



World Health
Organization

African Region

Atlas of African Health Statistics 2022

Health situation analysis of the WHO African Region

Summary Report



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GOALS

Atlas of African Health Statistics 2022

Health situation analysis of the WHO African Region

Summary Report

Atlas of African Health Statistics 2022: Health situation analysis of the WHO African Region — Summary report.

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Designed in Brazzaville, Republic of Congo

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Message of the Regional Director

Since 2019, we have been implementing Phase 2 of the regional Transformation Agenda, which informs and aligns with the global WHO Transformation, to ensure WHO is accountable, driven by results and providing value for money in the pursuit of better health. Our global priority in this period is to contribute to delivering on the triple billion targets of expanding universal health coverage, protecting people from emergencies, and promoting health and well-being for people across the Region.

This year's Atlas of African Health Statistics is being produced in the context of the COVID-19 pandemic that we have been experiencing for over two years. The ongoing coronavirus pandemic, together with other health emergencies in the WHO African Region, is yet again testing the strength and resilience of our health systems. Indeed, the impact of COVID-19 is visible in the disruption of services. The report also presents the latest data for more than 50 health-related indicators of the Sustainable Development Goals and WHO's "triple billion" targets and provides comprehensive country-level statistics using the results chain of the AFRO framework of actions for strengthening health systems to achieve UHC and the health-related SDGs.



The Atlas shows that, although the trend is upward and improving, health systems in the WHO African Region are still weak and lagging far behind other regions of the world. It also shows that unless we increase our pace, we will not be able to achieve most of our SDG targets. This is unacceptable! The need for more accurate and timely data to effectively measure the progress and performance of our health systems and improve health decisions and accountability has never been greater – and yet, data availability and quality remain key challenges in the WHO African Region. I promised the Regional Committee my full commitment and that of each person working for WHO in the WHO African Region in supporting the Member States we serve. I will ensure strong support for activities relating to data generation, analysis and use to track our progress towards universal health coverage and the health-related Sustainable Development Goals.

I wish to thank all those who contributed to the preparation of the Atlas for their work. It is my hope that Member States and partners will find this Atlas 2022 a useful reference source.

Dr Matshidiso Moeti

WHO Regional Director for Africa

Foreword by the Assistant Regional Director

The Atlas 2022 outline is informed by the framework of actions for health system strengthening towards universal health coverage and the health-related SDGs. It consists of seven compact sections that allow for (i) tracking the targets of international agendas: the Sustainable Development Goals and the WHO triple billion targets; and (ii) measuring the situation of the Region in relation to the components of the framework of actions from inputs to impact.

The Atlas of African Health Statistics remains the most comprehensive tool for monitoring the health situation in the WHO African Region, providing up-to-date information on the state of health in countries, and serving as a baseline for monitoring progress on internationally agreed targets. The report shows overall increases in life expectancy and healthy life expectancy over the last 20 years, as a result of progress in many health areas including maternal health. However, the Region is still facing the triple burden of communicable diseases, noncommunicable diseases and violence.

First, available evidence shows that the COVID-19 pandemic has slowed progress towards some SDG targets, which means that more efforts and interventions are required to get back on track. This Atlas offers the opportunity to take a deeper look at the country situation and learn from those that are performing well in certain areas.

Some subsections of the Atlas use data that are not recent or up to date, which means that it is urgent and important to invest in data systems if we want to have quality evidence for decision-making. This is a collective effort involving all stakeholders at the national, regional and global levels. The WHO Regional Office for Africa is committed to working with all partners to support countries to produce quality data.

Dr Lindiwe Makubalo

WHO Assistant Regional Director for Africa

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The first draft of the Atlas was developed by consultants from the Health Systems Strengthening and Development (HSSD) group under the coordination of Samuel Ndam Ebongue with Ebongue Mbondji and Ursull Saha.

The information is consolidated from products and deliverables of the Life Course, Communicable and Noncommunicable Diseases, Healthier Populations, and Emergency Preparedness and Response Clusters.

