The Work of the World Health Organization in the African Region

Report of the Regional Director,
1 July 2025–30 June 2026

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African Region

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Foreword


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Regional Director for Africa
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The year covered by this report — 1 July 2025 to 30 June 2026 – has been one of the most demanding in the recent history of our Region. It also marks the first full year of my mandate as Regional Director, during which the African Region began to chart a new course towards strengthened health sovereignty, enhanced emergency leadership and institutional reform. To us as a Region, health sovereignty means more robust national systems, greater regional manufacturing capacity, more resilient financing and African leadership in setting and implementing public health priorities.

During this period, the Region faced multiple converging health challenges rarely encountered simultaneously. These included the first-ever outbreak of Marburg virus disease in Ethiopia; the sixteenth Ebola virus disease outbreak in the Democratic Republic of the Congo; a multi-country Rift Valley fever event in Mauritania and Senegal. Alongside these diverse disease outbreaks, the Region maintained a response to sustained cholera, mpox and measles transmission.

The backcloth for all these pressures was the most significant financial reset of the World Health Organization in a generation. However, despite the ensuing unprecedented financial constraints, we protected core technical functions and maintained support to Member States while accelerating institutional reforms.

As this report goes to press, our Region is responding to its seventeenth outbreak of Ebola virus disease – caused by Bundibugyo virus – in Ituri Province, Democratic Republic of the Congo. I extend my deep appreciation to the health workers, communities and partners on the front line of that response, as well as to all those who led and supported outbreak responses across the continent throughout the year under review. The Region is indebted to your commitment and service.

The title of this report captures three core commitments that have guided our work over the past year. We delivered results: flagship outbreaks were brought under control within recommended timelines; tuberculosis deaths in the Region declined by 46% between 2015 and 2024; the African Small Island

Developing States Pooled Procurement Initiative received the 2025 United Nations SIDS Partnership Award in the Economic category; and Member States endorsed the Region's first comprehensive Oral Health Framework. We drove reform: the Regional Office used the financial pressures of the year under review to accelerate, rather than defer, the modernization agenda. Progress was made in strengthening prioritization, accountability, transparency, data and digital systems, and support to country-offices. The longer-term work of securing Africa's health future included advancing the Accra Reset and the Lusaka Agenda; supporting the implementation of the Pandemic Agreement and the 2024 amendments to the International Health Regulations, promoting the African Medicines Agency; developing the regional framework for local production; and deepening partnership with the African Union Commission and the Africa Centres for Disease Control and Prevention.

The year ahead will demand sustained effort and focus. We must bring the ongoing Ebola virus disease response in Ituri to a safe and complete close. We must consolidate the operating model established in the past 12 months and safeguard essential health services – including primary health care, immunization, noncommunicable diseases and emergency preparedness and response – from further erosion. At the same time, we must expand pooled procurement and local production beyond their current scope, and position the African Region coherently within the UN80 initiative and in the broader reform of the global health architecture. This will require alignment with the Fourteenth General Programme of Work and the African Union's New Public Health Order. Lastly, we must maintain our focus on the communities we serve. Behind every number in this report are lives protected, families supported and communities made more resilient.

I thank our Member States, partners across the United Nations system and global health initiatives, civil society, communities and the staff of the Regional Office and our country offices for their commitment throughout this exceptional year. I pay tribute to the memory of Dr Faustine Ndugulile, whose untimely passing led to this office being placed in my care, and to Dr Chikwe Ihekweazu for his stewardship during the transition.

Africa is ready. WHO in the African Region is ready to play its part.

Acknowledgements

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Abbreviations

AI	artificial intelligence
AIDS	acquired immunodeficiency syndrome
AMR	antimicrobial resistance
ASCEND	Accelerating the Sustainable Control and Elimination of Neglected Tropical Diseases
AU-IBAR	African Union Inter-African Bureau for Animal Resources
AUDA-NEPAD	African Union Development Agency–New Partnership for Africa's Development
AVMA	African Vaccine Manufacturing Accelerator
AVoHC-SURGE	Africa Volunteers Health Corps – Strengthening and Utilizing Response Groups for Emergencies
BVD	Bundibugyo (Ebola) virus disease
CARMMA (Plus)	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CCOM	Core Country Office Model
CEMAC	Central African Economic and Monetary Community
CFR	case fatality ratio
COVID-19	Coronavirus disease 2019
DHIS2	District Health Information System 2
DMPA-SC	depot medroxyprogesterone acetate – subcutaneous
DTP3	third dose of diphtheria-tetanus-pertussis vaccine
ECCAS	Economic Community of Central African States
ECDC	European Centre for Disease Prevention and Control
ECOWAS	Economic Community of West African States
ECSA-HC	East, Central and Southern Africa Health Community
EMRO	WHO Regional Office for the Eastern Mediterranean
ENDISA	Ending Disease in Africa
EVD	Ebola virus disease
EWENE	Every Woman, Every Newborn, Everywhere
FAO	Food and Agriculture Organization of the United Nations
G7	Group of Seven
GER	gender equality, health equity and human rights
GHO	WHO Global Health Observatory
GLASS	Global Antimicrobial Resistance and Use Surveillance System

GMC	Global Management Centre (Pretoria hub)
GPW14	Fourteenth General Programme of Work
HEAT & HEAT Plus	WHO's Health Equity Assessment Toolkit(s)
HIV	human immunodeficiency virus
HPV	human papillomavirus
IGAD	Intergovernmental Authority on Development
IHME	Institute for Health Metrics and Evaluation
IHR	International Health Regulations
IMST	Incident Management Support Team
IPC	Integrated Food Security Phase Classification (as cited in a Chapter 1 reference; not to be confused with "infection prevention and control", which is written in full throughout the report)
JEE	Joint External Evaluation
MOPAN	Multilateral Organisation Performance Assessment Network
NAPHS	national action plans for health security
NCD(s)	noncommunicable disease(s)
NTD(s)	Neglected tropical disease(s)
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OECD	Organisation for Economic Co-operation and Development
PABS	Pathogen Access and Benefit-Sharing (system)
PATH	A global health nonprofit organization; "PATH" is its proper name and is no longer used as an acronym
PDX	preparedness data exchange
PEN-Plus	Programme extending the WHO Package of Essential Noncommunicable Disease Interventions to severe noncommunicable diseases at first-level referral facilities
PHC	primary health care
PHEIC	public health emergency of international concern
PRSEAH	prevention of and response to sexual exploitation, abuse and harassment
RBM Partnership to End Malaria	Formerly "Roll Back Malaria"; RBM is retained as part of the partnership's current name
RC76	Seventy-sixth session of the Regional Committee for Africa
REC	regional economic community
RMNCAH	reproductive, maternal, newborn, child and adolescent health
SADC	Southern African Development Community

SAFER	WHO initiative to reduce alcohol-related harm (five areas of action: Strengthen restrictions on alcohol availability; Advance and enforce drink-driving counter-measures; Facilitate access to screening, brief interventions and treatment; Enforce bans on comprehensive restrictions on alcohol advertising, sponsorship and promotion; Raise prices on alcohol through excise taxes and pricing policies)
SDGs	Sustainable Development Goals (United Nations)
SIDS	Small Island Developing States
SPAR	State Party Self-Assessment Annual Reporting
STEPS surveys	STEPwise approach to noncommunicable disease risk factor surveillance
TrACSS	Tracking Antimicrobial Resistance Country Self-assessment Survey
UHC	universal health coverage
UN	United Nations
UN80	United Nations eightieth anniversary reform initiative
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNEP	United Nations Environment Programme
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UNHCR	United Nations High Commissioner for Refugees (the UN Refugee Agency)
UNICEF	United Nations Children's Fund
Unitaid	Global health initiative that invests in innovative health products, hosted by WHO
USAID	United States Agency for International Development
WAHO	West African Health Organisation
WASH	water, sanitation and hygiene
WCO	WHO country office
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organization
WHO PEN	WHO Package of Essential Noncommunicable Disease Interventions
WMO	World Meteorological Organization
WOAH	World Organisation for Animal Health
WUENIC	WHO/UNICEF Estimates of National Immunization Coverage

WHO Regional Director for Africa, Dr Mohamed Janabi, joins Tanzanian authorities to inaugurate a Maternal and Newborn Care Unit in Kwimba District, Mwanza Region – 28 February 2026-Tanzania

Executive summary

Regional context

During the reporting year, health services across Africa were kept running despite the deepest cut to international health funding in a generation, while several disease outbreaks were fought at the same time. Results held up far better than the scale of the funding cut alone would predict: **eight countries**[i] reached a major disease-elimination milestone, **71%** of outbreaks were detected within a week, and emergency responses left lasting infrastructure behind rather than disappearing once the crisis had passed. But the margin was thin, some results went backwards, and of the money pledged to close the remaining gaps, less than half had been supplied at the time of writing. What ministers and partners decide over the next year will determine whether this year's progress holds or is lost.

A year of change and challenges

International funding for health declined by approximately **20%** worldwide in a single year. The WHO African Region absorbed the largest share of that cut of any region, despite bearing the highest global burden of malaria and new HIV cases. These cuts affected a health workforce already operating at less than **50%** of required capacity, and their impact was uneven. Countries already dealing with conflict or displacement and those dependent on external funding were the hardest hit. Within those countries, the burden fell disproportionately on the most vulnerable, with women and children accounting for an estimated **80%** of the **12.7 million** people displaced by conflict in the reporting year in West and Central Africa alone.

The funding cut also coincided with an exceptionally complex operating environment. The Region faced several concurrent disease outbreaks, including Ebola, Marburg, mpox and a record wave of cholera, alongside worsening floods and droughts; and record levels of food insecurity. It was also the first full year in office for the Region's new Regional Director and of WHO's current four-year global strategy.

i. Algeria, Burundi, Cabo Verde, Guinea, Kenya, Mauritius, Senegal, Seychelles

Health system response and achievements

An estimated 21.7 million people living with HIV were maintained on uninterrupted treatment, and tuberculosis treatment coverage recovered to 74%, up from 52% in 2020.

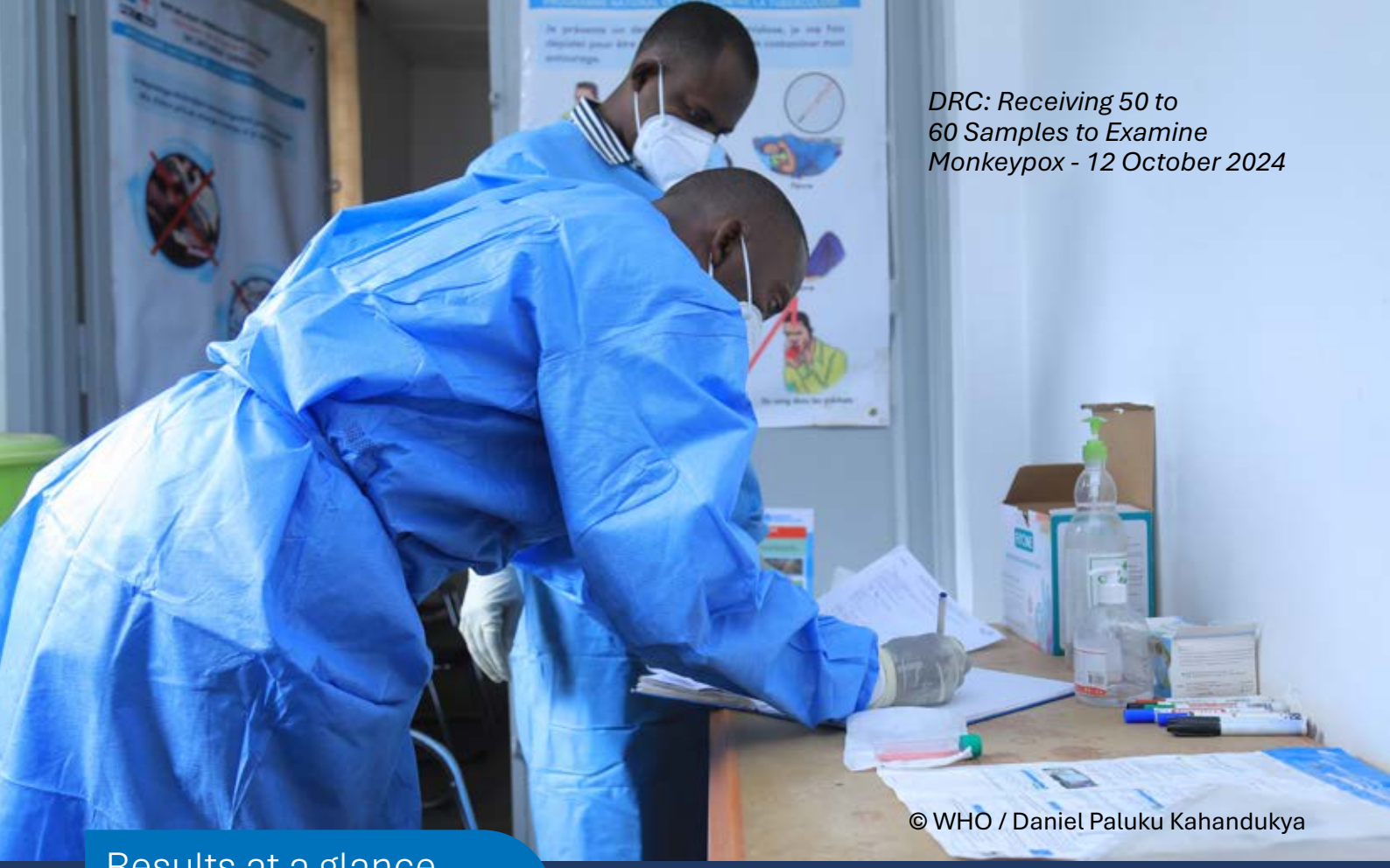
A total of 28.4 million doses of donated medicines for neglected tropical diseases were delivered despite a US$ 170 million funding freeze.

Eight countries reached major disease-elimination milestones this year, marking the best result in a decade – three eliminated trachoma, two eliminated sleeping sickness and three eliminated measles and rubella. Botswana became the first high-burden country globally to reach an advanced stage in stopping mother-to-child transmission of HIV.

In 2025, 71% of public health outbreaks were detected within one week of onset, continuing a steady improvement over several years and enabling faster control.

An Ebola outbreak in the Democratic Republic of the Congo was contained in 88 days; Ethiopia's first-ever Marburg virus outbreak was also contained in under three months; and the international emergency declared for mpox was lifted after cases fell by more than 60%. A separate Ebola outbreak – caused by a virus for which no licensed vaccine or treatment exists, making containment particularly challenging – continued to spread in the Democratic Republic of the Congo and Uganda at the time of reporting.

More than 20 000 residents of one Ebola-affected community in the Democratic Republic of the Congo gained access to improved water supply, solar power and a rebuilt hospital once the outbreak ended, an asset the community keeps long after the emergency has passed. The same principle applies at scale, as the laboratories and rapid response teams built to eliminate polio now also detect measles, yellow fever, mpox and cholera.



DRC: Receiving 50 to 60 Samples to Examine Monkeypox - 12 October 2024

© WHO / Daniel Paluku Kahandukya

Results at a glance

21.7 million people
kept on uninterrupted HIV treatment, through the year's funding cuts.

Eight countries
reached major disease-elimination milestones – the best result in a decade.

90 days
to control Ethiopia's first-ever Marburg outbreak

71% of outbreaks
detected within 7 days, up from far slower detection in past years.

88 days
to contain the Ebola outbreak in the Democratic Republic of the Congo

28.4 million doses
of donated medicines for neglected tropical diseases were delivered despite a US$ 170 million funding freeze.

US$ 769 million
in voluntary contributions raised in 2024–2025, as 22 of 47 countries pledged to WHO's first-ever global Investment Round.

23% smaller, 75% closer
WHO's Regional Office cut its own staffing by 23% and moved three quarters of remaining staff to country offices.

15 countries
reformed tobacco taxation. In Ghana, smoking fell by a third while tax revenue nearly quadrupled.

US$ 139 million
climate-and-health financing pipeline secured across 21 countries.

The role of WHO and partners

None of these results occurred in isolation. WHO set technical standards and guidance for disease programmes, supported countries to strengthen the detection and emergency-response systems that caught outbreaks faster, assisted in reforming how health financing is raised and managed, and represented the Region's interests in global decision-making. To this end, WHO restructured itself first. The Regional Office reduced both costs and staffing by **23%** during the year, from **2540 to 1948** personnel, and redeployed **three quarters** of its remaining staff to country offices closer to the ministries and communities it serves. That restructuring freed up more than **US$ 8 million** annually, now being redirected to country-level operations.

A broad range of partners contributed capabilities beyond those of WHO alone. The African Union and Africa CDC led continental strategy; Gavi, the Vaccine Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank and other financing institutions supported immunization, HIV, tuberculosis and malaria programmes directly; and United Nations agencies supported the humanitarian response to displacement. Noncommunicable diseases, including mental health, was supported by the Wellcome Trust, and The Leona M. and Harry B. Helmsley Charitable Trust, along with the NCDI Poverty Network.

Additional resources were mobilized. A total of **22 of the Region's 47 Member States** pledged funding to WHO's first-ever global fundraising round, and **48%** of those pledges had been converted into contributions by the close of the period, up from **12%** a year earlier. Voluntary contributions to the Region rose to **US$ 769 million** in 2024–2025, with a growing share now coming from private donors and foundations.

Continuing challenges

Four major problems remain unresolved. First, underfunding threatens core operations. Even after this year's pledges, WHO's basic running costs in the Region remain underfunded by **US$ 662 million** over the next two years. Patients still pay directly, out of pocket, for roughly **33%** of all health spending in the Region – a level high enough to push families into poverty in **35**[ii] **of 47** Member States.

Second, public health emergencies continue to escalate. The emergency threat has not passed. The particularly challenging Ebola outbreak described above was still spreading as this report was finalized, and cholera cases reached a regional record of more than **245 000** in 2025, driven primarily by unsafe water and sanitation.

Third, continuity of care remains a critical gap. Services that depend on repeated contact with the health system remain the weakest. Mental health support fell from an estimated **982 000 people** reached in 2024 to a projected **207 000** in 2025. Only **one country** meets the recommended standard of antenatal care for pregnant women, and noncommunicable diseases, already accounting for **37%** of all deaths, remain the most difficult health problem to monitor.

Fourth, data gaps obscure and health inequities. The Region still cannot reliably see who is being left behind. **Fourty-four of 47** countries have limited data on the actual causes of death among their populations, making it difficult to target the allocation of funds.

What needs to happen next

To close the funding gap, Member States must turn this year's pledges into actual disbursements on a fixed timetable, bring the remaining countries that have not yet pledged into the fundraising round and set a clear national timetable in each country for reaching the Region's long-standing target of spending at least **15%** of the government budget on health.

To resolve the remaining emergencies, countries need to bring the active Ebola outbreaks in the Democratic Republic of the Congo and Uganda to a complete and safe close and translate the response into lasting local capacity. They must also invest specifically in clean water and sanitation to achieve cholera elimination.

To strengthen services that are falling behind, and to resolve surveillance gaps, countries should fully implement surveillance systems that detect preventable maternal and newborn deaths, protect funding lines so that this year's elimination gains are not reversed, rebuild mental health support back to its previous levels, and ensure that every country reports basic health data disaggregated by sex and age within two years.

This calls for targeted action from each audience. Ministers should treat health as an investment, rather than a cost, by setting and funding national timetables towards the **15%** target, protecting essential front-line programmes that made this year's results possible from further reductions, and translating existing commitments on staffing and funding into filled posts and disbursed resources. Partners and donors must provide direct, predictable funding to national plans, rather than several separate projects; honour existing financial pledges, and invest in Africa's pharmaceutical manufacturing capacity.

The WHO African Region has demonstrated what it can deliver, even in its hardest year. Sustaining this year's progress now depends on adequate funding and honouring these commitments.

ii. Algeria, Angola, Benin, Burkina Faso, Burundi, Cabo Verde, Cameroon, Central African Republic, Chad, Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Mali, Mauritania, Mauritius, Niger, Nigeria, Republic of the Congo, Senegal, Seychelles, Sierra Leone, South Sudan, Togo, Uganda and the United Republic of Tanzania

Sexual Reproductive Health Outreach in Samburu, Kenya

©Genna Print / WHO

WHO delivers essential medical supplies to Rubaya, North Kivu, Democratic Republic of the Congo – 11 February 2026

©WHO / Daniel Paluku

Chapter 1.

Setting the scene: the forces reshaping health in the African Region

At the beginning of the reporting period of 1 July 2025 to 30 June 2026, the WHO African Region bore approximately one-fifth of the world's disease burden with about one-seventh of its population *(1)*. In the ensuing 12 months, nearly all external assumptions that had underpinned the health response in the Region in the previous two decades were immediately renegotiated: development assistance contracted sharply, there were concurrent emergencies and the rules governing the global health system were rewritten in real time.

This chapter sets the scene for the entire report. The 12-month backdrop can be visualized as a single chain of events set in motion by external forces collided with health systems that responded as best they could and absorbed the resulting shocks, which varied across countries and programmes. The Region was called upon to provide a consolidated response to a rising disease burden, address persistent inequity, manage recurrent emergencies and withstand a financing shock. The report demonstrates how the health sector adapted with the support of WHO and its partners. Primary health care (PHC) is the organizing principle that runs through the chain, the basis on which services are planned, financed, governed and improved; throughout the report, equity is treated not as a desirable outcome but as

the principle by which priorities are set in the Region, with its scarcest resources aimed to meet the needs of the populations and places carrying the heaviest combined disease burden.

The reporting period was also the first full year of the Fourteenth General Programme of Work (GPW14), WHO's global strategy for 2025 to 2028, and the first of Dr Mohamed Yakub Janabi's term as Regional Director. The response in the Region was dynamic: it delivered essential services throughout the sharpest financing contraction in a generation while rebuilding its own institution to bring it closer to the people it serves. This endeavour is far from finished – to consolidate it will still require sustained investment and partnership. This chapter establishes the landscape within which the results, reforms and repositioning of the Region must be read.

1.1. Five forces, one shock: the external environment that shaped the year

No health system operates independently of the world around it. Five families of external forces (social, technological, economic, environmental and political: the STEEP framework) carved the operating environment for every result in this report *(2)*. None of these external forces originates in the health sector, and all were brought to bear during the reporting period. Each is assessed for its effect on the health sector in general and on the health sector in the African Region in particular.

