are already delivering measurable impact.

Strategic priorities for 2025–2026

Looking ahead, WHO will deepen its support for Member States by focusing on a clear set of strategic priorities aligned with the Fourteenth General Programme of Work, the Lusaka Agenda and the African Regional Frameworks:

Strengthen primary health care and essential public health functions to improve resilience and service equity;

Support domestic resource mobilization and financial sustainability through national investment strategies and reforms;

Expand digital and climate-smart innovations to accelerate access and adaptation in fragile contexts;

Advance gender, equity and rights-based approaches at all levels of policy and service delivery;

Improve data systems and knowledge use for accountability, planning and community engagement;

Foster multisectoral partnerships that align with national priorities and amplify regional impact;

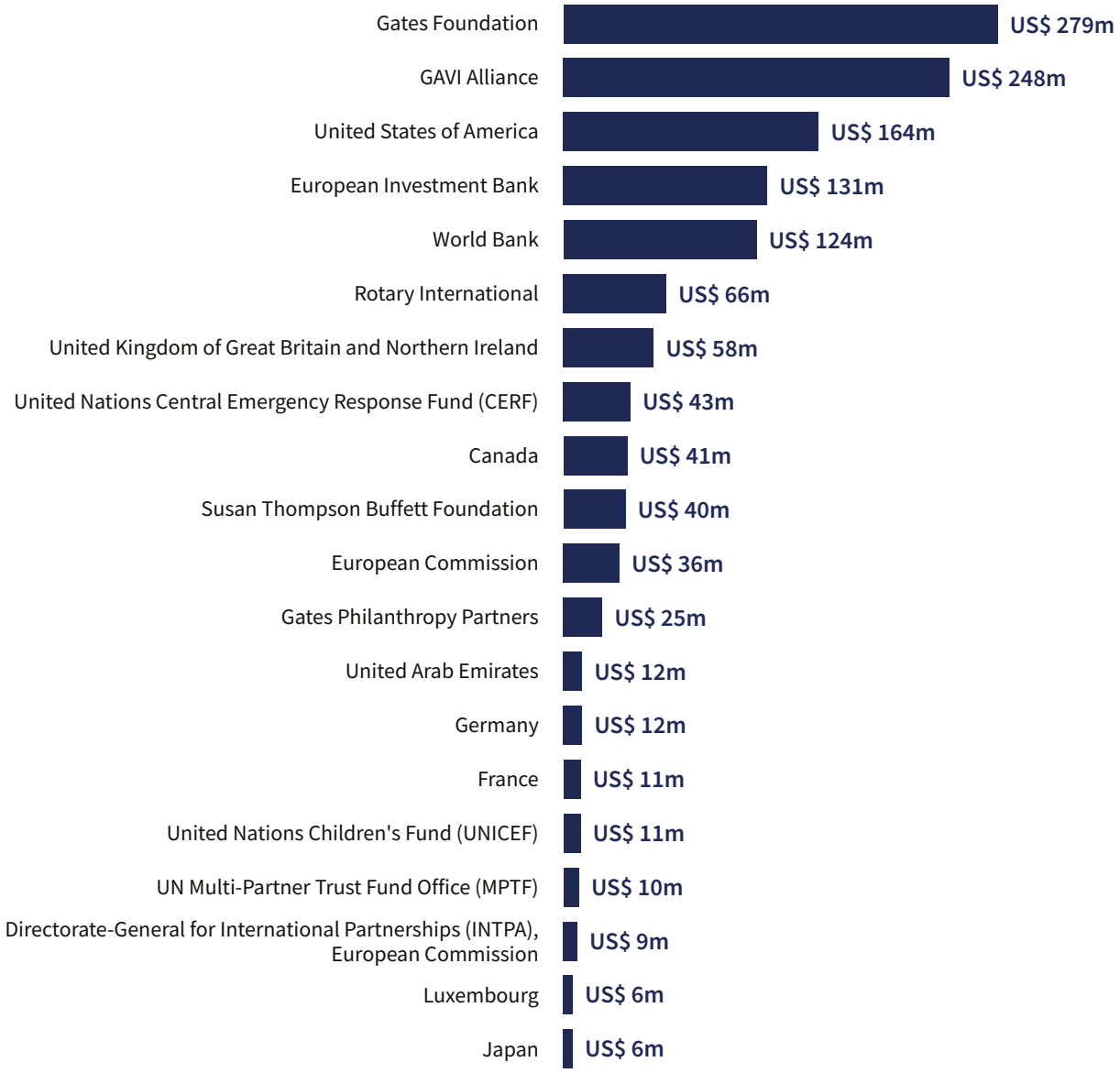
Build national capacity for emergency preparedness and response, particularly in conflict-affected and climate-vulnerable settings.

Achieving these goals will require greater coherence, predictable financing and shared accountability among all stakeholders. Donors and global partners are urged to invest in African-led solutions that are already delivering measurable impact.

Policy-makers should sustain reforms that strengthen system capacity, protect vulnerable populations and promote inclusive governance. For communities across the Region, the path forward means transformation that is anchored in equity, ownership and trust, not just recovery.

WHO remains committed to working alongside Member States to realize this vision of a healthier, safer and more self-reliant African Region, where no one is left behind.

Annex:
Top 20 donors to the Regional Office for Africa



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The WHO Regional Office for Africa

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Africa is one of the six regional offices throughout the world, each with its own programme geared to the particular health conditions of the Member States it serves.

Member States

Algeria
Angola
Benin
Botswana
Burkina Faso
Burundi
Cabo Verde
Cameroon
Central African Republic
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
Nigeria
Rwanda
Sao Tome and Principe
Senegal
Seychelles
Sierra Leone
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