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Abbreviations

| | | | |
|--------------|--|-------------|---|
| AFRO | WHO Regional Office for Africa | LIC | low-income country |
| AIDS | acquired immunodeficiency syndrome | LMIC | lower-middle-income country |
| ALG | Algeria | LSO | Lesotho |
| AGO | Angola | LBR | Liberia |
| BEN | Benin | MDG | Madagascar |
| BWA | Botswana | MWI | Malawi |
| BFA | Burkina Faso | MLI | Mali |
| BDI | Burundi | MRT | Mauritania |
| CD | communicable disease | MAU | Mauritius |
| CPV | Cabo Verde | MOZ | Mozambique |
| CMR | Cameroon | NAM | Namibia |
| CAR | Central African Republic | NCD | noncommunicable disease |
| TCH | Chad | NER | Niger |
| COM | Comoros | NGA | Nigeria |
| CON | Congo | RWA | Rwanda |
| CIV | Côte d'Ivoire | SARA | Service Availability and Readiness Assessment |
| DRC | Democratic Republic of the Congo | SDGs | Sustainable Development Goals |
| EQG | Equatorial Guinea | STP | São Tomé and Príncipe |
| ERI | Eritrea | SEN | Senegal |
| ETH | Ethiopia | SYC | Seychelles |
| EVD | Ebola virus disease | SLE | Sierra Leone |
| GAB | Gabon | SSD | South Sudan |
| GMB | Gambia | SWZ | Eswatini |
| GHA | Ghana | TB | tuberculosis |
| GIN | Guinea | TGO | Togo |
| GNB | Guinea-Bissau | TZA | United Republic of Tanzania |
| HIC | high-income country | UGA | Uganda |
| HIV | human immunodeficiency virus | UHC | universal health coverage |
| HRH | human resources for health | UMIC | upper-middle-income country |
| HSS | health systems strengthening | WB | World Bank |
| ICT | information and communication technology | WHO | World Health Organization |
| IHR | International Health Regulations (2005) | ZAF | South Africa |
| INFRA | infrastructure | ZMB | Zambia |
| JEE | joint external evaluation | ZWE | Zimbabwe |
| KEN | Kenya | | |