Social: a young, urbanizing and increasingly displaced population. Africa's population passed 1.5 billion in 2024 and is projected to approach 2.5 billion by 2050. About 60% of the population of the WHO African Region is under 25 *(3)*. This is the largest demographic opportunity of the century, with twin effects on the health sector. The first is sustained high demand for reproductive, maternal, newborn, child and adolescent health (RMNCAH) services, alongside a surging adult burden of noncommunicable disease (NCD) within the same households. The second is an opportunity, because a young and underemployed population makes the health sector one of the most credible engines of decent work on the continent. Urban populations in the Region are projected to double from roughly 700 million to 1.4 billion by 2050, absorbing most of that growth *(4);* urbanization concentrates both risks – with outbreaks amplifying in dense, informal settlements lacking adequate water and sanitation – and opportunities, since density lowers the unit cost of reaching people. Forced displacement reached record levels, increasing by 48% since 2020, with 12.7 million people forcibly displaced or stateless across West and Central Africa alone. Women and children account for approximately 80% of displaced people *(5)*.

Impact on the health sector: demand rises fastest exactly where systems are weakest, widening equity gaps in coverage and utilization and placing the heaviest new load on RMNCAH services and on care in fragile, conflict-affected settings.

Technological: a data and manufacturing transition that could widen or narrow the gap. Digital tools, data systems and artificial intelligence (AI) have changed what health systems can see and how fast they can act. This year, the change was incorporated into routine regional practice in the form of an AI-enabled regional mental-health dashboard; a Preparedness Data Exchange linking hazard, preparedness and health-system data; the gathering of epidemic intelligence from open sources in 44 Member States; and real-time district dashboards to steer immunization campaigns. The Region currently manufactures less than 1% of the vaccines it uses; the African Union has set a target of 60% locally produced vaccines by 2040 *(6)*. In addition, only about 38% of Africa's population used the Internet in 2024, the lowest of any Region, with the widest urban-rural divide *(7)*.

Impact on the health sector: technology is becoming a core determinant of health system performance and a route to sovereignty; however, without deliberate investment in access, interoperability and data governance these tools risk widening inequity rather than narrowing it.

Economic: a structural reset of health financing. The funding landscape shifted on three fronts simultaneously. Development assistance for health contracted by approximately 21% between 2024 and 2025, driven mainly by the approximately 67% fall in contributions from the largest bilateral donor. The cut hit sub-Saharan Africa the hardest: assistance dropped by approximately one-quarter *(8)*. Bilateral programmes that had supported significant parts of the disease-control response were withdrawn or restructured. The Accelerating the Sustainable Control and Elimination of Neglected Tropical Diseases (ASCEND) programme of the United Kingdom was terminated early, and the freezing by the United States of United States Agency for International Development (USAID) funding for the Act to End neglected tropical diseases (NTD) programmes disrupted an estimated US$ 170 million of funding across 16 Member States. At the same time, multilateral platforms recalibrated their activities, with Gavi 6.0 of Gavi, The Vaccine Alliance and the Eighth Replenishment of the Global Fund to Fight Aids, Tuberculosis and Malaria both closing below target *(9)*. This has a greater effect than earlier shocks for the following reasons. Firstly, about one-quarter of health spending on average in the Region is externally financed. Secondly, five Member States rely on

external aid for 45% or more of their health spending. Thirdly, 27 Member States have a high degree of financing vulnerability to the cuts, even as nearly half are already in, or at high risk of, debt distress *(10)*. Government health spending is an average of 7.3% of general government expenditure, less than half of the 15% set in the Abuja Declaration target of 2001 *(11)*.

Impact on the health sector: the era of assuming that external funds would serve as the base layer of health budgets has ended; the leveraging of domestic resources, increase in efficiency and regional self-reliance have moved from aspiration to necessity. HIV, tuberculosis, malaria and NTD programmes are the most vulnerable because they relied the most on external funding.

Environmental: climate as a threat multiplier, and food insecurity at record levels. Africa is warming faster than the global average. Although it contributes less than 4% of global carbon dioxide emissions, it is the most climate-vulnerable continent *(12)*. Extreme weather affected at least 13 million people and killed more than 3000 across Africa in 2025, with floods and drought the leading hazards *(13),* and a record 167 million people – the sixth consecutive annual rise – faced acute food insecurity, mostly in conflict-affected countries *(14)*. Environmental exposure also affects the air people breathe. Ambient air pollution, driven by growing transport emissions, expanding industrial activity, rising energy consumption and poor waste management, together with household pollution from solid-fuel cooking, accounts for an estimated 23 to 28 of every 100 premature deaths in the Region *(15)*.

Impact on the health sector: climate serves as a threat multiplier, shifting the range and seasonality of vector-borne disease, worsening child malnutrition, driving the floods and droughts that bring recurrent outbreaks of cholera, damaging infrastructure and triggering climate-related emergencies, whereas less than 1% of global climate finance reaches the health sector.

Political: concurrently designing a global health architecture and an African health sovereignty agenda. Several architectural changes defined the operating environment for the decade ahead. On 20 May 2025, the Seventy-eighth World Health Assembly adopted the WHO Pandemic Agreement, the first global framework for pandemic prevention, preparedness and response negotiated since the International Health Regulations of 2005; the 2024 amendments to those Regulations entered into force on 19 September 2025 *(16)*. In parallel, there was progress in the African health sovereignty agenda. Africa's New Public Health Order and the Lusaka Agenda, whose Continental Roadmap the Regional Committee for Africa endorsed in August 2025, are structured around five core shifts to align global health initiatives with national priorities and catalyse domestic financing *(17, 18)*. In addition, the UN80 Initiative Action Plan contained 87 actions to modernize the United Nations system *(19)*. This architecture is still being constructed. Following the World Health Assembly, much of the new settlement will take shape over the coming year and the strategic principles of the Accra Reset and the Lusaka Agenda will continue to guide its development.

Impact on the health sector: the terms on which ministers of health in the Region negotiate (who sets the agenda, who pays, and on what conditions) are being reset; increasingly, the Region is a co-author of the terms rather than a mere inheritor (see Chapter 7).

The convergence is the story. The forces described above did not act in isolation. The financing reset was visited on a Region that has only 46% of the health workers it requires, dispersed across fragmented, vertical and disease-specific programmes. Climate shocks and displacement raised demand in precisely the fragile settings where financing and workforce were thinnest. The three forces that had the greatest effect on the year – the financing contraction, meeting workforce and system-capacity gaps, meeting recurrent climate-driven emergencies – are the compounding pressures that have been brought to bear on every result detailed in this report. This STEEP assessment is the baseline for the report and will be referenced again in the closing chapter.

1.2. The obstacles within: why capable systems still struggle to deliver

The external forces landed on health systems whose inherent capacities determined how much damage they could absorb and how much progress they could still deliver. It is tempting to make an artificial distinction between the Region's low universal health coverage (UHC) service coverage index (51, against a global average of 71) and its government health spending, which is less than half of the target set in Abuja. It is more appropriate to read them as two expressions of a single capacity gap in financing and delivery. Four cross-cutting capacities determine performance: access, quality of care, demand for services and resilience to shocks. They rest on six pillars, which were tested during the year. The evidence for each is provided below.

Workforce. The Region has roughly 46% of the health workers its population needs and is projected to face a needs-based shortage of about 6.1 million health workers by 2030. This shortfall could be deepened to 6.4–6.6 million by the financing cuts if the ability to absorb new graduates falls, given that workforce absorption capacity stood at only approximately 70% before the cuts *(20)*. An estimated one million trained health workers are unemployed or underemployed, even as facilities remain understaffed. This is a

labour-market failure rooted in pay, geography and regulation, not training capacity alone.

Financing and financial protection. Beyond the 7.3% average government spending on health, which is below the 15% set by the Abuja Declaration, out-of-pocket payments account for approximately 36 of every 100 dollars spent on health and exceed the 20% financial-hardship threshold in 35 Member States *(10)*. In this report, financing is treated not only as a constraint but also as the principal driver of reform (see Chapters 5 and 6).

Governance and stewardship. In this context, governance is understood as stewardship; the capacity of ministries of health to set priorities, direct all resources (public, private and external) towards these priorities and account for results, rather than organizational reform alone. The year showed both the gap (fragmented, donor-driven planning) and the momentum (a wave of health-tax legislation and the elevation of health to Heads-of-State level).

Service delivery and integration. As previously mentioned, delivery gaps are widest exactly where need is greatest: for noncommunicable disease (NCD) and mental health care, and for communities in fragile settings. Integration in this context means more than delivering several interventions in one visit; it means integrated planning, financing, governance, information, workforce and accountability on shared public health care (PHC) platforms, which is the core service-delivery strategy employed in the Region.

Supply chains and products. The Region remains overwhelmingly dependent on imported medicines, vaccines and diagnostics. The supply shocks experienced during the year, from the shortfall in the oral cholera vaccine to disrupted donated-medicine pipelines, demonstrated how quickly external dependence could become a service interruption. The regulatory, pooled-procurement and local-manufacturing agenda (Chapter 6) is the structural response to this situation.

Data, surveillance and the (in)ability to see inequity. The Region made measurable gains: surveillance completeness rose from 70% to 88% and 71% of public health events were detected within seven days (Chapter 3). However, 44 of 47 Member States still lack cause-of-death data that meets WHO standards and too few headline indicators can yet be disaggregated by sex, age, disability or place. Equity-analysis tools, such as WHO's Health Equity Assessment Toolkit (HEAT and HEAT Plus) exist precisely to expose these gaps; a system that cannot see inequity cannot correct it.

All capacities are not uniformly affected: workforce and information systems are subject to the tightest constraints in the Central African and Sahel sub-regions; financing and financial protection are scarcest in settings with the lowest coverage; and service-delivery continuity is lowest in the fragile and conflict-affected states. That disaggregation is important, because the national averages used above conceal the variation within countries described in Part 3.

1.3. Not everyone was equally affected: who bore the brunt and which programmes paid

When the external and internal forces are analysed, it is clear that the combined impact of events that occurred during the year was severe but sharply uneven. The Region was not uniformly affected; the analysis below presents that effect in the order of country, neighbours of the country, its subregion and Region, and the global context. The criteria used are explicitly stated.

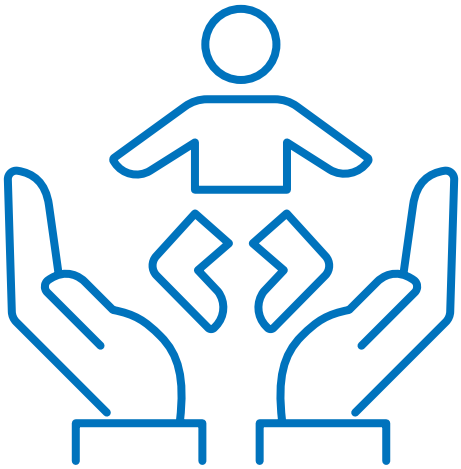
The country and its neighbours. The heaviest combined impact fell on Member States where three exposures overlap: high dependence on external health financing, protracted conflict or displacement, and a high malaria and HIV burden. On that basis, the hardest-hit group is concentrated in the fragile and conflict-affected settings of the Sahel and the Lake Chad basin and in the settings of Central and East Africa that have experienced protracted crises, where displacement and insecurity compounded the financing shock; and in the high-HIV-prevalence economies of East and Southern Africa, which received the largest volumes of the now withdrawn external health assistance. About three-quarters of that assistance went to 10 Member States, all but one of them in East and Southern Africa *(10)*. Exposure was lowest in the Region's upper-middle-income and small-island economies, where external financing is a small share of health spending and domestic systems can substitute. This section does not rank individual Member States: the criteria are stated so that each minister can locate their own country within the pattern. The subregional distribution is set out in **Table 1.**

The subregion and the Region. At the subregional level, the constraint differs. Financing dependence and HIV exposure dominate in East and Southern Africa; conflict, displacement and workforce scarcity dominate in Central Africa and the Sahel; and climate-driven food insecurity and cholera dominate across the Sahel and the Horn of Africa. Region-wide, the transmission was consistent: the withdrawal of external financing affected services through the programmes that received the most external financing.

Who is left behind. Within every subregion, the burden fell hardest on the same populations: women and children, who account for approximately 80% of displaced people *(5);* children in the poorest and most remote districts, where zero-dose immunization is concentrated; adolescent girls and young women, who carry a disproportionate share of new HIV infection; people living with NCD and mental illness, for whom coverage was lowest before the contraction began; and health workers themselves, in the settings where posts remained unfilled. The Region cannot yet report this systematically. As recorded in Part 2, too few headline indicators can be disaggregated by sex, age, disability or place and closing that gap is a priority addressed in Chapters 2 to 4.

The global framework. Set against the rest of the world, the Region absorbed the largest regional cut to development assistance for health while carrying the highest burdens of malaria and of new HIV infection. This is the clearest possible illustration of why sustained, and increasingly domestic, investment matters.

Which programmes paid. The impact reached programmes through a clear mechanism: the more a programme was externally financed and the more it was financed by the United States, , the more affected it was. About 75% of United States health assistance to the Region had funded HIV (and other sexually transmitted infections) and malaria control *(10),* making HIV, tuberculosis, malaria and NTD programmes the most exposed. Maternal and child health and emergency operations in fragile settings were the next most affected, as humanitarian funding also fell. Relatively less affected were programmes carried on domestically run or separately financed platforms, including polio eradication and elements of routine immunization, although these, too, depend on shared systems and cannot be assumed to be secure. The pattern is illustrated in **Table 1.**



Rwanda: Accessing primary healthcare to strengthen Universal Health Coverage, November 2022

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Table 1 Where the year's forces landed hardest, by subregion

Subregion	Member States	Principal forces felt most	Fragile and crisis-affected settings	Malaria high-burden countries	Programmes most exposed
North Africa	1	Low dependence on external health financing	0	0	Limited exposure; domestic financing predominates
West Africa	12	Financing; malaria	1	2	Malaria, HIV, RMNCAH, NTDs, immunization
Sahel and Lake Chad basin	5	Conflict and displacement; financing; climate; malaria	4	3	Malaria, immunization, RMNCAH, nutrition, emergency operations
Central Africa	8	Conflict and displacement; financing; malaria	3	3	HIV, malaria, immunization, RMNCAH, emergency operations
East Africa	12	Financing; conflict and displacement; climate	3	2	HIV, RMNCAH, malaria, immunization, nutrition
Southern Africa	9	Financing (HIV); climate	1	1	HIV, tuberculosis, RMNCAH, malaria
Region	**47**		**12**	**11**	

Criteria: the principal forces and the programme exposure shown are an analytic synthesis based on dependence on external health financing (10), malaria high-burden status (20) and recognized protracted-crisis and displacement settings (UNHCR and OCHA). Counts of fragile and crisis-affected settings and of malaria high-burden countries are drawn from those sources. Individual Member States are not graded for financing exposure. Subregional groupings follow WHO Regional Office for Africa conventions; island States are counted within their geographical subregion.

Sudanese refugees in Adre, Chad, July 2024

© WHO / Nicolò Filippo Rosso

1.4. How the Region held the line, and where it did not

The Region adapted to meet this environment, and that adaptation is the reason the results chapters can report progress at all. Four mechanisms accounted for most of that resilience.

First, **targeting.** Countries used routine data to direct scarce resources to priority districts (through real-time dashboards guiding vaccination and malaria responses, as well as the Big Catch-up and precision-elimination approaches), enabling fewer resources to be deployed with greater precision.

Second, **integration onto PHC platforms:** embedding vertical programmes within shared service delivery, procurement and workforce arrangements, so that a single facility, health worker and patient visit could deliver more value.

Third, **domestic financing measures:** including health tax legislation, budget reallocations and the absorption of specific external funding gaps. South Africa, for example, absorbed a substantial in-year shortfall in its HIV response, with domestic resources already financing about three quarters of the programme.

Fourth, **institutional redesign** to protect service delivery (see Chapter 5).

What worked: essential services were largely sustained, and several disease-elimination milestones were reached during the most challenging financing year in decades. This demonstrates that targeting and integration can help sustain results with fewer resources.

What did not work everywhere: where funding contractions outpaced the capacity of domestic systems to compensate, campaigns slipped and supply lines tightened. Member States received only 61% of the oral cholera vaccine doses they requested; more than 5 million praziquantel tablets were projected to expire (although rapid country-level adaptations preserved many of these); and tracked mental health support fell to a fraction of its 2024 level.

What remains fragile: gains that continue to depend on external financing, limited workforce capacity and supply chains that the Region does not yet fully control. The candid assessment is that the Region held the line in most places, lost ground in some, and did so on foundations that now require strengthening.

1.5. Standing with countries: what WHO delivered, and what partners added

Throughout the year, WHO in the African Region, including the Regional Office and its 47 country offices, supported Member States to navigate these pressures while simultaneously reshaping its own institution to operate closer to the people it serves. On 1 July 2025, Dr Mohamed Yakub Janabi assumed office as Regional Director. By August 2025, the Regional Office had completed its most extensive operating model redesign in two decades, consolidating technical clusters from six to four, reducing Director posts from nine to six and Team Lead posts from 49 to 33, and downsizing the workforce by about one quarter, from over 2500 to fewer than 2000 personnel, against a shortfall of roughly US$ 29 million in flexible funding. By January 2026, all 47 country offices had transitioned to the new Core Country Office Model, with roughly three quarters of the Region's staff positions now located at country level. Beyond its internal reform, WHO's support was delivered through four channels: technical leadership and normative guidance for disease control and RMNCAH programmes (as reported in Chapters 2 and 4)*;* emergency detection and response, including the data and surveillance systems that strengthened seven-day detection and outbreak response (Chapter 3)*;* support for countries' financing and stewardship reforms, ranging from health tax legislation to public financial management (Chapters 5 and 6); and convening and negotiating support that advanced the Region's priorities within the global health architecture (Chapter 7). WHO's strategic framework, *A new era of health for Africa: united action for Vision 2035, was published on 19 September 2025* and is further discussed in the closing chapter.

Partners made equally decisive contributions, acknowledged here and described in greater detail in subsequent chapters: the African Union and Africa CDC through continental strategy, the new public health order and local manufacturing; Gavi, the Global Fund, the World Bank and other financing partners through support for immunization, HIV, tuberculosis, malaria and system strengthening, with increasing emphasis on country ownership and integration; United Nations agencies through humanitarian health, displacement and nutrition interventions; and research institutions, civil society and communities through delivery and accountability.

1.6. What this report is, and why each chapter matters

This report is the Regional Director's authoritative account of how political, social, economic and environmental forces shaped health outcomes across the African Region between 1 July 2025 and 30 June 2026. It documents how Member States responded to these pressures, the progress achieved collectively by the Region, and the specific contributions WHO made in support of those efforts. The report is structured around the mission of the Fourteenth General Programme of Work to promote, provide and protect health, and around the RC76 theme, Delivering results, driving reform, securing Africa's health future. Each chapter connects back to the forces outlined in this section.

Chapter 2 examines the delivery of essential services and progress towards universal health and well-being. It shows how the Region sustained care and protected coverage through the financing shock, providing a direct test of the access and demand capacities.

Chapter 3 examines how the Region protected populations from health emergencies. It presents the operational response to an environment characterized by emergencies and demonstrates the resilience capacities discussed above.

Chapter 4 examines how the Region promoted health by addressing the social, commercial and environmental determinants that shape health outcomes. It reflects the health sector's response to the social and environmental forces.

Chapters 5 and 6 examine the institutional reforms and financing measures that made progress in all three areas possible. Together, they show how the adaptations described in Part 4 were translated into organizational change, with financing pressures acting as a driver of reform.

Chapter 7 examines the Region's positioning within the an evolving global health architecture. It shows how political dynamics were converted into strategic agency.

The closing chapter looks ahead, drawing on the STEEP baseline established here to set the Region's course to 2027 and beyond. A reader who understands this chapter understands the year; the chapters that follow show, in detail, what those forces, decisions and reforms meant for the people the Region serves.

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WHO response to Ebola disease caused by Bundibugyo virus, Uganda, 25 June 2026

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WHO response to Ebola outbreak in the Democratic Republic of the Congo (DRC), 1 June 2026

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Chapter 2.

Delivering results for universal health and well-being

Universal health coverage is the organizing goal of this chapter, and it has three dimensions against which the Region's progress during the year must be assessed: **population coverage,** or who is reached and whether those historically left behind are being brought in; **service coverage,** or what services are delivered across the life course, from antenatal care to the management of chronic conditions in later life; and **financial risk protection,** or whether people can access needed services without being pushed into poverty. These three dimensions are the means; the end is improved well-being: longer lives lived in good health, measured by healthy life expectancy, and protection from the financial hardship that illness can bring.

Primary health care is not merely the setting in which these outcomes are achieved; it is the organizing principle that produces them, through integrated service delivery, multisectoral action on the determinants of health, and the empowerment of communities and health workers. Integration emerged as the defining theme of the reporting period. In this chapter, the concept is understood broadly, encompassing not only co-delivery of services (through the same visit, health worker and platform) but also integrated planning, financing, workforce development, information systems, and shared accountability.

The chapter opens with the Region's overall position on universal health coverage and the test imposed by the year's challenges. It then reports results across the four areas that underpin the UHC service coverage index: reproductive, maternal, newborn, child and adolescent health; communicable disease and disease elimination; noncommunicable disease and mental health; and the service capacity that supports them all. A final section examines the cross-cutting work on gender and on the prevention of and response to sexual exploitation, abuse and harassment. Throughout, the outcomes belong to Member States. The contribution of the Regional Office and the 47 WHO country offices lies in the guidance, technical support, convening power and normative work that helped countries achieve them, and that contribution is highlighted in each area.

2.1. Where the Region stands on universal health coverage

Coverage is rising, but the pace of progress has halved

The universal health coverage service coverage index (SDG indicator 3.8.1) for the WHO African Region rose from 30 in 2000 to 51 in 2023, the last observed year *(1)*. Progress has been strongly front-loaded: 17 of the 21-point gain were achieved by 2015. Since then, the pace of progress has slowed markedly to roughly half a point a year, including a four-year plateau at 48 between 2017 and 2020. Variation across the Region's 47 Member States remains substantial, spanning approximately 54 index points between the highest and lowest performers, with nearly half of all countries clustered around the middle of the distribution. Because Nigeria, the Democratic Republic of the Congo and Ethiopia together account for roughly two fifths of the Region's population and all remain at or below an index score of 50, the population-weighted picture is less favourable than the Regional average suggests. The path to faster regional progress now runs through the large lagging countries.

The composition of the index explains both the rapid gains of the earlier period and the present slowdown and sets the agenda for the remainder of this chapter. Of its four subindices, infectious disease coverage has been the engine of regional progress, rising from 11 in 2000 to 42 in 2023, propelled by the scale-up of antiretroviral therapy, expanded tuberculosis case-finding, and sustained malaria interventions. The reproductive, maternal, newborn and child health subindex improved from 41 to 54 over the same period but has gained only four points since 2010. The noncommunicable disease subindex records the highest score, at 69, although it is the least informative about service delivery because it is influenced in part by risk-factor prevalence rather than treatment coverage. Service capacity and access, encompassing health workforce availability, hospital bed density and health security capacity, remains the weakest link: stagnating at 32 through the 2000s and reaching only 43 by 2023. Further gains must now come from the two slowest-moving components: completing the unfinished reproductive, maternal, newborn, child and adolescent health (RMNCAH) agenda and building capacity.

The tracer indicators show the same pattern. Coverage is high where established programmes exist. Antiretroviral therapy reached 83% of people living with HIV in 2024, tuberculosis treatment coverage reached 74%, and coverage with the third dose of diphtheria-tetanus-pertussis reached 76%. Coverage is low where sustained engagement with the health system is required: only 58% of women of reproductive age have their need for family planning satisfied with modern methods; second-dose measles vaccine coverage stands at 55%; and only about one quarter of adults requiring treatment for hypertension receive it. Within-region variation is as pronounced for individual tracer indicators as it is for the index overall, with the same eight to ten countries accounting for the bulk of unmet need for immunization, skilled birth attendance and treatment services. Geographic concentration, not service type, remains the defining service coverage challenge in the Region.

Financial risk protection remains the weaker dimension of universal health coverage. Out-of-pocket payments account for around 36% of every 100 dollars spent on health and exceed the hardship threshold in 35 Member States. Across the 42 Member States with available data, catastrophic out-of-pocket spending has a median incidence of 5.1%. Examining coverage against hardship reveals three distinct policy problems: countries where both coverage and protection remain low because services are simply not available; countries where coverage gains are being financed largely by households; and countries where coverage and protection are advancing together. The countries moving fastest share a common approach: sustained investment in primary health care, integration of services onto single platforms, and domestic financing reforms that make coverage affordable to both governments and households.

Equity: relative gaps are narrowing, absolute gaps remain wide. Since 2000, countries in the bottom quartile of the distribution have gained 23 index points, compared with 16 points for those in the top quartile. Over the same period, the ratio of the

ninetieth to the tenth percentile narrowed from 2.7 to 1.8. Yet the interquartile range widened from 10 to 15.5 points, as convergence at the bottom was offset by continued advance at the top. Progress at the bottom of the distribution is real, but the gap remains substantial.

The year's test: the essential services' floor held

The financing contraction described in Chapter 1 threatened to interrupt treatment, suspend prevention campaigns and break the supply lines for medicines and vaccines. The services at risk extended well beyond the major disease programmes: antenatal and delivery care, family planning, immunization outreach and nutrition services all depend on the same transport, supervision and commodity systems that external financing had long underwritten.

Measured against the service continuity and financial protection dimensions of universal health coverage, the floor held. Antiretroviral treatment was protected for an estimated 21.7 million people living with HIV *(2);* donated medicines for neglected tropical diseases continued to flow despite a US$ 170 million funding freeze; and insecticide-treated-net and seasonal malaria chemoprevention campaigns were protected in 21 countries. The programme-specific results are presented in section 2.3.

It held because services shared a platform. The response rested on integration for efficiency rather than retrenchment: 26 Member States revised their national strategic plans for HIV, tuberculosis and hepatitis under a single integrated design framework, enabling the presentation of one coherent domestic financing case to ministries of finance rather than three competing requests. Where resources were scarcest, routine data were used to direct them district by district to the populations and places carrying the heaviest burden.

What the Regional Office did. The Regional Office maintained the regional analytical baseline against which these assessments are made; supported Member States to produce and use disaggregated coverage and financial protection data; developed the integrated design framework and supported its implementation; and worked with countries to convert coverage analysis into district-level targeting decisions.

What still constrains progress. The margin remains narrow, and the functions that absorbed the shock, namely surveillance, laboratory and validation capacity and specialized staff for fragile settings, are the hardest to rebuild once lost. Integration is further constrained by an unresolved governance question: who holds the decision rights and the budget authority needed to make integration happen at district level? The fact that domestic financing dialogues were embedded in fewer than half of the revised strategic plans reflects a decision-space problem, not a planning lag.

Country spotlights

South Africa. A domestically financed HIV response absorbed an estimated US$ 420 million financing gap during the year without interrupting treatment, with domestic resources already covering roughly 74% of the programme.

Ghana. The financing contraction became a catalyst for primary health care reform: resources flowing through the National Health Insurance Authority rose by about 60% and free primary health care was launched, expanding both population coverage and financial protection at once.

2.2. Reproductive, maternal, newborn, child and adolescent health

Survival still depends on whether care arrives in time

Where the Region stands. In much of the African Region, survival for a mother and her newborn depends less on what medicine can do than on whether care reaches them in time. The Region remains off track for the Sustainable Development Goal targets on maternal and child survival. In 2023, maternal mortality stood at 442 deaths per 100 000 live births, with nearly 900 000 stillbirths occurring in the same period. In 2024, the under-five mortality rate stood at 70 deaths per 1000 live births and neonatal mortality at 26 per 1000 live births *(3)*. The adolescent birth rate remains the highest in the world, at 97 births per 1000 girls aged 15–19 years in 2024 *(4)*. Regional averages conceal profound inequities: West and Central Africa consistently lag other subregions, reflecting the combined effects of rapid population growth, fragility, conflict, climate shocks, constrained domestic resources and declining external financing.

The direction of travel is nonetheless positive. The reproductive, maternal, newborn and child health service coverage index rose from 50 in 2015 to 54 in 2023, with 30 Member States now above the regional average, and the proportion of women whose family planning needs are met with modern methods rose from 52.7% to 58.1% between 2015 and 2024.

Results benchmarked against the Every Woman, Every Newborn, Everywhere targets. The Region now measures itself against the seven acceleration targets, which give ministers a single scoreboard for the continuum of care (Table 2). The scoreboard carries two findings of equal weight. The first is the shape of the continuum: skilled attendance at birth is the strongest link, while antenatal care remains the weakest. Only one Member State has reached the target threshold of four antenatal care visits, meaning that women continue to enter care late. The postnatal period, when most maternal and newborn deaths occur, is covered in fewer than a third of Member States. The second finding is the absence of data for both emergency care targets. The Region cannot yet say whether a woman in obstructed labour, or a newborn who cannot breathe unaided, can reach the lifesaving care they need in time. That is not a gap in the report; it is a gap in what the Region can see, and closing it is a first-order investment.

Table 2. Member States meeting the threshold for 'Every Woman, Every Newborn, Everywhere' targets, 2026

Every Woman, Every Newborn, Everywhere target	Threshold	Member States meeting threshold
Antenatal care (four or more visits)	90% or above	1 *(5)*
Births attended by skilled health personnel	90% or above	17 *(6)*
Postnatal care for mothers	80% or above	14 *(7)*
Postnatal care for newborns	80% or above	15 *(8)*
Districts with at least 50% of the population within two hours of emergency obstetric care	80% or above	Data not yet available
Districts with at least one Level 2 newborn inpatient unit equipped with continuous positive airway pressure	80% or above	Data not yet available
Women making their own informed and empowered decisions	65% or above	5 *(9)*

Source: United Nations Population Fund (UNFPA), Global Database on SDG Indicator 5.6.1, via the UN SDG Indicators Database, last updated October 2025. World Health Organization, Global Health Observatory, last updated April 2026.

Maurice, a community health worker at Musovu Health Post, gives vitamin A supplements to Dative's daughter in Bugesera District, Rwanda.

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Results achieved. Several Member States now frame this agenda as a national development and equity priority rather than a health sector concern. In Kenya, the President and the First Lady launched the Every Woman, Every Newborn, Everywhere acceleration plan for 2026–2028, targeting 26 high-burden counties through strengthened accountability, improved service readiness, increased domestic financing, upgraded equipment, and the recruitment of 5000 additional nurses and midwives. Sierra Leone and Liberia elevated preventable maternal and child mortality to the status of a public health emergency, while the Central African Republic launched a national maternal health roadmap at presidential level. Since her appointment in February 2026 as African Union Champion for Maternal and Child Health, the President of the United Republic of Tanzania has provided continental leadership to accelerate progress across the Region.

Maternal and perinatal death surveillance and response has become the central pillar of quality of care strategies across the Region. The Democratic Republic of the Congo digitalized maternal death surveillance, reducing notification delays to nine hours. The country raised audit implementation from 25% in 2024 to 65% in 2025, finding 95% of deaths preventable. Malawi strengthened surveillance in 90 high-volume facilities, generating more than 120 quality-improvement actions and reducing maternal mortality from 439 to 224 deaths per 100 000 live births. Standards and workforce improved alongside these efforts: Malawi rolled out the E-MOTIVE bundle for postpartum haemorrhage in 180 facilities; Ethiopia adapted 16 national guidelines and rehabilitated maternity waiting homes and neonatal intensive care units; and Burkina Faso scaled up self-injection of DMPA-SC through 32 640 community health workers, raising contraceptive prevalence from 23.8% to 24.6% and reducing unmet need for modern methods from 19% to 15.7%.

Progress was also recorded for children and adolescents. Forty-two Member States are implementing the integrated management of childhood illness strategy and 33 have adopted early childhood development policies. The number of Member States with dedicated adolescent health focal points rose from 20 to 41, while those with national adolescent-friendly service standards increased from 28 to 36. A regional accountability framework brought 25 ministries of health and education across West and Central Africa onto a common platform. In Southern Africa, the Southern African Development Community launched a biennial scorecard tracking 20 indicators across 16 Member States as a peer accountability mechanism for ministers.

What the Regional Office did. The Regional Office supported Member States to translate political commitment into implementation by embedding acceleration priorities within national and subnational plans and strengthening the core interventions that drive survival: emergency obstetric and newborn care, care for small and sick newborns, death surveillance and response, respectful childbirth care, referral systems, commodities and routine data use. It developed the regional roadmap on self-care interventions for sexual and reproductive health and rights and supported seven Member States to institutionalize self-care within national policy frameworks. It worked through joint platforms with the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the Joint United Nations Programme on HIV/AIDS (UNAIDS), UN Women, regional economic communities and professional associations. The Regional Office also prepared the technical paper on accelerating progress in the health and well-being of women, children and adolescents that was considered by the Seventy-fifth session of the Regional Committee.

What still constrains progress. Policy commitment has outpaced implementation. The constraints are systemic: unpredictable financing, shortages and maldistribution of health workers, unreliable health products and infrastructure, and weak multisectoral coordination on the determinants of health that lie outside the health sector. Most Member States have adopted maternal and perinatal death surveillance and response, but operationalization remains suboptimal. Older children, younger adolescents and older persons remain the least well served.

Country spotlights

Burkina Faso. Self-care was institutionalized as national policy through the scale-up of DMPA-SC self-injection and community distribution of oral contraceptives by 32 640 community health workers. The programme increased contraceptive prevalence and reduced unmet need, reaching regions affected by acute insecurity.

South Sudan. Inpatient mortality at Al-Sabah Children's Hospital in Juba fell from 27% to 3.7% under a quality-improvement plan supported by the Regional Office.

2.3. Communicable disease control and elimination

The engine of two decades of progress, tested by the year's finances

Infectious disease programmes have driven the Region's coverage gains since 2000 and continue to account for the largest share of the remaining burden. These programmes were also the most affected by the financial contraction during the year. The results presented below are assessed against the global targets established for each programme.

Immunization coverage held, and the Region closed the pandemic immunity gap

Results achieved. According to the latest WHO and UNICEF national immunization coverage estimates, first-dose diphtheria–tetanus–pertussis coverage remained stable at 83% in both 2024 and 2025. Third-dose (DTP3) coverage rose slightly from 75% to 76%, while first-dose measles-containing-vaccine coverage held at 71% over the same period *(10)*. Sixteen Member States reached or exceeded the 90% target for DTP3 coverage, while nine recorded coverage below 70%. In 2025, the Region recorded 6.6 million new zero-dose children and 3.0 million newly underimmunized children, figures broadly unchanged from 2024 (6.7 million and 3.1 million respectively). An estimated 1.9 million future deaths were averted through immunization in 2024 *(11)*.

The Big Catch-Up initiative, launched in 2023 by WHO, UNICEF and Gavi, the Vaccine Alliance, concluded in June 2026. Implemented in 23 priority countries in the Region, the initiative reached 10.2 million of the 12.4 million targeted children aged 12–59 months (82%), with the first dose of diphtheria–tetanus–pertussis vaccine. Furthermore, the initiative successfully embedded defaulter tracking, microplanning and digital reporting into routine systems *(12)*.

Against the elimination goals of the Immunization Agenda 2030, 43 of the 47 Member States (91%) have been verified for the elimination of maternal and neonatal tetanus. The four countries yet to do so are Angola, the Central African Republic, Nigeria and South Sudan, with Nigeria pursuing a phased zonal approach. The number of countries reporting confirmed measles cases declined from 43 in 2024 to 40 in 2025, with seven recording no confirmed cases. Cabo Verde, Mauritius and Seychelles have been verified for the elimination of both measles and rubella. All 47 Member States have introduced the measles vaccine, although two have yet to introduce the second dose and 11 have not yet introduced the rubella vaccine *(13)*.

New vaccine introduction accelerated. Twenty-five of the 42 malaria-endemic Member States have introduced the malaria vaccine with support from Gavi, the Vaccine Alliance. Human papillomavirus vaccination (HPV) is now offered in 36 Member States, up from 12 in 2019, with six introducing it for the first time in 2025 and Burundi launching the vaccine across all health districts in April 2026. First-dose HPV coverage rose from 18% in 2019 to 43% in 2024, exceeding the global average of 31%, placing the Region second only to the Region of the Americas *(14)*. Campaigns increasingly delivered several interventions together: Kenya combined the measles–rubella vaccine with the typhoid conjugate vaccine; Ethiopia delivered the measles vaccination alongside vitamin A supplementation and malnutrition screening; and pentavalent meningococcal campaigns protected 3.3 million people in Chad, Niger and Nigeria.

What the Regional Office did. The WHO Regional Office supported the Big Catch-Up countries with microplanning and defaulter-tracking systems. It also expanded in-Region genomic sequencing capacity from two to four laboratories, raising the share of type-2 poliovirus isolates sequenced within Africa from 47% to 97%. In addition, the Office supported 12 Member States in West and Central Africa to conduct measles or measles–rubella campaigns, reaching 69.6 million children.

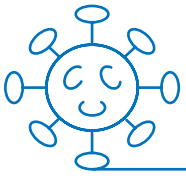
What still constrains progress. Data quality remains the binding constraint, with underestimation of target populations inflating administrative coverage. Third-dose coverage has plateaued, and human papillomavirus vaccine coverage remains well below the 90% target, particularly in the high-burden countries. The transition from Gavi support will also require Member States to assume costs that have not previously been financed domestically.

Malaria control focused on protecting campaigns that prevent resurgence

Results achieved. Malaria remains the Region's largest infectious disease burden, with an estimated 265 million cases and 580 000 deaths in 2024, accounting for 94%–95% of the global total, disproportionately affecting children under five years of age. Because the interventions that keep the burden under control are campaign-based and must be delivered on schedule, malaria is particularly vulnerable to financing disruptions. Despite these constraints, campaign delivery was sustained. Insecticide-treated net distribution and seasonal malaria chemoprevention campaigns were protected during the contraction, guided by a district-level resurgence risk framework. In parallel, the malaria vaccine moved from pilot implementation to integration into routine national immunization schedules.

What the Regional Office did. The Regional Office, in partnership with the RBM Partnership to End Malaria, developed a district-level resurgence risk framework to prioritize campaign protection, and shared it with all 47 Member States. It also established the Accelerated Malaria Vaccine Introduction and Rollout in Africa platform to coordinate partner support for introducing countries and to facilitate the exchange of operational learning across countries.

What still constrains progress. Artemisinin partial resistance has been confirmed in four Member States, threatening the efficacy of first-line treatments. Malaria vaccine coverage declines sharply between the first and the fourth doses. In addition, because the vaccine is recommended only in areas of moderate to high transmission, the geographic targeting of rollout is generating a perception of inequity within countries.

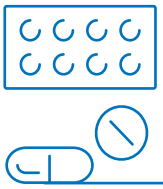


HIV, tuberculosis, hepatitis and sexually transmitted infections are a priority in the context of shrinking financing

Measured against the global 95-95-95 targets, antiretroviral therapy now reaches 83% of people living with HIV in the Region. Tuberculosis treatment coverage stands at 74%, recovering from 52% in 2020, marking one of the fastest service recoveries following the COVID-19 pandemic. Twenty-six Member States revised their national strategic plans for HIV, tuberculosis and hepatitis under a single integrated design framework (*section 2.1*), replacing three parallel financing cases with one and embedding domestic-financing dialogues in 12 of them. Lenacapavir, a twice-yearly injectable for HIV prevention, began deployment in late 2025.

What the Regional Office did. The Regional Office designed and rolled out the integrated design framework, supported Member States to build the domestic-financing case for their revised plans and provided the normative guidance and country support for the introduction of long-acting HIV prevention.

What still constrains progress. A tuberculosis financing gap of approximately US$ 3.6 billion, against an annual requirement of US$ 4.5 billion, is the principal constraint on case-finding and treatment. UNAIDS has warned that sustained reductions in HIV financing could result in more than 4 million additional AIDS-related deaths by 2030. The Region accounts for 63% of new hepatitis B infections globally, yet hepatitis remains the least-financed of the three programmes. In integrated service delivery, sexually transmitted infection services are often the first to be dropped when integration is driven by cost considerations rather than programmatic coherence.



Neglected tropical disease programmes delivered elimination milestones while sustaining the flow of donated medicines

Results achieved. Neglected tropical diseases are the clearest test of the Region's ability to sustain a public good that depends almost entirely on donated commodities and the logistics needed to deliver them. A funding freeze in early 2025 put both at risk. Despite this, more than 28.4 million doses of donated medicines were delivered across 16 Member States, following a US$ 170 million funding freeze, with wastage held below 3%. During the reporting period, Burundi, Senegal and Algeria eliminated trachoma as a public health problem *(15)*, bringing the regional total to 10. Kenya also eliminated human African trypanosomiasis in August 2025, following a decline in regional cases from 26 574 in 2000 to 583 in 2024.

These milestones build on long-term foundations. This year's elimination results continue a path established by Member States over the years. Togo became the first country in the world to be validated for eliminating four neglected tropical diseases, in 2022. Cabo Verde was certified malaria-free in January 2024, becoming the third country in the Region to achieve this status after Mauritius (1973) and Algeria (2019). In May 2025, Botswana advanced to the gold tier on the path to eliminating mother-to-child transmission of HIV, becoming the first high-burden country in the world to do so. The

milestones recorded here reflect sustained efforts by the programmes, health workers and communities whose investments long predate them. This chapter records the year the results matured, not the year the work began.

What the Regional Office did. The Expanded Special Project for Elimination of Neglected Tropical Diseases and its partners protected the donated-medicine supply chain during the funding freeze and redirected stocks to sites where they could be used within their shelf life. The Regional Office also supported Guinea and Kenya through dossier preparation and validation. In addition, the International Conference on Research and Control of Neglected Tropical Diseases held in Kigali in January 2025, established a process of transferring elimination evidence between Member States. These results reflect a joint effort by the Regional Office, Expanded Special Project partners, donating manufacturers and national programmes.

What still constrains progress. Mass drug administration depends on campaign financing, which is becoming increasingly uncertain. The Democratic Republic of the Congo still carries the heaviest residual burden of human African trypanosomiasis, and post-validation surveillance remains underresourced across the Region.

Country spotlights

Rwanda. Human papillomavirus coverage of 98% through school-based delivery, the Region's most replicable model.

Guinea and Kenya. Elimination of human African trypanosomiasis as a public health problem, the outcome of more than 20 years of case-finding, vector control and treatment supported by the Regional Office and partners.

Nigeria. Increased domestic tuberculosis financing and a commitment to expanded domestic HIV financing, set within a costed national plan.

2.4. Noncommunicable diseases and mental health

The mega-trend the Region cannot postpone

Where the Region stands. Noncommunicable diseases accounted for 37% of all deaths in the Region in 2019, up from 24% in 2000, with approximately 64% of NCD deaths occurring before the age of 70 *(16)*. In 2021, the probability of premature death from the four major NCDs in the Region was 21%, exceeding the global average of 18% *(17)*. The share is rising as populations age and urbanize. An estimated 150 million people in the Region live with a mental health condition. Public spending on mental health is US$ 0.5 per person per year, and the treatment gap for common mental disorders exceeds 80%. These services are among the least well captured by the coverage index. Action on the causes – tobacco, alcohol, salt, physical inactivity and air pollution – is addressed in Chapter 4, while this section focuses on service delivery.

Results achieved in service delivery. The WHO Package of Essential Noncommunicable Disease Interventions is now implemented at the primary health care level in 31 Member States. The Women's Integrated Cancer Services model reached more than 17 000 women in Côte d'Ivoire, Kenya and Zimbabwe, a sixfold increase, by linking cervical and breast cancer screening, pre-cancer treatment and human papillomavirus vaccination within a single visit. The Fourth United Nations High-Level Meeting on Noncommunicable Diseases, held on 25 September 2025, set fast-track targets for 2030 against which the Region will now report.

Results achieved: treatment for severe chronic diseases at the district level. For most people in the Region living with type 1 diabetes, sickle cell disease or rheumatic heart disease, the nearest specialist has always been hours away. This is a delivery failure, not a knowledge failure. PEN-Plus, which extends care for severe conditions to first-level referral hospitals where trained and mentored district clinicians deliver services previously available only in tertiary centres, is now active in more than 120 facilities across 20 Member States, supporting more than 170 000 people. Rwanda has achieved national PEN-Plus coverage, becoming the first Member State to do so. The Third International Conference on PEN-Plus, held in Dar es Salaam in June 2026, shared implementation experience between Member States and identified priorities for accelerating equitable access.

Results achieved in mental health. Through the Director-General's Special Initiative for Mental Health, 1.3 million people in Ghana and 2.7 million in Zimbabwe gained access to mental health services during the reporting period, and more than 50 000 received psychosocial support – the largest documented community-level expansion of mental health care in the Region. Neurology care was scaled in eight Member States under the intersectoral global action plan on epilepsy and other neurological disorders.