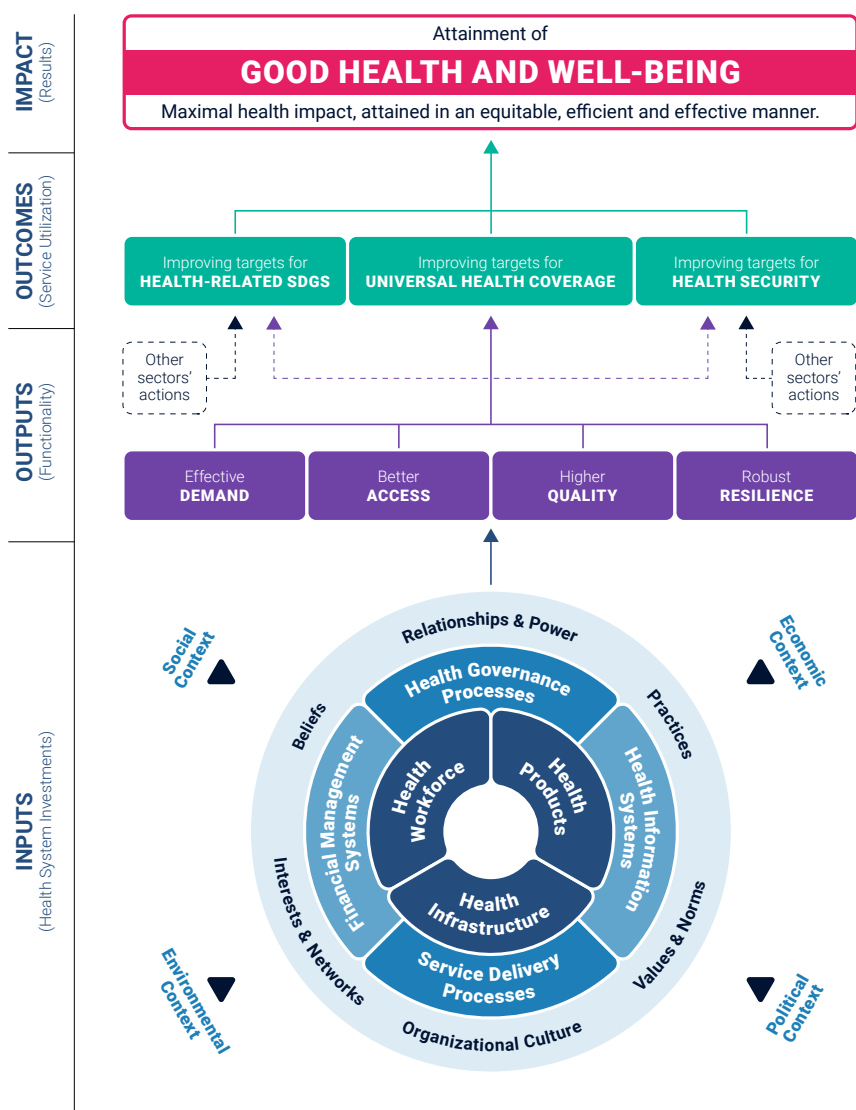
Conceptual Framework

In September 2015, Member States endorsed the overarching Agenda for Sustainable Development at the 70th UN General Assembly, following the post MDG-era. Attaining good health and wellbeing for all ages – goal 3 of the SDG agenda - became the focal point of health actions to be achieved through the health sector, under the overarching target of Universal Health Coverage (target 3.8), and in collaboration with other sectors.

Member States in the African Region have since focused on the need to develop strengthened health systems to attain their health goals, specifically, through commitment to achieving SDG 3 and UHC. A process to streamline movement towards UHC through a comprehensive PHC approach was initiated. In November 2016, all the 47 Member States of the region, agreed on the scope and expectations of a "Framework of Actions" to achieve UHC and other health-related SDG targets at a consultation in Windhoek, Namibia (Figure A). Further consultations led to the endorsement of a comprehensive framework at the 67th Regional Committee of African Member States at Dakar, Senegal in 2018.

This regional menu of options framework describes ‘what’ countries should focus on when designing their health systems by emphasizing ‘how’ countries should organize and target their efforts to achieve their health development goals (from inputs/investments to impact). A logical approach, derived from existing planning and monitoring and evaluation (M&E) frameworks, is utilized to guide expectations from when funds are mobilized for health until they achieve the desired health and well-being for all ages that a given Member State has identified for itself.

Figure A. Framework for health systems development towards UHC in the context of the SDGs



Methodology

This report mainly covers countries in the WHO African Region: Algeria, Burundi, Cabo Verde, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Eswatini, Ethiopia, Gabon, The Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe. However, the analysis of the indicators (to the extent that data are available) starts by presenting the overall situation of the Region in relation to the other WHO regions, then the distribution/coverage of the indicator among the countries of the Region, and when data allow, the report proposes a disaggregation by sex (Female/Male), residence (Rural/Urban), etc.

The Atlas 2022 relies on a range of data sources given the fact that there are many sections to develop. To enhance production of a robust and comprehensive view of Atlas of African health statistics, as well as to facilitate cross-country comparisons, data sources need to be consistent and comparable. The tables and figures will draw upon WHO Africa-wide and global datasets. For some indicators, there are instances where more accurate national or sub-national data is available through Demographic Health Survey or other standardized and international surveys such as SARA, HHFA, STEPS, etc. The following criteria are proposed to help identify the best data sources, although it is unlikely that every data source will satisfy all these criteria.

- (1.) Credibility and validity of the data
- (2.) National scope and potential to provide subnational level detail
- (3.) Availability and consistency of the data over time and across sources
- (4.) Timeliness of the data
- (5.) Ability to support subgroup- and condition-specific analyses
- (6.) Public accessibility of the data
- (7.) Generalisability of the data/results to the country context

We have several types of data sources: (1) international data sources, (2) national/domestic data sources; and (3) scientific literature.

International sources include global and specialised international databases and / or databases of the United Nations system, those of WHO, UNICEF, UNFPA, and the World Bank. We also used data from the integrated African Health Observatory available at <https://aho.afro.who.int> which has a repository of key health indicators for the countries of the region from the various international and national data sources (with the direct contribution of the Member States).

The primary national/domestic sources are:

- Any official document produced by the Government and / or the Ministry of Health (MOH).
- Documents produced under the supervision of MOH or other state structures.
- Documents produced by the National Institute of Statistics.
- National Vital Statistics System
- Any research report produced by institutes, centres or local research organisations with robust methodology. The results of the research produced by the institutions of the United Nations system represented in countries.

Scientific literature includes publications in peer-reviewed national, regional, or international journals. This may also include grey literature (unpublished) which is based on a robust methodology and is generalisable to the country or Region situation.