What the Regional Office did. The Regional Office provided clinical protocols and a mentorship model for district-level management of severe chronic diseases in settings without on-site

specialist support, and it assisted Member States in transitioning PEN-Plus from supported pilots into national programmes. Initiatives included integrating cervical and breast cancer services with human papillomavirus vaccination, on a single platform, and translating the Fourth High-Level Meeting targets into national milestones. The Regional Office established and launched the first WHO Africa mental health dashboard, consolidating indicators from the Mental Health Atlas, STEPS surveys and the Global Burden of Disease database. It also delivered the community-based mental health integration model in Ghana and Zimbabwe, and supported Eswatini to complete a national suicide-prevention analysis and plan.

What still constrains progress. Only 38% of Member States have fully established national NCD guidelines, and 44 of 47 lack cause-specific mortality data that meet WHO standards, which means the Region is managing its largest emerging burden without reliable mortality data. Essential medicines, including insulin, fixed-dose antihypertensives and hydroxyurea, remain unreliable at facility level, and PEN-Plus is not yet institutionalized in national budgets. Mental health programming was the hardest hit by the contraction. Tracked support fell from an estimated 981 850 people in 2024 to a projected 207 030 in 2025, while the number of health workers trained dropped from 55 911 to 5908 in a single year. Of the 34 Member States reporting, 25 have a mental health policy, while only seven have functional integration into primary health care. Policy without integration does not deliver care.

Country spotlights

Côte d'Ivoire. Cervical and breast cancer screening, pre-cancer treatment and human papillomavirus vaccination delivered to women and girls in a single visit, on the same platform.

Rwanda. National PEN-Plus coverage achieved, demonstrating that care for severe chronic disease can be taken to scale within a domestic budget.

Ghana and Zimbabwe. Community-scale mental health integration reaching some 4 million people through the primary health care platform.

2.5. Service capacity and access

The weakest link, and the year it began to be treated as one

Where the Region stands. Service capacity and access are the lowest of the four coverage sub-indices, at 43 out of 100 in 2023, and they underpin every other result in this chapter. The Region has 3.1 doctors and 13.3 nurses and midwives per 10 000 population (2024), or 16.4 health workers in total, about 37% of the Sustainable Development Goal index threshold and the lowest of any WHO region. On the needs-based measure, it holds less than half (46%) of the workforce it requires. The stock of health workers is growing, from 4.3 million health workers in 2018 to 5.7 million in 2024, but not fast enough to keep pace with population growth and rising demand. The challenge goes beyond numbers: an estimated one million trained health workers in the Region remain out of work or underemployed, while rural and underserved facilities continue to face staffing shortages. This reflects a health labour market failure, in pay, geography and professional regulation, that recruitment targets alone will not resolve.

The single most significant result was a cluster of country-level employment commitments. Ethiopia committed to 39 000 new positions; Zimbabwe committed to 32 000, alongside a real-terms health budget increase of more than 30%; Kenya to 20 000; the Central African Republic to 2000; and Eswatini to at least 1000. Together, these commitments approach 100 000 posts and constitute the largest single-year political shift on health workforce employment the Region has recorded. Eswatini also lifted its employment freeze. Member States adopted the Africa Health Workforce Agenda 2026–2035 in November 2025, structured around plan, train and retain. Competency-based curricula were launched for 10 priority health professions, and 10 Member States advanced the Africa Health Workforce Investment Charter.

Thirty-eight Member States (81%) completed the health information system functionality self-assessment in 2024, placing regional maturity at 59%, and within the early band of WHO's five-level scale. The domain profile is diagnostic: communication and use scored highest, at 64%, while data generation and management scored lowest, at 52%. The Region is better at using and presenting data than at producing complete, high-quality data at source. DHIS2 has now been adopted by 43 of the 47 Member States, providing a platform on which the analytics of the next decade can be built.

The regional strategy to strengthen rehabilitation in health systems 2025–2035 was adopted at the Seventy-fifth session of the Regional Committee for Africa, in alignment with the WHO Rehabilitation 2030 initiative and resolution WHA76.6 (2023). For the first time, it gives Member States, a common framework for building rehabilitation into health systems rather than treating it as a specialist add-on. The need is substantial and growing. More than 210 million people in the WHO African Region, approximately one in five, needed rehabilitation in 2020 *(18)*, and years lived with functional limitation increased by 125% between 1990 and 2019. Road safety, the largest single driver of injury in the Region, is discussed in Chapter 4 (*section 4.5*) as a determinant.

What the Regional Office did. The Regional Office developed the Africa Health Workforce Agenda and the competency-based curricula with more than 300 experts and jointly convened the Second Africa Health Workforce Investment Forum with Ghana in May 2026. It also supported Member States to complete the health information system functionality assessment and act on its findings, and it developed the regional rehabilitation strategy adopted by the Regional Committee.

What still constrains progress. Commitments to new posts have not yet translated into funded and filled positions, and the conversion rate is the measure that matters. Workforce planning remains fragmented among ministries of health, finance, education and labour, while workforce financing remains heavily externally dependent in at least 14 Member States. Routine data remain incomplete, civil registration and vital statistics coverage is poor, and facility-level digitization is limited. Injury is not routinely measured, making it difficult to prioritize rehabilitation needs fairly against better-measured conditions.

Country spotlight

Ethiopia. Thirty-nine thousand new positions set within a wider workforce reform spanning community health workers and integrated nutrition services, illustrating workforce investment as the common platform beneath every result in this chapter.

2.6. Gender, and the prevention of and response to sexual exploitation, abuse and harassment

Health results depend on who is reached, who is protected and who delivers care

Gender shapes every result in this chapter – who falls ill, who reaches care in time and who provides it. Women and girls face distinct barriers to reproductive, maternal and adolescent health services, HIV services and care for noncommunicable diseases. Women also make up an estimated seven in 10 of the Region's health and care workforce, yet remain under-represented in leadership. The prevention of and response to sexual exploitation, abuse and harassment (PRSEAH) is the other half of this agenda: both a protection obligation and a condition for the trust on which every health service depends. Risks are greatest in fragile and emergency settings, where the Region's operations reach farthest. WHO in the African Region is advancing the "leaving no one behind" principle by integrating gender equality, health equity and human rights (GER) to ensure that the needs of the most vulnerable and marginalized populations are addressed.

The GER unit has been repositioned, together with the prevention of sexual exploitation, abuse and harassment, under the Office of the Regional Director, with a focus on enhanced visibility, oversight and cross-cutting integration.

Results achieved. Capacity to integrate gender, equity and rights into health policies, strategies and plans was strengthened through a biennial baseline strategic assessment covering 41 countries. Most country offices reached the developing or satisfactory maturity levels, while ministries of health were more evenly distributed, with none yet at the highest level. The findings are informing differentiated country-level technical support, and the assessment report is in preparation for publication. A newly established monitoring tool recorded 35 requests for technical assistance during the period, compared with 17 in the previous year. Thirty-five country teams applied the priority actions of the GER Special Programming Initiatives, and five country teams – Ghana, Malawi, Kenya, Senegal and Rwanda – improved GER-related skills and competencies.

Policy dialogue, advocacy and partnership for GER integration were enhanced through a regional consultation on the draft Global Plan of Action for the Health of Indigenous Peoples. Resource mobilization support resulted in GER considerations being incorporated into 15 countries' Pandemic Fund proposals and into African Development Bank proposals for health systems strengthening and emergency preparedness.

GER was integrated into the 2026/2027 operational planning guidelines, with the Gender Equality Marker applied to 2026/2027 products and services. Eight tracer countries were identified for the programmatic indicator on gender equality, human rights and equity. The unit also supported the review of national strategic health plans for GER responsiveness.

The unit continued to support the Gates Foundation-funded Women's Leadership Engagement and Strategic Planning initiative to strengthen leadership accountability and organizational culture for women's leadership in the Region.

Institutional capacity was strengthened through mandatory PRSEAH training for WHO personnel, complemented by large-scale capacity-building initiatives that reached more than 41 000 ministry of health officials and implementing-partner staff. Community engagement and prevention efforts expanded just as markedly: in 2025 alone, more than 2600 awareness-raising activities reached over 14 million community members with key PRSEAH messages.

A milestone of the reporting period was the first African Strategic Conference on the Prevention and Response to Sexual Misconduct in Joint WHO–Member State Health Operations. This conference convened representatives from 42 Member States to advance the operationalization of the WHO–Member State PRSEAH Accountability Framework, endorsed by the 156th session of the Executive Board and the Seventy-eighth World Health Assembly. Member States reviewed progress, exchanged good practice and agreed on six regional priority action areas to guide national implementation; the resulting Regional Commitment Framework will be submitted to the Regional Committee for Africa for consideration.

PRSEAH is now fully institutionalized as a dedicated pillar of the Regional Incident Management System, embedded in every Grade 2 and Grade 3 emergency response across the Region. The current Ebola response, for instance, includes dedicated PRSEAH capacity within its incident management team.

In July 2025, the WHO Regional Office for Africa completed the third and final phase of two projects delivered through local non-governmental organizations Heal Africa and *Dynamique des Femmes Juristes*. These projects provided integrated medical, psychosocial, legal and socioeconomic support to victims and survivors of legacy cases linked to the tenth Ebola outbreak in the Democratic Republic of the Congo. The Regional Office also finalized and validated a comprehensive mapping of internal and external victim and survivor support services, which is to be updated annually. Partnership and accountability mechanisms were further strengthened: more than 90% of implementing partners operating in the Region's highest-risk countries have been assessed against the United Nations common implementing-partner assessment tool and registered in the United Nations Partner Portal, and PRSEAH focal points have been designated in more than 90% of ministries of health.

What the Regional Office did. It implemented WHO's organization-wide policy for preventing and responding to sexual misconduct and the United Nations protocol on assistance to victims and survivors. It also extended the focal points, accessible reporting channels and survivor-centred referral as regards PRSEAH across all 47 country offices; built the capacity of staff, partners and national counterparts; embedded PRSEAH requirements in grants and contracts; and supported gender-responsive planning, gender analysis and the collection and use of sex-disaggregated data. This work was made possible by committed partners, including the Gates Foundation, the United Kingdom's Foreign, Commonwealth and Development Office, and United Nations partners including UN Women, the United Nations Population Fund and the United Nations Children's Fund.

Remaining obstacles to progress. Under-reporting remains the central obstacle: abuse continues to be systematically under-disclosed and survivor-centred services remain unevenly available. The remaining priorities are to sustain PRSEAH capacity through the financing contraction, close the gaps in sex-disaggregated data and translate gender from a mainstreaming principle to a measured outcome.

2.7. The Secretariat calls on Member States to:

- **Target** the districts and populations carrying the largest share of unmet need, since geographical concentration, rather than service type, now drives the regional coverage gap.
- **Close** the continuum of care for women and neonates: fully operationalize maternal and perinatal death surveillance and response and measure whether emergency obstetric and newborn care is within reach; the Region is currently unable to determine progress in this area.
- **Cost** and finance the revised integrated strategic plans, taking them to ministries of finance as a consolidated request case rather than three separate ones, and sustain the treatment and campaign cycles that cannot be recovered retrospectively.
- **Fund** post-validation surveillance and Gavi-transition costs as standing budget lines, so that the milestones for this year are not reversed in the next.
- **Convert** workforce pledges into funded and filled posts, reporting the conversion rate.
- **Invest** in data generation at source, which remains the weakest link in the Region's information systems and the reason for the insufficient visibility of its largest burdens, noncommunicable disease and injury.
- **Reduce** out-of-pocket payments as an explicit policy target alongside service coverage, to ensure that gains in access are not made at the household's expense.
- **Prioritize** leaving no one behind in the accelerated achievement of the Sustainable Development Goals and universal health coverage by integrating gender, equity and human rights and reducing gender-related inequalities.

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Dative snuggles her daughter in the waiting area at Musovu Health Post in Bugesera District, Rwanda.

WHO response to Ebola disease caused by Bundibugyo virus, Uganda, 24 June 2026

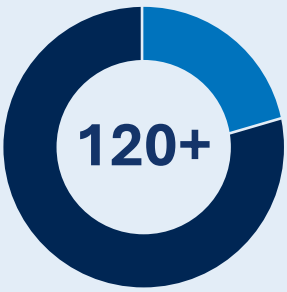
Chapter 3.

Protecting populations through stronger health security

A HEAVY AND PERSISTENT BURDEN

120+

public health emergencies recorded every year in the African Region



80% Outbreaks

20% Humanitarian Crisis

Recurrent, overlapping and interconnected emergencies continue to threaten health, disrupt services and deepen vulnerabilities across the Region.

For the African Region, the period 2025-2026 was not a year of isolated outbreaks set against a calm baseline; the baseline was recurrent emergency. The Ebola virus disease (EVD) outbreak in Bulape, followed by the Bundibugyo Ebola virus disease (BVD) outbreaks in the Democratic Republic of the Congo and Uganda, unfolded in parallel with cholera, mpox, Marburg, meningitis, dengue, floods and humanitarian crises. These were among more than 120 public health emergencies recorded each year in the Region, 80% of them outbreaks and the remaining 20% humanitarian crises *(1)*.

In 2025, more countries were affected by cholera than in any of the previous three years, with 245 472 cases, including 5344 deaths – a case fatality ratio (CFR) of 2.2% – recorded in 24 countries *(2),* reversing progress towards the 2030 cholera elimination targets. Between July 2025 and June 2026, mpox continued to spread, reaching 21 306 confirmed cases and 121 deaths – a CFR of 0.6% – in 30 countries, despite the lifting of its PHEIC status in 2025. Other outbreaks were equally significant, including Lassa fever, dengue, Rift Valley fever and diphtheria, alongside climate-related events such as floods and cyclones affecting East and Southern Africa.

In September 2025, the 2024 amendments to the International Health Regulations (IHR) entered into force in 46 African Member States. Furthermore, the hantavirus cluster aboard a cruise ship in May 2026 drew 23 IHR National Focal Points across four continents into a coordinated response — a clear demonstration of IHR compliance. Preparedness capacities are strengthening as countries respond with growing independence, and the response itself is more agile: the Ebola outbreak in Bulape was controlled within 88 days. The current BVD outbreak, however, is a stark reminder of how much more complex it is to manage public health emergencies that overlap with armed conflict.

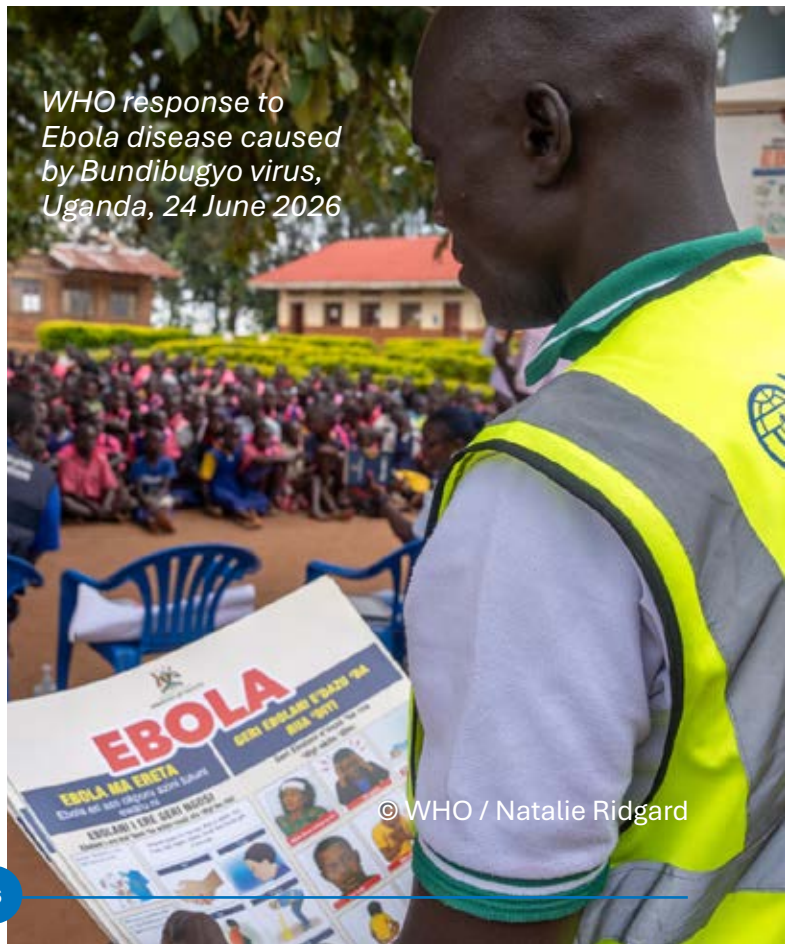
The Region's contribution to the "*protect health"* mission of the Fourteenth General Programme of Work (GPW14) centres on preventing, preparing for, detecting and responding to health emergencies to ensure that a shock in one community is not replicated as a catastrophe across many. These efforts share one unifying logic with the rest of the report: capacity built for an emergency is built to last. Drawing on the primary health care platform that delivers routine care, the workforce mobilized for an outbreak, the laboratory network that sequences a poliovirus and the surveillance system that catches an event early all continue to serve the population once the emergency has passed.

This chapter sets out how this was possible, across **six result areas**: strengthened emergency preparedness; collaborative surveillance and early warning, rebuilt under the 2024 IHR amendments; faster outbreak control, with a workforce that became deployable across borders within hours and left permanent capacity behind; a polio infrastructure that now protects the Region against far more than polio; a One Health response to antimicrobial resistance that has kept today's medicines effective and continuity of essential health services.

Against the landscape set out in Chapter 1, the WHO Regional Office for Africa worked with Member States to build capacity that would last. The institutional reforms that underpinned this response are explored in Chapter 5, the financing on which it depends is carried in Chapter 6, and the resilience agenda it feeds is detailed in Chapter 7.

3.1. Countries are prepared to tackle public health threats and prevent cross-border spread of pathogens

This section reports on the Region's contribution to the prepare and respond functions of the "*protect health"* mission: putting in place the legal frameworks and preparedness capabilities needed to identify and prevent high-risk hazards, measuring preparedness capacities, and identifying the priorities that protect health and limit the socioeconomic consequences of emergencies.



WHO response to Ebola disease caused by Bundibugyo virus, Uganda, 24 June 2026

© WHO / Natalie Ridgard

Key results

All 47 Member States

adopted the 2024 IHR amendments, and 46 completed the process for entry into force in 2025; 13 established national IHR authorities, one of the new elements introduced by the amendments.

State Party self-assessment

annual reporting (SPAR) was completed in full for the ninth consecutive year: the regional core-capacities average rose from 42% in 2018 to 51% in 2025, with the largest gain in the surveillance domain. The details of IHR implementation in Africa are set out in the Region's first annual IHR report.

41 of 47 Member States

(87%) completed a second-round Joint External Evaluation (JEE) of IHR core capacities, with 10 countries achieving level 3 (developing capacity) or higher in 2025, compared with just one in 2016; only three countries remained at the lowest level of capacity (level 1) in 2025, down from 27 in 2016. Forty-one countries used their JEE results to develop national action plans for health security (NAPHS), and US$ 225 million in Pandemic Fund resources was mobilized to strengthen IHR core capacities.

Eleven more countries

(bringing the total to 35) identified their hazard risk profiles using the Strategic Toolkit for Assessing Risks (STAR) during the reporting period. An innovative Preparedness Data Exchange (PDX) — an AI-enabled Integrated Preparedness Intelligence system serving as an all-hazards early-warning platform integrated with anticipatory and predictive action — was developed and now covers all 47 countries.

By June 2026, 19 countries

(up from five in 2023) had identified their Priority Areas for Multisectoral Interventions (PAMI), a prerequisite for cholera elimination and preventive vaccination; 24 454 867 doses of oral cholera vaccine were delivered in 11 countries, and 2 332 368 people were vaccinated against mpox in 17 countries. For EVD, 52 010 vaccine doses were delivered to the Central African Republic to support preventive vaccination of health and front-line workers, while 48 090 doses were delivered to the Democratic Republic of the Congo to support outbreak-response vaccination.

Country spotlight

Ghana domesticated the 2024 International Health Regulations amendments inside its universal health coverage legislation, in a single legislative package rather than two separate processes. The Region is now actively promoting this model, as it aligns the legal basis for health security with the legal basis for health financing, ensuring that both preparedness obligations and the funding to meet them are written into law.

3.2. All 47 Member States transform their surveillance and laboratory systems for faster detection

This section reports on the Region's contribution to the prevent and detect functions of the "*protect health*" mission: the surveillance and early-warning capacity, built under the IHR amendments, on which everything else rests. The practical payoff shows up where it matters most — in how quickly events are now detected.

WHO response to Ebola disease caused by Bundibugyo virus, Uganda, June 2026

© WHO / Natalie Ridgard

Key results

Detection has come earlier
as a result of the legal reforms: 71% of public health events in 2025 were detected within seven days, continuing the steady decline in time-to-detection since 2017.

The completeness of integrated
disease surveillance and response rose from 70% in 2024 to 94% in 2025 across 46 Member States, with timeliness ranging from 55% to 66%; the centralized integrated disease surveillance and response platform is now in use in 40 Member States (85%), with 24 countries trained in advanced outbreak analytics, collaborative analytics and modelling.

The Dakar Hub
working in partnership with Institut Pasteur and the laboratory networks of the Africa Centres for Disease Control and Prevention, anchors the regional surveillance backbone.

The epidemic intelligence
from open sources initiative was extended to 44 Member States (94% of the Region), with more than 1500 staff trained in 67 training sessions; more than 100 signals a year are now detected, with a 60% confirmation rate.

The strategic toolkit
for assessing risks was applied in 11 additional countries, a 13% increase compared to 2024. The Region also developed the AI-enabled Preparedness Data Exchange, which links hazard, preparedness and health-system data, accompanied by the first expert consultation on AI for health emergencies to be held in Africa.

The Emergency
Preparedness and Response Laboratory Unit of the WHO Regional Office for Africa significantly advanced the strengthening of laboratory systems and diagnostic capacity across the Region, through targeted laboratory assessments, rapid diagnostic scale-up, quality-assurance initiatives and expanded genomic surveillance.

All Member States
now have sequencing capacity. Sequencing output has grown accordingly: for COVID-19, from fewer than 5500 sequences in 2020 to more than 183 500 in 2025; for mpox, from fewer than 500 sequences in July 2024 to more than 2700 in November 2025.

WHO response to Ebola disease caused by Bundibugyo virus, Uganda, 24 June 2026

© WHO / Natalie Ridgard

3.3. Faster responses to public health emergencies, leaving behind stronger national capacities

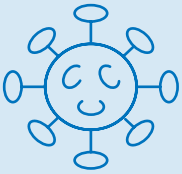
During the reporting period, July 2025 to June 2026, WHO supported Member States across the African Region to respond rapidly to public health emergencies by drawing on national, regional and global capacities. This support was aligned with the priorities of the Protect pillar of GPW14, the Regional Strategy for Health Security and Emergencies 2022–2030, and the WHO Emergency Response Framework. It focused not only on containing outbreaks and reducing the health impact of emergencies, but on ensuring that response investments also strengthened national systems, sustained essential health services and improved readiness for future shocks.

Africa accounted for an estimated **45% of the global humanitarian caseload**, with about **134 million people in need in 2025** *(3)*. Following a record 167 million Africans who faced acute food insecurity in 2025, an estimated 120 million people are projected to experience crisis-level food insecurity across the continent in 2026 *(4)*. Within the Region, **18 countries** were classified as fragile, conflict-affected and vulnerable, with **11 Health Clusters in response mode**, meaning that outbreak control, humanitarian health coordination and continuity of essential services had to be managed together, particularly in areas affected by conflict, displacement, food insecurity and climate shocks.

WHO response to Ebola disease caused by Bundibugyo virus, Uganda, 24 June 2026

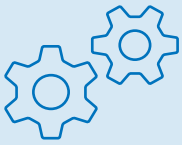
© WHO / Natalie Ridgard

Key results



The EVD outbreak
in Bulape Health Zone, Democratic Republic of the Congo, was contained within 88 days, with 64 cases, 45 deaths and 19 survivors reported; it did not spread beyond the affected health zone *(5)*.

In fragile, conflict-affected and vulnerable settings,
implementation of the H3 Essential Health Services Package increased service availability from about 50% to more than 80%, with several countries reaching at least 90% coverage. WHO and its partners supported the continuity of essential services through 9865 health facilities in 18 fragile settings, reaching more than 23 million people in 2025 *(6)*.



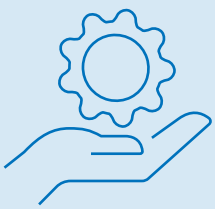
Additional data
for July 2025 to June 2026 indicate that H3 package implementation increased from 50% to 83%, while the Health Resources and Services Availability Monitoring System tracked 26 354 service-delivery units across 9865 health facilities.

National and regional surge
capacity also expanded significantly: through African Volunteers Health Corps (AVoHC)-SURGE, more than 2600 responders were trained across 32 countries, and 26 countries activated national rosters.

There were 1300 AVoHC-SURGE
deployments in 2025 – 1218 national and 82 international – alongside 489 additional responders trained in eight countries, and 40 African institutions now active in the Global Outbreak Alert and Response Network (GOARN).

The mpox response
moved from emergency control to transition and integration. Following sustained regional and continental effort, the WHO Director-General determined on 5 September 2025 that the mpox upsurge no longer constituted a PHEIC *(7)*. The Democratic Republic of the Congo subsequently declared the end of its national outbreak, and the continental mpox Incident Management Support Team was deactivated, bringing to a close a response of nearly two years.

The multi-country cholera
response achieved measurable gains despite continued transmission risk. Cholera remained widespread, with more than 245 000 cases and 5238 deaths reported across 24 countries during 2025–2026; integrated response actions nonetheless drove the reported case fatality ratio down from 2.01% to 1.14% by the end of 2025. Between the third and fourth quarters of 2025 alone, the case fatality ratio fell from 2.46% to 1.57% and deaths fell by 65%, despite continued transmission. Nearly 30 million oral cholera vaccine doses were administered, integrated with surveillance, case management, water, sanitation and hygiene (WASH) and community-level interventions. Cholera was successfully contained in Chad *(8)*, Namibia, Rwanda, the United Republic of Tanzania, Kenya, the Republic of the Congo, Zambia and Angola, with significant reductions in cases reported in South Sudan.



Regional logistics capacity
underpinned the speed of the emergency response. The annual report records nearly US$ 5 million in life-saving commodities moved through the Nairobi and Dakar hubs in 2025; draft RC76 data further indicate 218 inbound shipments valued at more than US$ 4 million, 240 outbound deployments valued at US$ 9.39 million, and emergency procurement exceeding US$ 9 million across 24 countries through 377 purchase orders that were issued between July 2025 and June 2026.

The ongoing Ebola outbreak (Bundibugyo virus) in the Democratic Republic of the Congo and Uganda

WHO AFRO Regional Director's visit of the Mpox treatment centre in Bujumbura, Burundi -March 2026

©WHO

A brief history. On 5 May 2026, WHO was alerted to a high-mortality illness of unknown cause in Mongbwalu Health Zone, Ituri Province, in the Democratic Republic of the Congo. Among the first to die were health workers. Laboratory testing confirmed EVD caused by the Bundibugyo strain on 15 May; on 17 May, the outbreak in the Democratic Republic of the Congo and Uganda was determined a PHEIC *(9)*.

Where we stand. As at 14 July 2026 (data to 13 July), the Democratic Republic of the Congo had reported 2011 confirmed cases and 754 deaths, with 366 people recovered. Ituri remains the epicentre, with 1808 cases and 631 deaths across 26 of its 36 health zones, and transmission has extended to North Kivu, South Kivu, Haut-Uele and Tshopo: 42 of 140 health zones across five provinces are now affected. In Uganda, 20 confirmed cases and two deaths have been reported, all detected in Kampala – 15 linked to travel from the Democratic Republic of the Congo and five to local transmission. The most recent case was confirmed on 21 June and none has been reported since. Three cases have been exported beyond the Region, two evacuated to Germany and one reported in France (*9,10,11*).

Progress to date. Uganda's experience shows what preparedness buys: importation was detected, transmission was confined to a small number of linked cases in the capital and no case has been reported for more than three weeks. In the Democratic Republic of the Congo, the response has scaled across surveillance, contact tracing, case management, infection prevention and control, safe and dignified burials and community engagement, with 81.5% of identified contacts under follow-up in Ituri and North Kivu. The countermeasure pipeline has progressed: on 12 July, clinical trials of two therapeutics (remdesivir and MBP134) began, a Phase 1 trial of a candidate vaccine was authorized and the WHO-sponsored PARTNERS trial protocol is being deployed in both countries (*9*).

The major issues. Four stand out. Firstly, there is no licensed vaccine or specific treatment for the Bundibugyo species: the tools that ended recent Zaire strain EVD outbreaks are not applicable and the response rests on classical public-health measures while candidates are tested. Secondly, the outbreak is located in a remote yet densely populated area affected by conflict, insecurity and a humanitarian crisis. This delays detection, interrupts contact tracing and endangers responders – among the first to die were health workers. Thirdly, significant gaps remain in surveillance and epidemiology, with a widening geographical footprint across five provinces. Fourthly, high population and trade movement alongside three exportations beyond the Region, keep the risk of further spread real.

Proposed next steps. Sustain and finance the response in the Democratic Republic of the Congo until transmission is interrupted; hold Uganda's containment and maintain cross-border surveillance, ensure the readiness and preparedness of points-of-entry in neighbouring Member States; accelerate the therapeutic and vaccine trials so that the Region is never again without countermeasures for a known filovirus; protect health workers through infection prevention and control; and keep communities at the centre, because trust determines whether cases are found early.

Response spotlight

The mpox response demonstrated that sustained regional coordination can move large multicountry emergencies from escalation to control. The joint WHO–Africa CDC continental response aligned surveillance, laboratory support, vaccination, clinical care, risk communication, partner coordination and country support within a single operational framework. This contributed to a 61.5% reduction in cases from earlier peaks and supported the delivery of more than 1.17 million vaccine doses across affected countries. Testing coverage improved from 57% in 2024 to 66% in 2026, reflecting strengthened laboratory capacity *(12)*.

The lifting of the mpox PHEIC in September 2025, the closure of the national mpox emergency response in the Democratic Republic of the Congo, and the deactivation of the continental Incident Management Support Team (IMST) marked a transition from emergency response to sustained surveillance, readiness and integration into routine systems.

Country spotlights

Democratic Republic of the Congo

The Ebola virus disease outbreak in Bulape Health Zone, Kasai Province, illustrated how an emergency can help strengthen longer-term resilience. Declared on 4 September 2025 and officially over on 1 December 2025, the outbreak resulted in 64 cases, 45 deaths and 19 survivors, with a case fatality ratio of 70.3%.

The response combined early deployment, surveillance, contact tracing, vaccination, case management, infection prevention and control, logistics, community engagement and health facility strengthening. WHO mobilized approximately US$ 6 million, deployed 112 personnel, supported the verification of more than 3300 alerts, monitored over 2300 contacts, supported the vaccination of more than 45 000 people, established two Ebola treatment centres and mobilized more than 150 metric tonnes of supplies and logistics equipment *(13)*. The treatment infrastructure included a 40-bed Ebola treatment facility and a 32-bed infectious disease treatment module.

Beyond the outbreak, the response left behind assets for the local health system. Investments in water supply, solar power, treatment capacity and logistics strengthened Bulape General Hospital, including a 2.5 km water pipeline, water storage capacity of more than 20 000 litres *(14)* and solar power support.

These investments supported the outbreak response and will continue to support future emergency readiness and routine care.

This experience shows the value of a response-to-resilience approach. The same investments that helped stop transmission also strengthened water, power, treatment, logistics and workforce capacity in the affected district. This should become standard practice after major outbreaks.

Outbreak of Ebola virus disease, Kasai Province, Democratic Republic of the Congo, September 2025

© WHO / Josua Mulala

Ethiopia

Ethiopia's first Marburg virus disease outbreak was contained in less than three months through strong national leadership and rapid WHO support *(15)*. The Ministry of Health and the Ethiopian Public Health Institute activated national and regional public health emergency operations centres (PHEOCs), strengthened surveillance and contact tracing, designated treatment centres, deployed a mobile laboratory in Jinka and engaged communities. WHO supported all response pillars, including coordination, laboratory diagnostics, case management, infection prevention and control, safe and dignified burial, logistics and risk communication.

The outbreak resulted in 14 confirmed cases, including nine deaths and five recoveries, with five additional probable deaths *(16)*. WHO activated its emergency response within 24 hours, deployed 36 experts and repurposed 28 staff to reinforce field operations. The response was further enabled by Ethiopia's prior investments in public health preparedness, including strengthened laboratory capacity, disease surveillance systems, a trained surge workforce and established coordination mechanisms through the PHEOC. Supported through initiatives such as the Ethiopian Pandemic Multisectoral Prevention, Preparedness and Response Project and the AVoHC-SURGE programme, these capacities enabled early detection, rapid scale-up of diagnostics, timely deployment of responders and continuity of essential health services.

Mozambique

As climate change increases the frequency and intensity of floods and other extreme weather events, climate-related emergencies are becoming a recurrent health security risk, requiring stronger preparedness, surveillance and continuity of essential services. In Mozambique, WHO supported the government-led response to floods that affected more than **720 000 people** across six provinces and Maputo City. Support included coordination at national, provincial and district levels, prepositioning of essential supplies, strengthened disease surveillance, and deployment of rapid responders and a medical coordinator to sustain care in accommodation centres.

As the response shifted to recovery in Gaza Province, WHO supported efforts to restore and sustain health services in affected areas. The floods affected **100 health centres**, including **20** that were flooded and **23** that were temporarily closed, while **710 health workers** were directly affected *(17)*. WHO deployed a health emergency officer and Health Cluster coordinator, shipped **9 tonnes** of essential medicines and supplies for cholera prevention and treatment, and supported daily digital reporting from more than **160 health units** to strengthen early detection and reduce the risk of secondary outbreaks.

Floodwaters Contaminate Medical Supplies at Chókwè Rural Hospital, Mozambique –February 2026

©WHO / Júlio Dengucho

3.4. Resilience: continuity of essential health services protected populations during emergencies

The Region does not return to a quiet baseline between emergencies. As the regional outlook shows, more than 120 public health emergencies are recorded each year, four in five of them disease outbreaks, and during the reporting period many occurred concurrently rather than in sequence. Recurrent emergencies have become the operating environment, not the exception. Resilience is therefore reported here as a result in its own right.

This persistent burden coincided with a period of financial contraction, and the evidence is consistent: weak systems cannot be resilient *(18)*. Systems absorb shocks through the everyday capacities already in place before the shock – governance, financing, workforce, information and service delivery – rather than through structures raised after the event *(19)*. A 2026 scoping review of health system resilience in Africa identified the same foundations, while also highlighting trusted community engagement and adaptable infrastructure as additional pillars or resilience *(20)*. In a period of financial contraction, the implication is practical: the Region neither needs nor can afford a parallel emergency architecture.

The Region's answer is therefore to ensure that every response delivers a double dividend. In Bulape, for example, the Ebola response left more than 20 000 residents with improved access to safe water, solar power and a rehabilitated emergency operations centre after the outbreak had ended – a double win under the Region's Framework for sustaining resilient health systems to achieve universal health coverage and promote health security, 2023–2030 *(21)*. Communities carry that resilience: the engagement built during a response is what sustains detection and care between them. Recovery feeds preparedness, and preparedness strengthens the next response. It is that loop, rather than the speed of any single activation, that turns a sequence of responses into a system that grows stronger over time. For ministers, the conclusion is concrete: in a contraction, the cheapest preparedness available is the capacity that the last response has already paid for. The priorities below make that principle standard practice.

Persisting challenges

The emergency programme faces a set of interconnected constraints, beginning with financing. Investment in emergency preparedness remains low, even though the chance of another pandemic emerging in any given year is estimated at one in fifty. Funding cuts across sectors have affected surveillance and laboratory capacities, constraining the implementation of priority activities. Meanwhile, funding gaps, workforce shortages and staff fatigue have limited both the scale and quality of response operations.

Core capacities remain uneven. IHR core capacities for chemical and radiation events have lagged for decades, with little in place to reverse that trend. Other lagging capacities (including human resources for health, food safety, and infection prevention and control) are within reach if the investment is made. Collaborative surveillance, a cornerstone of the global architecture for health emergency preparedness, response and resilience, remains unevenly implemented across Member States. Weak digital health infrastructure and limited analytical capacity continue to constrain the scale-up of digital integrated disease surveillance and response systems.

Outbreak of Ebola virus disease, Kasai Province, Democratic Republic of the Congo, September 2025

© WHO / Josua Mulala

Laboratories face related challenges. Despite real gains, variations in sequencing capacity and delays in sample submission continue to limit the timeliness of genomic intelligence. Logistics and procurement bottlenecks affect the supply of reagents and consumables in some settings, while insufficient laboratory personnel constrain both the provision and expansion of technical support.

In emergency response operations, the main challenge is increasingly one of endurance rather than activation crises. Conflict and insecurity, climate-related shocks, water and sanitation gaps and weak health systems continue to affect deployment, supply delivery, field supervision, service continuity and recovery planning. These constraints are most pronounced in fragile and conflict-affected settings.

Cholera is where these constraints converge. The Region is off track for elimination by 2030: progress is poor on 10 of the 20 critical milestones of the Regional framework for cholera elimination (AFR/RC68/7), and all ten relate to water, sanitation and hygiene interventions that require long-term investment. In 2025 Africa recorded its largest number of cholera cases, amplified by cross-border transmission associated with large population movements, persistent preparedness gaps and weaknesses in health infrastructure, particularly water, sanitation and hygiene.

Priorities

Over the next 18 months, the Regional Office will support Member States to domesticate the 2024 International Health Regulations (IHR) amendments and the 2025 WHO Pandemic Agreement through a single legislative package aligned with national universal health coverage frameworks. Progress will be reviewed at the Seventy-seventh session of the Regional Committee (RC77) in 2027, with a focus on how the legal milestones secured in this period have been translated into operational capacities and measurable improvements at country level. Efforts to strengthen regional One Health governance and partnerships will culminate in the first regional One Health conference and the submission of a proposed regional framework on One Health for ministerial adoption at RC77.

Enhancing public health intelligence and integrated disease surveillance and response remains the core priority for faster detection. Building on gains recorded in IHR core capacities through State Party self-assessment and Joint External Evaluation reports, the Region will accelerate collaborative surveillance and expand diagnostic and genomic capacities to improve the detection of pathogens with pandemic potential. The Preparedness Data Exchange will be rolled out across all Member States, aligning its data architecture with national health management information systems.

In emergency response, the next phase will focus on predictable financing, stronger national surge systems, prepositioned supplies and climate-informed readiness. The Regional Office will work with Member States and partners to maintain 24- to 48-hour surge readiness, preposition critical supplies closer to high-risk areas, expand access to rapid and flexible financing, strengthen country-led incident management systems and public health emergency operations centres, integrate climate-informed and One Health readiness, protect essential services in fragile settings, and strengthen accountability and learning.

Over the next 12 months, the Regional Office will also make post-emergency resilience a standard component of major outbreak responses, using the Bulape post-outbreak approach as the model for future transitions. Particular emphasis will be placed on decentralizing health security functions, protecting the continuity of essential services and strengthening district-level platforms. Water systems, treatment platforms, trained responders, digital tools, public health emergency operations centres, logistics assets and service continuity platforms established during emergencies will be maintained as part of national health security capacity, so that the Region can respond faster while leaving countries stronger for the next emergency.

The Secretariat calls on Member States to:

- **invest** in the core capacities required to implement legal reforms and sustain these gains, particularly in fragile and humanitarian settings;
- **entrench** the right to protection established through the amendments in order to reach the most exposed populations;
- **protect** the gains achieved during emergencies responses through domestic financing, more predictable and flexible funding, and stronger national ownership; and
- **invest** in water, sanitation and hygiene to put cholera elimination by 2030 back within reach.

3.5. Polio infrastructure now protects the Region against far more than polio

This section reports a result that lies at the heart of the "*protect health*" mission and extends well beyond it. Africa remains free of indigenous wild poliovirus, and despite a 30% reduction in global polio financing during the reporting period, the Region still drove transmission down for a third consecutive year. This progress was sustained through country-led emergency operations centres under direct Ministry of Health leadership and the rapid deployment of response teams within 72 hours of every confirmed outbreak. The infrastructure built to find and stop poliovirus – surveillance networks, laboratories and rapid-response teams – has become a shared backbone for detecting and responding to many other threats.

KENYA: Polio Vaccination Campaign - 11/13 November 2024

© WHO / Genna Print

Key results

Approximately 200 million children
under 5 years of age were reached with more than 420 million doses of oral poliovirus vaccine across 17 priority countries.

Cases of paralysis
caused by circulating vaccine-derived poliovirus type 2 fell from 245 in 2024 to 172 in 2025, and further to 40 by mid-2026. Over the same period, the number of distinct emergence groups dropped from 22 to six.

Nine circulating vaccine-derived
poliovirus type 2 outbreaks were interrupted within two to three campaign rounds in Burundi, the Republic of the Congo, Gambia, Ghana, Guinea-Bissau, Liberia, Mauritania, Sierra Leone and Uganda. Mozambique has recorded no virus detection since early 2024.

Regional genomic sequencing
capacity expanded from two to four laboratories, and the share of type 2 poliovirus isolates sequenced within Africa rose from 47% in 2024 to 97% in 2026.

Fifty-three synchronized
supplementary immunization activities were implemented across 17 priority countries, with 80% of targeted districts achieving high-quality coverage; more than 2400 surge personnel were deployed.

Forty-six of the Region's 47 Member States
now operate environmental surveillance systems, while 16 accredited laboratories process more than 100 000 specimens annually.

Polio-funded surveillance and laboratory
networks now support the detection of measles, yellow fever, mpox and cholera, and polio rapid-response teams were deployed in support of the mpox response in the Democratic Republic of the Congo.

Challenges and priorities

Three consecutive years of declining case counts have not removed the threat of poliovirus transmission. The persistent circulation of vaccine-derived poliovirus type 2 in the Lake Chad Basin, the Horn of Africa, the Democratic Republic of the Congo and Angola demands sustained attention. At the same time, the Global Polio Eradication Initiative faces a residual funding gap of US$ 1.7 billion through 2029, while a 30% reduction in the 2026 operational budget threatens to compress surveillance and outbreak response capacity in lower-priority countries. These pressures are compounded by insecurity, population displacement and climate stress, particularly in the Sahel, the Horn of Africa and the Democratic Republic of the Congo. Polio transition planning remains uneven across the Region: only a minority of Member States have developed costed transition plans aligned with the WHO strategic action plan on polio transition.

Over the next 18 months, the Regional Office will intensify efforts to interrupt transmission in the high-risk subregions, particularly the Horn of Africa, the Lake Chad Basin and parts of Southern and Central Africa, through focused subnational interventions and strengthened cross-border coordination. It will work with Member States to close immunity gaps by embedding polio vaccination within essential health services, with a deliberate focus on zero-dose and under-immunized children; further expand genomic surveillance and strengthen acute flaccid paralysis and environmental surveillance to bring the median detection time below 35 days by 2027; and operationalize the polio transition framework adopted at the Seventy-fifth session of the Regional Committee through costed national plans in at least 15 priority countries by the Seventy-seventh session in 2027.

The Secretariat calls on Member States to:

- **mobilize** domestic funding to support routine immunization and outbreak response through existing emergency mechanisms; and
- **adopt** costed transition plans that will carry the polio infrastructure into its next role as a shared regional asset.

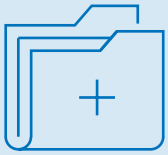
3.6. Antimicrobial resistance was met with One Health governance, surveillance and stewardship

This section reports the Region's response to the slowest-moving emergency within the "*protect health*" mission. When the antibiotics that a clinic depends on stop working, ordinary medicine becomes dangerous again: a caesarean section, a child's pneumonia or a routine surgical procedure can once again become life-threatening. During the reporting period, the Region shifted from awareness to action, strengthening the governance, surveillance and stewardship needed to slow antimicrobial resistance through a One Health approach linking human, animal and environmental health. This ties antimicrobial resistance to health security preparedness.

The Regional Office convened the Region's One Health response through collaboration with the quadripartite partners, the Food and Agriculture Organization (FAO), the World Organisation for Animal Health (WOAH), WHO and the United Nations Environment Programme (UNEP), as well as the African Union, including Africa CDC and the African Union Inter-African Bureau for Animal Resources (AU-IBAR). It delivered training on costing and budgeting, the Tracking Antimicrobial Resistance Country Self-assessment Survey (TrACSS) and the Global Antimicrobial Resistance and Use Surveillance System (GLASS), and produced country and regional profiles to support evidence-informed decision-making. The Regional Office also conducted the Region's first simulation exercise for antimicrobial resistance-related outbreaks; led the continental awareness week; and provided specialized technical support on antimicrobial stewardship and antimicrobial use to countries. This included an assessment of stewardship core elements across 26 health facilities in Sierra Leone that generated a replicable model. It sustained the regional evidence base by publishing analyses of resistance trends and national action plan implementation, and by contributing peer-reviewed evidence on surveillance, laboratory capacity, health care-associated infections and the role of vaccines (*22–30*).

Key results

All 47 Member States
are now enrolled in the GLASS, and 33 are reporting resistance data to inform clinical and public health decisions.



The 2025 TrACSS platform
achieved a 100% regional submission rate, strengthening accountability for implementation of national action plans.

Seventeen Member States
strengthened their capacity to develop costed and budgeted national action plans on antimicrobial resistance, while five institutionalized antimicrobial stewardship and antimicrobial use monitoring programmes.

Country spotlight

Antimicrobial resistance has long been treated as a laboratory concern, easy for a health ministry under pressure to defer. In 2025, the United Republic of Tanzania hosted the African continental World Antimicrobial Resistance Awareness Week, convened jointly by the quadripartite organizations and African Union institutions. In doing so, it helped move antimicrobial resistance from the margins of policy discussion to the centre of the regional health security agenda. The choice of host matters: By placing its national platform behind a continental awareness initiative, the Government of the United Republic of Tanzania signalled to Member States that antimicrobial resistance requires coordinated governance across the human, animal and environmental health sectors, and that the surveillance data now flowing from all 47 Member States enrolled in the Global Antimicrobial Resistance and Use Surveillance System are there to be acted upon.

Remaining challenges

The architecture is in place but remains incomplete or not yet fully self-sustaining. Of the 47 Member States enrolled in GLASS, only 33 are currently reporting data, leaving important gaps in the regional picture. Surveillance must translate into changes in prescribing practices and stronger infection prevention and control, which remains the more difficult task. Costed national action plans, where they exist, now face the same financing pressures affecting health security more broadly, at precisely the point when implementation matters most.

Priorities going forward

Over the next 18 months, the Regional Office will support Member States that are not yet reporting to GLASS to begin contributing data, moving the Region closer to comprehensive surveillance coverage. It will support more Member States to develop costed and budgeted national action plans and institutionalize antimicrobial stewardship and use monitoring programmes. The Regional Office will also deepen integrated surveillance across the human, animal and environmental health sectors, while further strengthening the food systems dimension of antimicrobial resistance, including surveillance of resistance in foodborne pathogens, as discussed in *Chapter 4*.

The Secretariat calls on Member States to:

- **cost, budget and finance** national action plans from domestic resources and integrate antimicrobial resistance into health security investments and pandemic fund proposals;
- **report antimicrobial use** as well as resistance data to GLASS and strengthen surveillance of health care-associated infections and laboratory capacity;
- **institutionalize antimicrobial stewardship** and infection prevention and control at facility level; and
- **sustain multisectoral One Health governance** and high-level political commitment beyond awareness campaigns.

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Chapter 4.

Building healthier populations and tackling the drivers of disease

Most conditions now responsible for premature death and disability in the African Region are not addressed in clinical settings; they are shaped by underlying determinants long before individuals seek care. Noncommunicable diseases accounted for 37% of all deaths in the Region in 2019, up from 24% in 2000, with approximately 64% of these deaths occurring before the age of 70 *(1)*. This is the highest rate of premature NCD mortality of any WHO region. Climate change, unsafe food and water contribute to cholera, malaria and malnutrition. Rapid and unplanned urbanization, road traffic injuries and air pollution disproportionately harm the same communities. These drivers interact and reinforce one another. Climate change deepens food insecurity and overwhelms water and sanitation systems, air pollution amplifies the harms of tobacco use and poverty compounds exposure, especially for children and women.

This chapter sets out the Regional Office's contribution to the focus of the Fourteenth General Programme of Work on promoting health by acting on the determinants and root causes of ill health upstream of clinical care, so that fewer people fall sick in the first place. In a year of sharply contracting international financing, this contribution focused on instruments designed to be self-sustaining and to outlast project cycles. These include a tobacco tax that helps fund the response to the harm it reduces;

a climate finance pipeline that ministries of health could not access independently; regulatory measures on food, nutrition and water embedded in national legislation; and a community platform that protects populations before they require clinical services. A final section addresses road safety and interpersonal violence, areas that remain undermeasured in the Region, where this year, the contribution was primarily diagnostic and normative rather than financial. Related results are presented in Chapter 2 (services) and Chapter 3 (health security). The institutional reforms underpinning these efforts are described in Chapter 5, financing aspects in Chapter 6, and the strategic priorities raised here are further developed in Chapter 7.

4.1. Tobacco taxation became the Region's leading domestic resource lever, and the first to pay for itself

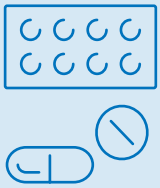
A tobacco tax is one of the few health measures that strengthens public finances and protects population health. By increasing prices, the tax reduces the affordability of the most harmful legal products, particularly for young people, while generating domestic revenue at a time of contracting external financing. Fifteen Member States adopted progressive tobacco excise reforms between 2025 and 2026, marking the largest synchronized tobacco tax reform cycle in the Region in a decade. These reforms move countries closer to the WHO benchmark of a 75% total tax share of the retail price and to compliance with Article 6 of the WHO Framework Convention on Tobacco Control. The Regional Office combined three elements rarely delivered in a single package: technical authority in tax modelling through the WHO Tax Simulation Model; normative authority on compliance with the Framework Convention; and convening authority across ministries of health, finance, customs and justice, as well as across parliaments. Of the four instruments addressed in this chapter, tobacco taxation is the only one that generates the domestic revenue required to sustain its own implementation.

Key results

Fifteen Member States *(2)* adopted progressive tobacco excise reforms. In Zambia, import duty on cigarettes rose from 452 to 750 kwacha per 1000 sticks and domestic excise rose by 66%, from 113 to 187.5 kwacha. Sierra Leone moved from a weak ad valorem regime to a mixed system combining a specific rate per pack with a 30% ad valorem component, and raised the specific rate again in 2025.

Twelve Member States strengthened legislation under the Framework Convention, expanding smoke-free coverage, graphic health warnings and cessation services.

More than 1500 enforcement officers were trained across 14 Member States.



Botswana, Kenya, Madagascar and Namibia developed national clinical guidelines for tobacco cessation and began adding nicotine replacement therapies and other cessation medicines to national essential medicines lists, integrating cessation into primary health care.

More than 14 000 smallholder farmers in Kenya and Zambia transitioned from tobacco to food and cash crops under the Tobacco-Free Farms Initiative – 53% were women and 22% young people. More than 13 500 acres were converted to higher-value food and cash crops, 16 200 trees were planted and 46% of farmers adopted agroforestry. The share of participating households reporting that they had three meals a day rose from 46% during tobacco-growing periods to 79% after transition.

A US$ 1.7 million grant from the Gates Foundation, with US$ 200 000 from the Melkus Family Foundation, was secured to scale the farm-transition model to Malawi, Uganda and the United Republic of Tanzania.

Country spotlight

As the longest-running example in the Region, Ghana demonstrates exactly what this fiscal tool can deliver. Cigarette consumption fell by nearly one third, while excise revenue rose almost fourfold between 2021–2022 and 2023–2024, with excise per stick rising almost sixfold. It is the clearest evidence in the Region that a single reform can reduce consumption and fund the response at the same time.

4.2. Climate finance has become a measurable health-sector capability

Climate change is no longer a future variable in the Region's health planning. It is a present operating condition, reflected in shifting vector-borne disease patterns, lean-season nutrition admissions and the destruction of health infrastructure. Yet less than 1% of global climate finance is allocated to health, and only 0.3% of adaptation finance supports health systems. Ministries of health in the Region cannot directly access the largest adaptation funds at all. Because the Regional Office is accredited to the Adaptation Fund and ministries of health are not, it designed the Region's bids as a single portfolio rather than 21 separate proposals, assembling the largest climate-and-health financing pipeline in the Region's history and turning access to climate finance from an aspiration into a practical health-sector function.

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Key results

WHO developed a US$ 139 million

pipeline through eight coordinated Adaptation Fund proposals covering 21 Member States, positioning an estimated 490 million people to benefit from multi-hazard early-warning systems, climate-resilient health infrastructure, water, sanitation and hygiene services, epidemic preparedness and clean energy for health facilities. Four of the eight projects advanced to full concept-note stage and secured US$ 600 000 in project preparation grants, pending disbursement. Furthermore, Mozambique secured a US$ 1 million project to strengthen the climate resilience of its health care facilities, through a separate grant from the Hong Kong Jockey Club Institute of Philanthropy. Mozambique is also a part of the Adaptation Fund Portfolio.

The Alliance for Transformative

Action on Climate Change and Health now includes 31 of the 47 Member States, representing 66% of the Region and the largest share in any WHO region. Twenty-two Member States include health co-benefits in their nationally determined contributions, up from 15 in 2022. Nine have completed or updated Health National Adaptation Plans and a further eight began vulnerability and adaptation assessments in 2026 *(3)*.

Solar electrification

has reached more than 1500 health facilities, serving 13 million people in Ethiopia, Uganda and Zambia, taking facility-level adaptation beyond pilot stage *(4)*.

Thirteen Member States

addressed the mercury-related health risks of skin-lightening products and dental amalgam. Burkina Faso, Gabon and Uganda adopted national mercury-management guidelines, while Senegal became the first African country to fully operationalize the Minamata Convention obligation on the phase-down of dental amalgam. In addition, under the Bloomberg-funded Global Lead Elimination Initiative, a US$ 2.3 million programme launched national awareness campaigns on lead elimination across six Member States *(5)*, with a combined population of 338 million people, laying the foundation for reduced exposure to a toxicant linked to irreversible cognitive impairment and cardiovascular disease.

The Region

has moved from advocacy to direct action in the global climate architecture. The Regional Office co-convened the Global Conference on Climate and Health in July 2025 and contributed to the Belém Health Action Plan. The Pan-African Conference on Environment, Climate Change and Health in Nairobi produced the Nairobi Declaration on Climate Change and Health. A Climate Change and Health Negotiators' Curriculum was launched with Clim-HEALTH Africa partners at the Second Africa Climate Summit held in Addis Ababa in September 2025, where the Minister of Health of Senegal was designated as the WHO Champion on Climate Change and Health.

Country spotlight

Mozambique produced the first proposal to transition from design to delivery. Now approved and actively disbursing, this project demonstrates that the regional portfolio is more than a set of documents, and it establishes the baseline for accreditation, project design and disbursement, that all subsequent proposals will follow.

4.3. Diets, food and water protections transitioned from policy to national law and front-line delivery

Diseases linked to unhealthy diets, unsafe food and contaminated water are preventable long before a patient ever reaches a clinic. True protection relies less on medical services and more on the regulations countries write and enforce. The high stakes of this approach are clear in the case of cholera. The African Region accounted for 95% of global cholera deaths in the first half of 2025. Inadequate water, sanitation and hygiene, alongside flooding, displacement and overstretched health systems were repeatedly identified as the direct drivers. During the reporting period, the Region advanced on three fronts simultaneously: integrating healthy diet and food safety rules into national law, placing water and sanitation planning on a secure financial footing, and expanding child wasting services under acute humanitarian pressure. The Regional Office's contribution here was regulatory and scientific rather than fiscal. It provided nutrient-profile models, Codex-aligned standards, and the planning instruments that translate health coverage data into investment cases that ministries of finance will fund.

Key results

Forty-six Member States now implement at least one WHO-recommended healthy-diet policy *(6)*, including sugar-sweetened beverage taxation, sodium reduction, front-of-pack nutrition labelling and restrictions on the marketing of unhealthy foods to children. Thirty-four have legal measures in force aligned with the International Code of Marketing of Breast-milk Substitutes, and 23 meet the WHO target of at least half of all infants being exclusively breastfed for the first six months of life.

Kenya adopted its national Nutrient Profile Model and a fiscal policy taxing sugar-sweetened beverages. Mauritius doubled its sugar-sweetened beverage tax and adopted the Region's first national obesity roadmap. The East African Community revised and adopted standards on nutrition labelling and published a draft front-of-pack labelling guideline for consultation.

Fifty-five Codex Alimentarius food-safety standards were operationalized across Malawi and Sierra Leone; food-safety reform roadmaps were completed in Madagascar and Sierra Leone; a healthy food market initiative reached more than 3000 traders and consumers across 26 markets in Douala, Cameroon; a regional monitoring framework was established for the WHO Global Strategy for Food Safety 2022–2030; and more than 200 national experts were trained on integrated surveillance of antimicrobial resistance in foodborne pathogens.

Core nutrition indicators were integrated into the national health information systems of all 47 Member States, with 20 Member States initiating costed plans to accelerate anaemia reduction. Eighteen Member States validated their revised child wasting protocols, and eight of them finalized their operational tools.

The WHO Water and Sanitation for Health Facility Improvement Tool was extended to 18 Member States. Nine Member States applied the Hand Hygiene Acceleration Framework Tool, and 15 completed national water and sanitation accounts that convert coverage data into investment cases for ministries of finance. In addition, four climate-resilient water and sanitation proposals – for Malawi, Mozambique, Zambia and Zimbabwe – are already in the Adaptation Fund pipeline described in section 4.2.

Country spotlight

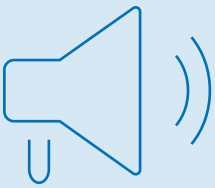
Kenya assembled the most comprehensive regulatory package among Member States during the reporting period. It finalized and adopted its national Nutrient Profile Model in April 2025 and subsequently built on this foundation with draft regulations on front-of-pack labelling, restrictions on the marketing of foods high in sugars, fats and sodium to children, and the elimination of trans-fatty acids. These measures are complemented by a national fiscal policy that taxes sugar-sweetened beverages with an explicit public health objective.

4.4. Community protection became a standing platform for addressing commercial and behavioural determinants

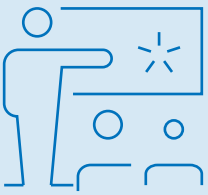
When an outbreak begins, the speed of the community response often determines its scale. Communities act as both the first line of defence against outbreaks and a primary target for harmful commercial products. Crucially, both challenges respond to the same behavioural science principles and engagement tools. During the 2024–2025 mpox public health emergency of international concern and the continental cholera emergency, the Regional Office positioned community engagement as a core component of preparedness rather than a parallel response pillar. It operationalized resolution AFR/RC73/R3 on Strengthening Community Protection and Resilience in 11 frontline Member States and developed the Region's first integrated training package. The result is a single platform for addressing the commercial, behavioural and cultural determinants of health, and provides the means through which the results outlined in this chapter reach communities.

Key results

Resolution AFR/RC73/R3 on Strengthening Community Protection and Resilience was operationalized in 11 frontline Member States *(7)* during the mpox and cholera emergencies; the Region's first integrated Community Protection and Resilience training package has since been adopted by more than 20 Member States and is now informing other WHO regions.



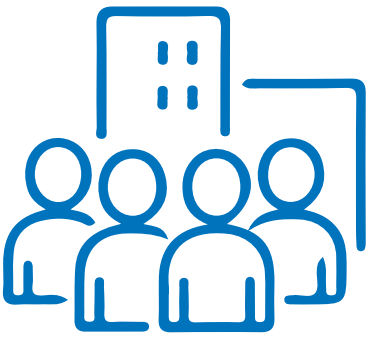
Community-led contact tracing, survivor-led stigma reduction, infodemic management and behaviourally informed communication supported the continental mpox response, delivered jointly with the Africa Centres for Disease Control and Prevention under "one team, one plan, one budget and one monitoring system" approach.



An intercountry workshop on the WHO SAFER initiative to reduce alcohol-related harm convened 55 participants from 15 Member States to develop national roadmaps across the health, transport, finance and justice sectors, with multisectoral coordination platforms established in several Member States afterwards.

Country spotlight

The United Republic of Tanzania demonstrates what the platform can achieve when it is fully resourced. Through the joint PATH, WHO and International Olympic Committee Community Sport and Health Cooperation Initiative, more than 128 000 people were reached with sport-based health promotion. At the same time, the country advanced food-labelling and school physical-activity policies, providing the clearest example in the Region of community engagement, behavioural insight and the regulation of commercial determinants operating as a single, nationally owned system.



4.5. Road safety and interpersonal violence remained the Region's least visible drivers of premature death

Road traffic crashes and interpersonal violence account for a large share of premature deaths and disability in the Region, yet they remain among the least-measured public health drivers. An estimated 259 601 people died in road traffic crashes in Africa in 2021, accounting for 24% of the global total. The Region has the world's highest road traffic fatality rate in the world, at 19.6 per 100 000 population. The burden falls disproportionately on those least protected. Indeed, pedestrians account for 31% of deaths, users of two- and three-wheeled vehicles account for 17.5%, and cyclists 4.4%, together making up more than half of all road deaths. Intimate partner violence affects around one in five women in sub-Saharan Africa, the highest level of any region. Both burdens are systematically under-recorded: estimated road traffic deaths in 2021 were roughly three times the number reported by countries, and violence is under-disclosed wherever survivor-centred services are limited. This invisibility is itself the first finding, and a key reason these drivers are consistently under-prioritized relative to burdens the Region measures more accurately.

With the substantive service response reported elsewhere in this report, the Regional Office's contribution to these two determinants this year was normative and diagnostic. It maintained the established road safety legislative package addressing the five proven risk factors: speed, drink-driving, helmets, seat-belts and child restraints. It also supported Member States in aligning national road safety strategies with the United Nations Decade of Action for Road Safety 2021–2030 and its target of halving road traffic deaths by 2030, as well as with the African Union's African Road Safety Charter, African Road Safety Observatory and African Road Safety Action Plan 2021–2030. Multisectoral work on shared risk factors, including drink-driving, advanced through the SAFER initiative reported in section 4.4. On violence, the Regional Office embedded prevention within its work on gender, mental health and community protection rather than as a standalone programme.

Key results

The five-factor road safety legislative package (speed, drink-driving, helmets, seat-belts and child restraints) remained the Region's operational benchmark. Across the African continent, 38 of 55 States now operate a national road safety strategy. Twenty-four of them have set a fatality-reduction target and 19 align that target with Sustainable Development Goal target 3.6.

The substantive service and protection response is reported in the specific sections where it is delivered: rehabilitation and injury care, including the regional strategy to strengthen rehabilitation in health systems 2025–2035, (found in Chapter 2, under service capacity); survivor-centred care and the prevention of and response to sexual exploitation, abuse and harassment, also in Chapter 2; and mental health and psychosocial support, also in Chapter 2.

4.6. Challenges and priorities

The instruments are real, but most are running ahead of the systems needed to sustain them. Tobacco industry interference, increasingly framed around new and emerging nicotine products as harm reduction, remains the principal sustained threat to implementation of the Framework Convention, and political turnover has paused or reversed reforms in some Member States. Most allocate little or no domestic budget to tobacco control, because excise receipts accrue to the general treasury with no legal requirement to earmark a share for health, while administrative gaps in customs and excise continue to erode the gains realized. The climate pipeline is in place but is not yet disbursing at scale, and the bilateral co-financing on which several proposals depend has been reduced. Policy is moving ahead of implementation on diets and food safety. While 46 Member States have a healthy-diet policy, none of the five countries advancing regulations has fully enforced rules across all four core policy areas. Furthermore, the population-level effects of mandatory labelling, marketing restrictions and

beverage taxation are not yet monitored . Twenty-eight Member States score below 50% on the Water Security Index, and persistent cholera outbreaks show that national gains in water and sanitation are not reaching the most exposed communities.

Those communities bear the greatest burden. The rural poor, women and children in fragile and drought-affected districts, and populations in informal urban settlements face the heaviest combined exposure to these drivers, and equity disaggregation by sex, age, disability and rural-urban status remains incomplete across every result reported here, which limits the Region's ability to direct resources to them.

Over the next 18 months, the Regional Office will work with the 15 reforming Member States to reach the 75% share-of-retail-price benchmark, institutionalize inflation indexation and implement Article 5.3 protections against industry interference in every reforming jurisdiction by the Twelfth Conference of the Parties in 2027. It will also support Member States to legislate earmarking of a defined share of tobacco-excise revenue for health, and publish an annual ratio of tobacco-tax revenue to tobacco-control budget allocation. In addition, it will move the US$ 139 million Adaptation Fund pipeline from preparation to disbursement, open the first Green Climate Fund pipeline for African health, and bring the remaining 16 Member States into the Alliance for Transformative Action on Climate Change and Health. It will finalize and enforce front-of-pack labelling and marketing restrictions in the reforming Member States and secure financing for the regional Quality-of-Care Improvement Tool for severe acute malnutrition. It will require every Member State to operationalize resolution AFR/RC73/R3 through a costed national community protection and resilience action plan, and disaggregate every top-line driver-of-disease indicator by sex and age by June 2027.

These priorities feed the "promote" pillar of the Region's forward agenda, carried into Chapter 7.

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KENYA: Emergency flooding response - 3 May 2024

Accessing sexual reproductive health care through resilient primary healthcare systems - Tana River, Kenya.

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Chapter 5.

Delivering for impact: a leaner Regional Office moving closer to countries

A health system in any of the 47 Member States of WHO in the African Region can only act on what reaches it: a workforce with the right skills deployed at the right time; the procurement and supply of goods and services delivered on time; audit recommendations that are closed promptly and sustained; and operational decisions taken close enough to the country to reflect national needs and priorities. During the reporting period, the global transformation agenda continued to enhance enabling functions and operational efficiency despite significant funding constraints Under the WHO Director-General's leadership, the prioritization and realignment process was initiated alongside the UN80 system-wide reform *(1)*.

The WHO Regional Office for Africa downsized its workforce from 2540 in January 2025 to 2046 in January 2026, and further to 1948 by July 2026. This restructuring represents and overall staffing reduction of 23.3%. Three quarters of the remaining staff (1434) now deployed directly in country offices. It transitioned all 47 country offices to a global, function-based operating model, the Core Country Office Model (CCOM). It also clarified decision-making across the three levels of the Organization through a well-defined delegation of authority. It identified more than US$ 8 million in recurring annual savings and

projected up to US$ 15.5 million in additional gains over the next biennium. Furthermore, it strengthened institutional oversight through internal and external audits, implementing efficiency mechanisms to ensure high performance and strict compliance with organizational rules and policies.

5.1. Responses and what was achieved

A leaner, country-focused operating model

WHO country office support to ministries of health must be high quality and timely. However, the 2025 funding reduction resulted in a 13% drop in the approved Base Programme Budget for the Region, falling from 1.31 billion in 2024–2025 to 1.14 billion in 2026–2027. This contraction affected the level of technical support WHO country offices could provide to host countries. In response, the Region implemented the global adjustment framework, restructuring operations and staffing through a comprehensive prioritization and realignment exercise.

As a result of the restructuring, prioritization and realignment in the African Region, Director positions were reduced from nine in January 2025 to six in July 2025, while Team Lead positions dropped from 49 to 33. All budget centres were required to identify core functions and priority positions that fit within the allocated funding envelope. At the same time, WHO country offices were requested to follow the CCOM as they reviewed and prioritized their core functions and critical positions. By January 2026, all 47 country offices had transitioned to the Core Country Office Model. This framework operates on the principle of one core team backed by a core funding stream ensuring a country office's capacity directly tracks its realistically available financing *(2)*. As a result, overall staffing in the African Region was reduced from 2540 in January 2025 to 1948 in July 2026, a reduction of 23.3%.

A mapping and matching process was carried out to ensure transparency and accountability, resulting in the successful placement of 2540 staff members. Staff who were not mapped or matched were provided support through the separation process, including payment of all relevant indemnities. In addition, staff development and learning services supported staff in curriculum vitae writing and competency-based interviews to prepare them for potential opportunities to compete for the vacancies that became available.

The Regional Office invested in leadership development, learning systems and staff well-being during a period of intense transition. A joint Leadership Programme cohort was conducted for the WHO African Region, the WHO Regional Office for Europe (EURO) and the WHO Regional Office for the Eastern Mediterranean (EMRO). A transition coaching programme supported newly appointed Directors, Team Leads and WHO representatives through personalized executive coaching delivered by International Coaching Federation-certified coaches.

Psychosocial and mental health services were made widely available to all staff. Staff were engaged in the change process through regular, transparent communication. This built awareness and ownership of the reform and, coupled with sustained leadership engagement, began to shift the Organization towards a country-centred, collaborative and results-oriented culture. These investments are consistent with the Multilateral Organization Performance Assessment Network's (MOPAN 2025) findings that efficiency gains within the United Nations system only translate into sustained effectiveness when accompanied by deliberate change-management capacity *(3)*.

Country support, delegated authority and operational performance

As part of the Regional Office restructuring, a dedicated WHO country support office attached to the immediate office of the Regional Director was maintained and is being resourced. The Regional Office also established a dedicated Monitoring, Evaluation, Special Initiatives and Change Management Unit (MSC) to support institutional learning, performance monitoring and adaptive management. This represents an important milestone in embedding organizational learning, performance tracking and change leadership into the governance architecture of the Region.

The new operating model clarified the specific, separate areas of responsibility assumed by WHO headquarters, the Regional Office and WHO country offices. With the addition of a new WHO Representative seat in the restructured Executive Management meeting, country leadership gained a direct voice in decisions at the regional level. The Executive Management meeting is organized in two formats. A core team and an extended team, ensuring that the most important decisions are taken by a focused group while the wider body retains oversight.

Over time, the regular meetings with WHO representatives contributed to support that was more closely aligned with the actual stated needs of countries. The Resource Allocation Committee was strengthened to allow it to direct financial and technical resources towards the most urgent operational and programmatic needs.

To convert intent into delivery, time-bound task teams were created to address the bottlenecks hampering efficiency, transparency and accountability, leading to the establishment of a Transparency and Fairness Committee to hear staff complaints. Concurrently, audit ratings and risk management were strengthened across the Region.

Compliance and risk mitigation

Digital payment solutions to support field campaigns continued to expand and have since been adopted as a good practice by other WHO regions. The number of implementing Member States increased from 23 to 25 between March 2025 and March 2026, while more than two million health workers in 12 countries received payments through mobile money or bank transfers, with 95% being paid within 10 days. This new mechanism made for prompter, more transparent and more easily accountable payments, improved satisfaction among health workers, reduced cash-handling risks and reinforced financial controls across campaign operations.

Several other initiatives to enhance efficiency in the supply chain process were adopted. The successful completion of the first pooled procurement tender under the Africa small island developing States (SIDS) initiative in June 2023 led to a second tender, launched in June 2026. This resulted in both higher indicative quantities and a substantial increase in the number of medicines and product formulations, from 67 to 239 – a nearly fourfold expansion in four key product categories: (i) anaesthetics; (ii) anti-infective medicines; (iii) immunomodulators, antineoplastics and supportive treatments; and (iv) medicines for noncommunicable diseases.

In parallel, the annual forecasting value increased by 69%, reaching US$ 22 million, with the potential to generate at least 20%, equivalent to an estimated US$ 4.5 million, in cost savings for participating Member States. The result is a critical mass of momentum for the Africa SIDS initiative, which has inspired other subregional economic communities and regional entities, including the Southern African Development Community (SADC), the Central African Economic and Monetary Community (CEMAC) and the West African Health Organization (WAHO), as well as Sahel countries, to approach the WHO Secretariat on the possible replication of similar pooled procurement and market-shaping approaches.

Value for money: efficiency, effectiveness and equity

Value-for-money gains and cost savings reported by 36 country offices and the Regional Office amount to US$ 10 million, consolidated across a number of strategic focus areas. Particularly pertinent were direct cost-reduction practices, direct contract negotiations, bulk and pooled purchasing arrangements and the use of alternative logistics solutions.

One of the most obvious operational improvements has been the strengthened supply chain and procurement support to country offices. A procurement readiness and capacity scorecard, covering 19 parameters – including staffing levels, required competencies, monitoring arrangements and compliance practices –is now being used to classify country offices by level of readiness, ranging from weak and needing strengthening to adequate or strong. This tool makes it possible to provide more targeted, differentiated and delivery-oriented support.

The gradual incorporation of AI into selected areas of the supply chain process represents an important step towards greater efficiency, transparency and data-driven decision-making.

Process improvements and cost saving

During the reporting period, the process-improvement and efficiency programme of the Regional Office identified more than US$ 8 million in recurring annual savings and cost avoidance, with further projected gains of up to US$ 15.5 million in the 2026–2027 biennium *(1)*. Cost-recovery mechanisms and a restructured supply chains account for approximately US$ 4 million a year. These savings positioned Regional Office procurement as a candidate common service under the UN80 “operational enablers” workstream *(4)*. Compliance and risk reforms, including the establishment of regional shared services and the strengthened Regional Risk Committee, contribute savings of approximately US$ 2 million annually.

The deployment of Starlink satellite Internet across 94 sites in 36 country offices, particularly in hard-to-reach duty stations in Nigeria, the Democratic Republic of the Congo, South Sudan and Mozambique, alongside the phasing out of expensive legacy satellite communication systems, is expected to release more than US$ 3 million across the biennium, with further automation and AI-enabled gains to follow in 2026–2027, comparable in direction to the reported US$ 18.7 million in 2025 digital-

and-AI efficiencies reported by the United Nations Development Programme.

Tighter operational services in the Brazzaville premises, including transport rationalization, controls on housing subsidies, solar installation and improved maintenance, are expected to deliver more than US$ 1.8 million annually in savings.

Operational services closer to the country offices: a regional services hub in Pretoria

In a bid to improve efficiency and effectiveness and to streamline transaction processing for quality support to country offices, the regional operational services approach was reinforced by creating two separate operational units, the Regional Office Support Unit (ROSU) focused on the Regional Office in Brazzaville, and the Regional Support Unit, to support the General Management and Coordination Cluster hub already established in Pretoria in providing operational support to the 47 country offices. The model mirrors the shared-services consolidation direction set out in the UN80 Action Plan *(5)*.

5.2. Challenges and priorities

These reforms and initiatives are substantial and commensurate with the financial environment of the reporting period. The focus remains on the residual financing gap; digital and AI utilization; country data monitoring and reporting; and workforce diversity.

Residual financing gap. Reforms do not automatically offset the residual 2026–2027 funding gap of US$ 662 million in the Region's base programmes, against the backdrop of a WHO-wide funding gap for base programmes of approximately US$ 1.1 billion *(1)*. For progress to be sustained, Member States will need to support the WHO Investment Round, honouring their commitments to the 20% increase in assessed contributions agreed at the Seventy-eighth World Health Assembly. Equally necessary will be continued advocacy under resolution WHA75(8) to finance 50% of base programmes with flexible funds by 2030–2031.

Digital and AI strand. The modernization of connectivity, including the purchase of Starlink units and the decommissioning of legacy very-small-aperture-terminal systems, has been delivered. The next biennium must add a deliberate AI and automation strand to back-office processes, including cloud-native enterprise resource planning and AI-enabled efficiencies *(5)*.

Country-level indicators of service-delivery improvement. The Regional Office will introduce service-level indicators of efficiency savings, including procurement lead time, human-resources transaction time and emergency deployment speed, to demonstrate the country-level value of the new operating model. These indicators will serve as the background for next year's report. Over the next 18 months, the Regional Office will institutionalise and monitor the impact of the new operating model.

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Sixty-fifth Regional Programme Meeting (RPM65) of the World Health Organization (WHO) African Region : Brazzaville, 9-10 October 2025

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Chapter 6.

Financing, ownership and partnership

A health improvement only lasts for the population that achieved it if it can be sustained financially in subsequent years. As detailed in Chapter 1, the reporting period started in the most adverse health-financing environment of recent memory.

Against this backdrop, the Region mobilized a historic regional bloc of sovereign pledges to the first-ever WHO Investment Round. It boosted the amount of voluntary contributions through a regional surge emergency resource mobilization plan and increased assessed contributions and expanded its private-sector and foundation share to 24%. Furthermore, the Region supported Member States in accelerating health financing reform and domestic resource mobilization under the Lusaka Agenda, revamped collaborations with regional economic communities and deepened the WHO–African Union strategic partnership at the heads-of-state level. This chapter sets out the resources mobilized, the sources of financing, national strategies for domestic health system financing, and the future trajectory of the global partnership architecture.

6.1. The first-ever WHO Investment Round: a historic regional bloc of sovereign pledges

Predictable financing is the difference between a programme that runs to the end of the year and one that runs to the end of the disease. During the reporting period, 22 Member States,[iii] representing 47% of the 47 Member States of WHO African Region, pledged to the WHO Investment Round. Overall, the Investment Round mobilized US$ 3.8 billion globally from 71 contributors, reaching 53% of the target of US$ 7.1 billion. These pledges include a deliberate mix of low-, lower-middle- and upper-middle-income economies acting in solidarity, validating Africa's leadership in the wider effort to secure predictable, flexible and resilient core financing for WHO.

Over the past year, 48% of these pledges were converted into liquid funds, up from 12% in July 2025. These commitments underpin the sustained delivery of essential services for the populations served by the pledging ministers. Three operational moves drove this outcome: the Regional Committee for Africa was used as an innovative resource-mobilisation platform for the first time in the WHO system, with the Seventy-fourth session of the WHO Regional Committee for Africa held in Brazzaville in August 2024 hosting the first Investment Round event ever held during a Regional Committee meeting and the Seventy-fifth session of the Regional Committee for Africa, held in Lusaka in August 2025, anchoring the next wave of pledges. In addition, more than 10 high-level briefings were prepared for the participation of African Member States in global pledging events.

Increased voluntary contributions reached US$ 769 million in 2024–2025

This increase was the result of a multi-biennium diversification strategy: between 2020–2021 and 2024–2025, contributions from private-sector and foundation to the Region grew from US$ 91 million to US$ 171 million, an 85% increase across two biennia. By the close of the reporting period, governments accounted for 39 of every 100 dollars of voluntary contributions; banks, funds and multilateral actors accounted for 37 dollars, and the private sector and philanthropic foundations accounted for the remaining 24 dollars.

This represents a more balanced portfolio than at any prior point, with a structure comparable to the most successful United Nations-system partnership functions. This shift reduces the Region's exposure to the withdrawal or change of priorities by any single donor and places it in a better position to align external resources with country priorities through the Investment Round, the 20% increase in assessed contributions agreed at the Seventy-eighth World Health Assembly and the resolution WHA75(8) target to finance 50% of base programmes from flexible funds by 2030–2031.

Stewardship of the broader partner relationship strengthened alongside the financial totals: 105 United Nations-to-United Nations partnerships and joint programmes were signed during the biennium; 186 engagements were processed under the Framework of Engagement with non-State Actors, each subject to due diligence and risk assessment within 72 hours; 470 funding proposals were submitted; and donor reporting timeliness improved from 38% on-time in 2020–2021 to 51% on-time in 2024–2025, with 1972 reports submitted in 2024–2025. Together these achievements form the stewardship foundation on which repeat funding is built.

In addition to the country partnerships highlighted below, multi-country flagship engagements included the Children's Investment Fund Foundation, which supported maternal and child health, nutrition and NTDs, and the WHO Foundation, which contributed procurement assistance to WHO emergency responses. New high-level engagements concluded in early 2026 included a Letter of Mutual Understanding with Unitaid, which was signed on 2 February 2026, and the strategic mission of the Gates Foundation to the Regional Office on 23–25 February 2026. These engagements shaped the 2026–2030 Strategic Vision and the Women in Leadership initiative.

Member States accelerated health financing reform and domestic resource mobilisation

Accelerated reform of health financing at the country level is necessary in a Region where out-of-pocket spending accounts for over 20% of health expenditure and where average government expenditure on health falls short of the Abuja Declaration target of 15%. To address this, the Regional Office convened regional and national platforms to accelerate reform at the pace demanded by the circumstances.

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

At least seven Member States adopted or updated national health financing strategies aligned with the five key shifts set out in the Lusaka Agenda. These shifts are country ownership of priority-setting; domestic financing growth; joint approaches to equity and PHC; strategic and operational coherence among global health initiatives; and accountability.

Two high-level convenings, one in Johannesburg for 24 English-speaking and French-speaking Member States and another in Abidjan for 14 French-speaking Member States in February 2026, assembled representatives of ministries of health and finance together with development partners to agree on practical domestic resource-mobilization and efficiency measures. Furthermore, more than 30 senior officials from five Portuguese-speaking Member States[iv] completed competency-based training on national health accounts and the health financing progress matrix in June 2025. Following this training, Guinea-Bissau resumed its data collection for national health accounts and Angola initiated preparations for its first national health accounts exercise in alignment with the System of Health Accounts 2011 framework, expanding the evidence base for monitoring financial protection and health expenditure trends across the Region. Eight countries *(3)* assessed their health financing systems through the health financing progress matrix, generating the country-level evidence necessary for guiding the revision of national health financing strategies.

A tripartite capacity-building programme on monitoring financial protection brought together national statistical offices and ministries of health across the Region. With support from the African Union Statistics Institute, WHO and the World Bank, 23 French-speaking Member States convened in Dakar in September 2025, followed by 24 English-speaking countries in June 2026. The Region's first UHC Knowledge Hub cohort, organized in February 2026, brought together representatives of ministries of health and finance to exchange experiences from ongoing health financing reforms, thereby sustaining the political-technical bridge required by the Lusaka Agenda. Through the Health Impact Investment Platform, Burundi and Angola received financial support to develop costed investment plans for PHC. The regional health financing progress matrix dashboard expanded coverage to 31 Member States, enabling annual benchmarking against the resolution adopted at the Seventy-fourth session of the Regional Committee for Africa (AFR/RC74/8) on health financing for UHC.

The Region's first cohort of Africa Health Financing Forum 2026 country leads, drawn from ministries of health and finance, was constituted in March 2026. At the Seventy-sixth session of the WHO Regional Committee for Africa, the Regional Office will present the Strategy for the Future of Health Financing in the WHO African Region 2026–2035 for endorsement by Member States, providing that the 10-year normative framework through which the domestic resource-mobilisation reforms agreed in Johannesburg and Abidjan is operationalized.

The WHO–African Union strategic partnership was deepened at the heads-of-state level, advancing continental governance for health

Through the WHO Liaison Office to the African Union and the United Nations Economic Commission for Africa, the Regional Office significantly deepened its strategic partnership with the African Union system during the reporting period. The Regional Office supported the institutional transition processes underpinning the operationalisation of the African Medicines Agency. This included the consolidation of the African Medicines Regulatory Harmonization initiative into the Agency, technical secondment arrangements and strengthening of regulatory systems, in accordance with the African Medicines Agency Treaty which has been in force since 2023 and the Pharmaceutical Manufacturing Plan for Africa.

Although the official theme of the African Union Summit of February 2026 was focused on water and sanitation, the summit offered an opportunity to secure unprecedented visibility for health priorities at the level of heads of state and government, including immunization (as reflected by the Addis Ababa Declaration on Immunization), women's health and the Campaign on Accelerated Reduction of Maternal Mortality in Africa Plus, sustainable health financing and the Africa Health Sovereignty Agenda. Parliamentary engagement with the Pan-African Parliament also expanded substantially in the same period.

iv. Angola, Cabo Verde, Guinea-Bissau, Mozambique and Sao Tome and Principe.

Building on the 2024 framework, the Framework of Collaboration and Joint Action Plan agreed between WHO and Africa CDC progressed through structured engagement platforms, harmonized policy dialogue, joint planning processes and coordinated technical support to Member States in nine priority areas: health sovereignty; resilient health systems; sustainable financing; local manufacturing; immunization; RMNCAH; health security; workforce development; and digital health. The Africa Health Partners Group serves as the central convening platform. Consistent with the Lusaka Agenda's call for reduced fragmentation across global health initiatives, the Regional Office for Africa, the Eastern Mediterranean Regional Office and Africa CDC are converging on a single continental response to the post-aid environment.

Closer collaboration with regional economic communities

During the reporting period, the Regional Office strengthened engagement with regional economic communities and regional health organisations as a bridge between continental policy and coordinated implementation across Member States. Through the WHO Liaison Office to the African Union, collaboration was also expanded with the Addis Ababa-based regional economic community liaison offices and the Inter-Regional Economic Community/ Regional Mechanisms Coordination and Collaboration Platform, supporting greater participation by regional economic communities and alignment on health priorities shared by the African Union and WHO.

In 2025, collaboration with the Intergovernmental Authority on Development (IGAD) advanced in the areas of sustainable health financing and regional health security. WHO technical engagement complemented the Africa Demographic Dividend and Sexual and Reproductive Health programme of the IGAD-African Union Development Agency–New Partnership for Africa's Development (IGAD–AUDA-NEPAD) coalition, including development of the IGAD Regional Health Financing Strategy and the roadmap for establishing a Regional Health Financing Hub to promote domestic resource mobilisation, capacity development and shared learning.

In West Africa, collaboration already established with the Economic Community of West African States (ECOWAS) through the WAHO was reinforced with joint regional initiatives, including the ECOWAS Lassa Fever International Conference in September 2025, and was subsequently formalised through a memorandum of understanding signed during the reporting period.

In December 2025, the Regional Office and the East, Central and Southern Africa Health Community (ECSA-HC) signed a memorandum of understanding establishing a structured framework for cooperation on UHC, health security, health workforce development, regulatory harmonisation, digital health, research, climate change and antimicrobial resistance. In 2026, the partnership began approaching operational delivery, including the participation of ECSA-HC in the high-level consultation convened in Brazzaville on 4–5 May 2026 to strengthen cross-border preparedness and response.

Collaboration with SADC was progressively reinforced through the placement of a WHO senior health adviser at the SADC Secretariat, high-level engagement with the SADC Executive Secretary in June 2026 and WHO support to the SADC Joint Meeting of Ministers of Finance and Health, held on 2–3 July 2026. WHO contributed to discussions on sustainable health financing, resilient health systems and pandemic preparedness, including a dedicated session on the evolving EVD situation and regional readiness, and a high-level event on sustainable financing for sexual and reproductive health and rights and for RMNCAH.

In the Economic Community of Central African States region, WHO support included the development of a regional community protection and risk communication and community engagement plan covering all 11 Member States, together with a repository of risk-based community messages to support preparedness and response. This engagement is timely: the 2026 report of the United Nations Secretary-General on Central Africa highlighted the development of the Economic Community of Central African States Commission Strategic Plan 2026–2030 and the need for adequate and predictable partner support to translate regional priorities into meaningful action.

Country spotlights

United Republic of Tanzania: securing health-security financing in the same year in which an outbreak tested it. In the same year that the Region responded to a Marburg virus outbreak in the United Republic of Tanzania, the country secured a US$ 25 million grant from the Pandemic Fund to boost health security and pandemic preparedness, pledged to the WHO Investment Round and hosted a high-profile partnership with the Coalition for Epidemic Preparedness Innovations through the African Vaccine Regulatory Forum. The sequence (domestic resource mobilisation, sovereign pledging and outbreak response in the same 12 months) is the operational form that the partnership architecture is meant to take.

Madagascar: a foundation partnership tied to lymphatic filariasis elimination. The partnership for lymphatic filariasis elimination in Madagascar demonstrates how a contribution by a foundation can be linked to a defined elimination end-point, rather than to an open-ended programme line. The model, in which foundation capital, ministerial leadership and WHO technical assistance are all measured against a single elimination target, is one of the clearest country-level translations of the call for strategic coherence among global health initiatives contained in the Lusaka Agenda.

Zambia: private-sector capital solving the electricity problem that holds back primary health care. Reliable electricity is not a luxury in healthcare: it is essential. A health facility that cannot keep a vaccine cold cannot deliver the immunization gains that the rest of the system pays for. The solar electrification of health facilities in Zambia is one of the most practical demonstrations during the reporting period that, when channelled through an effective partnership with WHO and aligned with the stated priorities of the ministry of health, private-sector capital can solve a binding infrastructure constraint at the primary care level. By leveraging an existing multilateral programme, this initiative demonstrates how private sector co-financing can expand health infrastructure efficiently, without creating parallel systems. As development assistance declines, such models offer a practical pathway for sustaining essential health services in resource-constrained settings. Importantly, such models are also replicable across the Region's energy-poor health facility networks.

6.2. Outstanding challenges

The work is not yet done. The Region will face four unresolved challenges in the next biennium.

Firstly, the residual financing gap for base programmes. Reforms and mobilisation reflect part, but not all, of the WHO 2026–2027 funding picture. The Region's base programmes carry a residual funding gap of US$ 662 million, set against a WHO-wide funding gap of approximately US$ 1.1 billion for the same biennium. Closing the Region's share requires both expanded sovereign pledging, with a focus on the 25 African Member States that have not yet pledged contributions to the Investment Round and continued private-sector and foundation engagement.

Secondly, the conversion of pledges into disbursements. Pledges are far from actual disbursements. The most consistent failure mode across comparable Gavi and Global Fund replenishment cycles is the slippage between political commitment and budgetary execution. The Region will establish a quarterly tracker for the 22 Investment Round pledges by African Member States and report quarterly to the Regional Director on disbursements compared to pledges. Engagement with ministries of finance, alongside ministries of health, should deepen for that conversion to occur.

Thirdly, the exposure to G7 aid reductions. Almost all G7 nations have announced reductions in development assistance, with material implications for the Region's mobilisation potential in 2026–2027. The Regional office will build a defensive risk register to monitor exposure to the top 10 sovereign donors and a corresponding mitigation plan, drawing on the call for stronger domestic resource mobilisation as the complementary strategy contained in the Lusaka Agenda. Domestic financing is no longer just an option for the future; it is the central plank of the next biennium. Out-of-pocket spending on health accounts for at least one quarter of current health expenditure in 35 Member States, increasing the risk of financial hardship and limiting financial protection. The contraction of and official development assistance has reduced the fiscal space for health systems strengthening investment in at least 14 highly dependent countries.

Fourthly, the digital stewardship infrastructure required to scale. Sustaining stewardship of the WHO African Region Partnerships Network without proportionate staffing growth requires a region-wide partner-relationship management platform and a digital stewardship architecture. Investment in both is required in 2026–2027.

6.3. Priorities going forward

The Region's priorities for partnerships and financing over the next biennium are anchored in three specific political moments and one operational shift. The political moments are the Seventy-sixth session of the WHO Regional Committee for Africa in 2026, at which the Regional Committee is expected to endorse the Strategy for the Future of Health Financing in the WHO African Region 2026–2035; the Seventy-seventh session of the WHO Regional Committee for Africa in 2027, at which the Regional Committee will assess implementation of the Lusaka Agenda Continental Roadmap; and the Africa Health Financing Forum in 2026, at which Member States will commit to updated national health financing strategies and costed PHC investment cases. The operational shift is fivefold: converting pledges to disbursements and reporting on conversion evert quarter; expanding Investment Round engagement to the remaining 25 African Member States, with a target of full regional

participation by the end of 2027; targeting a 30% private-sector and foundation share of mobilised resources by the end of 2027; operationalizing the WHO–Africa CDC Joint Action Plan with quantified deliverables; and deploying a region-wide partner-relationship management platform underpinning the Partnerships Network. The single most consequential step toward replacing external grants with domestically owned and financed health systems is to operationalize the 2026–2035 health financing strategy, with at least 25 countries publishing updated national health financing strategies and costed PHC investment plans by 2028. Progress will be reported in relation to the Seventy-seventh session of the WHO Regional Committee for Africa in 2027.

6.4. The secretariat calls on Member States to

- **Continue** supporting WHO with flexible and predictable funding by:
- **honouring** their assessed contributions and continue the increase in line with the investment case 2025-2028;
- **continuing** the momentum for growth in voluntary contributions realised over the past year through domestic resource mobilization and increased health investment; and
- **Innovatively expanding** their donor base, including by engaging with non-state actors in the private sector.

Sexual reproductive health outreach in Samburu, Kenya

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Chapter 7.

Securing Africa's health future: the road to 2027 and beyond

This closing chapter of the Regional Director's report looks up and forward. It sums up the achievements of the preceding reporting period to 30 June 2026 and outlines what remains unfinished; analyses the political, economic, social, environmental and technological forces that will shape the next five years; states the Region's public health vision and the policy shifts it requires; sets out the Regional Director's agenda across three time horizons, namely 2027, 2030 and 2035; and closes with decision-ready requests to Member States and partners. Its argument is simple: the African Region is no longer waiting for a global health order designed elsewhere. It is helping to shape one that is owned, financed and led from within Africa, and the choices ministers and partners make will decide how far and how fast that future arrives *(1–2)*.

7.1. How far we have come – and the gaps that still decide lives

The reporting period was one of the most demanding in the Region's recent history, but also one of its most productive. Member States, supported by the Secretariat, kept essential services running through the sharpest health-financing contraction in decades, brought several outbreaks under control, and recorded the largest cluster of verified disease-elimination milestones in a generation, while the Regional Office rebuilt itself to move even closer to the people it serves. The full record is set out in the preceding chapters; this section distils it, and outlines the gaps that still decide whether a mother or child lives.

The pattern beneath the results is as important as the results themselves. Where services shared a single primary health care platform, and where scarce resources were targeted on a district-by-district basis using routine data, coverage held. Conversely, where programmes stood alone, they were the most exposed to these shocks. The achievements are therefore not a list of separate victories but evidence of a system beginning to respond appropriately. Equally, the persisting challenges resolve into a small number of cross-cutting themes rather than a catalogue of programme shortfalls: a financing gap widening faster than domestic substitution can close it; coverage that has plateaued where inequity is greatest; system foundations – workforce, data, supply chains – that remain too weak to absorb shocks; and the recurring difficulty of converting political commitment into funded, delivered results. A synthesis of both sides of the ledger, organized by theme so the reader sees the pattern rather than the pieces, is set out in the Annex (**Table A1**).

The message for ministers and partners is threefold. First, the Region delivered under conditions that would have reversed progress a decade ago – proof that the reforms of recent years are changing what the system can withstand. Second, the gains are real but not yet secured: they rest on financing that has not been replaced by other sources, on platforms that must be protected, and on commitments that must now be funded. Securing them is the work of the period this chapter focuses on. Third, Member States should be resolute and ensure the sustainability of these commitments and their translation into concrete actions.

7.2. Forces shaping the next five years – and what they mean for health

The outlook for 2027 and beyond is best read through the social, technological, economic, environmental and political forces acting on health from outside the sector. Chapter 1 established the baseline for the reporting period; this section takes it forward and draws out, for each dimension, the manner in which these forces are shaping public health *(3)*.

Political. Sovereignty is becoming the grammar of global health. The defining political shift of the period is the consolidation of an African health sovereignty doctrine. The Africa Health Sovereignty Summit in Accra (August 2025) and its outcome, launched as the Accra Reset at the 80th session of the United Nations General Assembly, moved the Region's contribution from technical negotiation to political norm-setting: country ownership, domestic financing and fair partnership are now stated terms, not aspirations *(4)*. They build on Africa's New Public Health Order (African Union and Africa CDC, 2022) and are carried forward by the African High-level Ministerial Committee on Global Health Architecture Reform, which brings together ministers of finance in a standing mechanism *(5)*. The implication for public health is structural: health financing, partnership and governance in the Region will increasingly be set by African institutions and instruments, and external support will be judged by how well it aligns with nationally led plans. Sovereignty is no longer a slogan; it is the framework within which ministers now negotiate.

Economic. If growth is coming, health must claim its share. Africa's economies are projected to grow by 4.2% in 2026 and 4.4% in 2027, with 12 of the world's 20 fastest-growing economies on the continent and several Member States – among them Ethiopia, Rwanda and Uganda – growing at or above 6% *(6)*. Growth on this scale widens the fiscal space that could finance resilient health systems, but only if health claims it. More than two decades after the Abuja Declaration committed governments to allocate at least 15% of national budgets to health, that target remains largely unmet, and government health expenditure across the Region averages about half of it *(7)*. This infers the need for a clear domestic financing path to translate growth into ring-fenced health budgets – through pro-health taxes, solidarity

levies and insurance reform – and to treat spending on health not as a recurrent cost but as an investment that protects the very productivity on which growth depends *(1)*.

Social. A younger, louder Africa is claiming the right to health. The Region's population, more than 1.2 billion people across 47 Member States, is among the world's youngest, with around 60% aged under 25 years; a rights-conscious generation that increasingly holds governments to account for the services they receive *(8)*. At the same time, forced displacement reached record levels during the period – 12.7 million people were displaced or stateless in West and Central Africa alone, up by 48% since 2020, with women and children comprising about 80% of that number *(9)*. The inference is twofold: a demographic dividend that makes the health sector one of the continent's most credible engines of decent employment, and rising demand, equity and accountability pressures that health systems must manage or forfeit public trust.

Environmental. Resilience is now a health mandate. The Region is warming faster than the global average, and environmental determinants – unsafe water and sanitation, air pollution, and the floods and droughts that drive recurrent cholera outbreaks – already shape its disease burden, while conflict and insecurity in parts of the Region compound the harm *(10)*. Yet less than 1% of global climate finance reaches the health sector. This calls for a resilience and multisectoral agenda: health systems must be built to keep delivering essential services through shocks, and the health sector must become a competent operator in climate and environmental finance rather than a bystander to it.

Technological. The chance to leapfrog and the risk of a new divide. Digital tools, data systems and artificial intelligence, together with the first serious investments in African manufacture of vaccines, medicines and diagnostics, offer the Region a rare opportunity to leapfrog towards efficiency and self-reliance. Over the reporting period, this shift has become routine practice – from real-time district dashboards to in-Region genomic sequencing and continental regulatory harmonization. The outcome is double-edged: technology can deliver sovereignty and efficiency gains at scale, but only deliberate investment in equitable access will prevent a widening divide between and within countries, and only sound data governance will keep African health data in African hands. The five dimensions, their outlook and their public health implications are summarized in the Annex (**Table A2**).

So, what is the way forward for public health? Taken together, these forces converge on two or three that will most shape health to 2027 and beyond. The first is the end of assumed external financing and the rise of domestic resource mobilization as the base layer of health budgets – the economic and political dimensions acting together. The second is the shift of resilience from a programme to a system property, as climate, conflict and recurrent emergencies make continuity of essential services the true test of a health system. The third, cutting across all of them, is sovereignty: the growing capacity and expectation that Africa finances, governs, produces and informs more of its own health response. The vision that follows is built to meet these forces head-on.

7.3. Africa as a shaper, not a recipient, of global health

The Region's public health vision for 2027 and beyond can be stated in a single line a minister can repeat: **an African Region that finances, governs and delivers its own health – where care is affordable, trusted and protected during shocks, and where health is treated as a foundational investment in stability, productivity and sovereignty** *(1)*. This vision is consistent with the WHO Fourteenth General Programme of Work, 2025–2028 (GPW 14) and with the Regional Director's strategic direction, and it reframes the Region's posture from implementing decisions taken elsewhere to co-authoring the rules of global health itself *(2)*.

Four organizing priorities give the vision shape: **universal health** – the promise of affordable, quality health services for all, built on primary health care; **resilience** – health security and whole-system continuity that hold through emergencies; **modernization** – the digital, data, workforce and institutional capabilities that make delivery possible; and **ownership and sovereignty** – domestic financing, African medicine regulation and manufacture, and African data governance that together move the Region from dependency to leadership. These priorities are drawn from the sound architecture of the Region's draft strategy, *A new era of health for Africa: united action for Vision 2035*, which is reviewed critically below; they replace and are deliberately clearer than earlier framings *(8)*.

The policy orientation that follows from the outlook is a set of deliberate shifts in posture. The first shift is from donor alignment to **fiscal stewardship** – institutionalized health-finance-planning dialogues, ring-fenced domestic financing, and health treated as macroeconomic risk management. The second is from fragmented, disease-specific projects to **regional public goods** – pooled procurement, regulatory harmonization, local manufacture and shared digital platforms. The third is from response to **whole-system resilience**, with continuity of essential services embedded as a design requirement. The ultimate shift is morphing from an implementer to a **steward**: the Regional Office is redefining its own role from a technical body to a fiscal and policy steward and architect of African health sovereignty – a technical steward, implementation-support partner, convenor, systems integrator and accountability platform *(1–2)*. In practice, this means prioritizing upstream normative, standard-setting and stewardship work while continuing to support downstream implementation where Member States most need it – the two together, not one at the expense of the other.

Africa is already co-authoring the rules of global health. The claim that the Region shapes global health rather than receives it is not aspirational; it is evidenced by the instruments of the reporting period. The WHO Pandemic Agreement, adopted in May 2025 with its Pathogen Access and Benefit-Sharing system, and the 2024 amendments to the International Health Regulations, in force since September 2025, carry equity provisions that the African Group negotiated and secured *(12–13)*. The Lusaka Agenda's principle of "one plan, one budget, one report" – an African-led reform of how global health initiatives operate – was embedded in binding WHO policy through a financing resolution led by the Region *(5)*. Additionally, regulatory and manufacturing sovereignty is being built through the African Medicines Agency and the African Vaccine Regulatory Forum, and through the first serious investments in African manufacture of vaccines, medicines and diagnostics *(14–15)*. These are the means by which the Region protects essential services, finances its own health and responds to shocks as external support recedes – and they are propelled by two complementary institutions whose division of labour is deliberate: the WHO Regional Office for Africa leading on normative standards, technical guidance, country support and accountability, and Africa CDC leading on continental political coordination and the interface with Heads of State and Government. It is the coherence of that relationship, more than any single declaration, that turns continental consensus into country-level result.

7.4. The Regional Director's agenda

The vision is delivered through a medium-term framework organized over three time horizons – a near-term sprint to 2027, a medium term to around 2030, and a longer horizon to 2035 – and along seven delivery flagships. Ending Disease in Africa and the decade-long Transformation Agenda are the delivery spine that carries them *(17–18)*. The framework is deliberately differentiated: it speaks to all 47 Member States by segmenting delivery for fragile and conflict-affected settings, for the many countries facing a dual burden of disease, and for those already advancing towards universal coverage – so that the pace of each reform reflects each country's circumstances.

The seven flagships are the lines along which the vision becomes delivery: **district-centred primary health care and community systems**; **preparedness and whole-system resilience**; **digital transformation**; **a fit-for-purpose workforce and leadership**; **institutional modernization**; **regional manufacturing and pooled procurement**; and **sustainable financing and partnerships**. Each is grounded in results already reported and pointed forward to a measurable milestone.

The near-term sprint to 2027 – stabilize and reset. The immediate period is defined by two simultaneous pressures: ongoing health emergencies and a structural financing shock. The first task is to hold hard-won gains while resetting the operating model, bring active emergencies under control and convert the response into durable, country-owned detect-to-respond and cross-border capacity – beginning with a safe and complete close of the Bundibugyo Ebola public health emergency *(20)*. Another near-term task is to cushion the financing shock by protecting essential services and accelerating domestic-financing measures tied to the Abuja commitment and the Lusaka Agenda, while protecting immunization and primary health care gains through the Gavi transition. Again, there is need to sustain the modernization capability – the regional

data backbone, the workforce and the digital and governance foundations on which every priority rests – and secure political endorsement of the vision at the Regional Committee and within the African Union architecture, translating it into country compacts with shared milestones.

Sustaining this agenda also requires the Regional Office to protect its own agility. The restructuring of the reporting period – a leaner structure, decisions taken closer to the country level, and stronger accountability – will be carried through with a deliberate set of internal strategies: consolidating the core country office model, completing the digital-and-AI modernization of back-office processes, converting efficiency savings into country support, and embedding a results and risk culture so that the institution remains fit to deliver as conditions change.

The medium term to 2030 – scale and institutionalize. As emergencies are contained and the reset takes hold, the focus shifts to building systems that endure: scale up family health teams and PEN-Plus so that chronic and severe noncommunicable diseases are managed close to where people live; sustain the gains and accelerate action on combating major communicable and noncommunicable diseases, and address maternal and child mortality; institutionalize regional manufacturing and pooled procurement; embed climate-smart, resilient facilities and surveillance in national plans; drive the financing transition so that domestic public spending becomes the principal source of health financing and external assistance becomes catalytic and counter-cyclical; and complete the shift in the Regional Office's own role as convenor, standard-setter and accountability partner for country-owned systems.

The 2035 horizon – the transformative goal. By 2035 the ambition is for the Region to finance, govern and deliver its own health: 1.2 billion people with affordable, trusted care close to home; outbreaks detected and stopped early, with prevention prioritized over response; and domestically financed, resilient health systems in which partners are catalytic rather than structural. Delivery across all three horizons rests on a single accountability discipline: one results framework aligned with GPW 14, explicit and time-bound milestones for each horizon, and candid annual reporting to the Regional Committee on outcomes rather than activities. The three horizons and their signature deliverables, as well as the seven flagships and their forward milestones are set out in the Annex (**Tables A3** and **A4** respectively).

7.5. What we ask of Member States – and of partners

This is the Report's closing request. It is specific, and it is addressed to the two audiences whose decisions will secure Africa's health future.

To Member States: own it, finance it, deliver it

1. **Finance health as the investment it is.** Set an explicit national trajectory towards attaining the Abuja benchmark of devoting at least 15% of the national budget to health; ring-fence domestic financing through pro-health taxes, solidarity levies and insurance reform; and institutionalize health–finance–planning dialogues to ensure that growth translates into health budgets.
2. **Commit to sovereignty and delivery.** Endorse the vision and translate it into a costed country compact with shared milestones to 2030; sustain political and financial commitment to African medicines regulation, pooled procurement and local manufacture; and protect the primary health care, immunization, surveillance and workforce platforms that underpinned this year's results. Honour the commitments already made by Member States in successive Regional Committee resolutions – on primary health care and universal health coverage, health security, domestic financing and local production of health commodities – and move them from resolution to implementation.
3. **Reform to deliver.** Convert political commitments – workforce posts, replenishment pledges, adopted protocols and legal instruments – into funded, staffed and operational reality, through joint planning by the ministries of health, finance, education and labour.

To partners, including donors: align and make support predictable

1. **Align financing with national plans.** In the spirit of the Accra Reset and the Lusaka Agenda, provide multiyear, flexible, pooled and counter-cyclical support that aligns behind a single national plan – "one plan, one budget, one report" – rather than parallel, disease- specific projects *(4–5)*.

2. **Build capacity, do not only deliver it.** Invest in African regulation, manufacturing, data systems and workforce so that support strengthens the Region's own institutions and leaves durable capacity behind.

3. **Account through African data.** Ground shared accountability in national data and the Region's results framework, so that partnership is measured by the health outcomes it secures for the Region's people.

Securing Africa's health future is not a promise to be admired; it is a set of choices to be made. Even in the most challenging years, the Region has demonstrated what it can deliver when it leads. What is now required – from governments and partners alike – is a clear commitment to finance, reform and sustain that leadership. Health is the investment that pays every other dividend.

Chapter 7 References

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Annex tables

Table A1. Main achievements and persisting challenges of the reporting period, by theme

Theme (see chapter)	Main achievements (reporting period)	Persisting challenges
Essential services and UHC (Chapter 2)	Antiretroviral treatment protected for ~21.7 million people; 28.4 million NTD medicine doses safeguarded; malaria campaigns held in 21 countries; UHC service coverage index at 51 (up from 30 in 2000).	Out-of-pocket payments ~36% of health spending, above the hardship threshold in 35 Member States; tuberculosis financing gap ~US$ 3.6 billion.
Immunization (Chapter 2)	DTP3 held at 76%; Big Catch-Up reached 18.3 million children (12.3 million zero-dose); malaria vaccine in 24 countries; HPV in 36.	Coverage plateaued (DTP3 76% for five years; HPV 47% vs 90% target); the world's largest subnational equity gap; campaigns financially exposed.
Health security (Chapter 3)	All 47 Member States adopted the 2024 IHR amendments; 71% of events detected within seven days; Bulape Ebola outbreak contained in 88 days and converted to permanent capacity.	Bundibugyo Ebola PHEIC ongoing; cholera persists; core-capacity average ~51%; fragile settings lag furthest behind.
Healthier populations (Chapter 4)	15 Member States adopted tobacco-tax reforms; a US$ 139 million climate-and-health pipeline across 21 States; 46 Member States implement a healthy-diet policy.	Prevention still under-financed; NCDs cause ~37% of deaths, highest premature-NCD mortality of any WHO region.
Institution and financing (Chapter 5)	Workforce reduced by ~25% and ~75% shifted to country level; >US$ 8 million recurring savings; voluntary contributions up 7% to US$ 769 million; 21 Member States pledged to the Investment Round.	Residual 2026–2027 base-programmes gap US$ 662 million; pledges not yet disbursements.
Global-health positioning (Chapter 6)	Pandemic Agreement adopted with the PABS system; IHR amendments in force; Lusaka Agenda road map endorsed; African Medicines Agency operationalized.	PABS Annex unresolved; Abuja target largely unmet; translating continental consensus into country-level results.

Table A2. The outlook to 2027 and beyond, and its public health implications

Dimension	Outlook to 2027 and beyond	What it means for public health
Political	An African health sovereignty doctrine consolidated (Accra Reset; New Public Health Order; High-level Ministerial Committee).	Financing, partnership and governance increasingly set by African institutions; external support judged by alignment behind national plans.
Economic	African growth ~4.2% (2026) and ~4.4% (2027); 12 of the world's 20 fastest-growing economies are African.	Widening fiscal space – but health must claim it; translate growth into ring-fenced budgets towards the Abuja benchmark.
Social	A young population (~60% under 25) and record displacement (12.7 million in West and Central Africa alone).	A demographic dividend and an employment engine; rising demand, equity and accountability pressures on health systems.
Environmental	Faster-than-average warming; water, air and climate shocks; conflict in parts of the Region; <1% of climate finance reaches health.	Resilience becomes a system property; health priorities must operate in climate and environmental finance mechanisms, rather than in isolation.
Technological	Digital health, data and AI at scale; first serious investment in African manufacture of vaccines, medicines and diagnostics.	A chance to leapfrog towards sovereignty and operational efficiency – but mitigate risk of digital divide by ensuring equitable and robust data governance in Africa.

Table A3. Medium-term framework: three time horizons and their signature deliverables

Horizon	Strategic intent	Signature deliverables
Near term to 2027	Stabilize and reset	Close the Bundibugyo Ebola emergency response and convert it into permanent health security capacity; cushion financing shocks; protect immunization and PHC gains; build modernization capabilities; and secure endorsement of the vision and sign country compacts.
Medium term to ~2030	Scale and institutionalize	Family health teams and PEN-Plus transitioned to nationwide scale-up; regional manufacturing and pooled procurement; climate-resilient facilities and surveillance; and a financing transition to domestic-led health budgets.
Long horizon to 2035	Transform	A region that finances, governs and delivers its own health system: affordable, trusted care close to home; outbreaks detected and stopped early; and resilient, domestically financed systems, with partners playing a catalytic rather than structural role.

Table A4. The seven delivery flagships and their forward milestones

Delivery flagship	Means of delivery and forward milestone
District-centred PHC and community systems	Integrated services on one platform; family health teams scaled up to more Member States by 2030.
Preparedness and whole-system resilience	Detect-to-respond capacity institutionalized; continuity of essential services embedded as a design requirement.
Digital transformation	A regional data backbone and disease-prevention-and-control data capability; AI-enabled surveillance and decision support.
A fit-for-purpose workforce and leadership	Costed workforce investment plans in all 47 Member States; competency-based education and leadership development.
Institutional modernization	The core country office model consolidated with the Regional Office as steward, integrator and accountability platform.
Regional manufacturing and pooled procurement	African Medicines Agency and AVMA scaled up; maturity-level-3 regulators strengthened; regional supply of products assured.
Sustainable financing and partnerships	Domestic financing towards the Abuja benchmark; catalytic and blended finance; partners aligned behind one national plan.

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
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