NOTE: Some data from international and standardized data sources (which are derived from standard and validated methodologies) may be different from some values collected at national level via the routine data collection system. Indeed, to ensure a certain comparability between countries, only sources that could produce data for at least part of the countries in the WHO African Region were considered. On the other hand, for the country profiles (2 pages) countries were allowed to make inputs and for certain indicators with data from national sources (not always standardized) but validated and/or used by the country in various documents.

The development process of the Atlas of African Health Statistics 2022, required the following steps :

- (a.) Development of the structure of the Atlas 2022 together with other WHO/AFRO clusters and country Offices. The structure is inspired by the results chain of the framework of actions with two additional sections dedicated to the general programme of work 13 (GPW 13) and the monitoring of the Sustainable Development Goals
- (b.) Identification of data sources as defined above;
- (c.) Extraction of data from the aforementioned sources: the most recent validated data were used;
- (d.) Data review / cross-checking of additional information with programmes and clusters of the WHO Regional Office
- (e.) Preparation of data collection matrices on Excel spreadsheet, for the production of charts and tables using Excel and Tableau Software;
- (f.) Production of the first draft report for feedbacks and inputs from all the programmes of the WHO Regional Office
- (g.) Second iteration of the full report and copy edit by Translation Interpretation and Printing Team in WHO/AFRO;
- (h.) Production of the final document for validation in the e-Publication System;
- (i.) Launch and dissemination of the report.

The first drafts were developed by a group of consultants under the supervision of the WHO Regional Office for Africa, then an internal review process (including countries) resulted in the final version.

However, the report has some limitations, including

- The age of some data sources: in fact, several indicators present data that are more than five years old and in the absence of new information, we have used them as such. This means that the situation presented could have improved or deteriorated, and there is an urgent need to invest in sustainable systems for monitoring indicators in the countries
- The poor capacity of the health information system to produce reliable routine data: in fact, some indicators remain unavailable for several countries, which limits the capacity to monitor certain themes
- The low dissemination of the results of certain studies: the results of several studies that could help to capture additional information are not accessible because they are not available in the public domain, which limits their effective

SECTION I

CONTEXT

- 1.1 Sociodemographic context
- 1.2 Economic context
- 1.3 Health system organization structure

Africa is characterised by a spatial dispersion of its dynamic population, but with low purchasing power. However, demographic and economic projections give Africa a key role in globalisation. With demographics, great changes that take place on the continent will be able to boost economic growth through new activities and rigorous governance.

1.1 Sociodemographic context

Based on 2020 UN data, the population of Africa makes it the third largest region in the world after South-East Asia and the Western Pacific. Estimated at 1 120 161 000 people and growing continuously over the past 10 years (26.9%), the population of the WHO African Region represents 14.4% of the world’s population, estimated at 7 758 157 000 people.

In a single year, between 2019 and 2020, the population of the Region grew by 2.5%, which represents an increase of more than 28 million people. Five countries (Nigeria, Ethiopia, DR Congo, South Africa and United Republic of Tanzania) out of the 47, represent more than 45% of the population of the Region. Nigeria and DR Congo alone represent more than 45% of the population of the West and Central African regional economic communities, while Ethiopia accounts for 20% of the population of Southern and Eastern Africa.

In 2022, the United Nations published new world population projections. The threshold of 8 billion people should be crossed before the end of the year 2022, and the planet will have 8.51 billion people in 2030, then 9.7 billion inhabitants in 2050 and peak at around 10.4 billion in the 2080s. The population of the WHO African Region is expected to almost double by 2050 to 2.09 billion, while that of Europe and North America will increase by only 0.4%. Indeed, the annual population growth in Africa is the highest in the world at 2.7% (varying between 0.8% in Lesotho and 3.7% in Niger), against 1.1% at global level for the year 2020. This growth is linked to a fertility rate that is higher than anywhere else. The population density in the Region (36 inhabitants per km) is not high, compared to other parts of the world. In fact, many countries are uninhabitable, while some countries with a smaller area have many inhabitants or population concentrations in certain cities. Population density is a very important parameter for the implementation of health policies and for governments more broadly, because of access to various services.

Figure 1.1.1. Population distribution, both sexes, by WHO regions, 2020, WHO

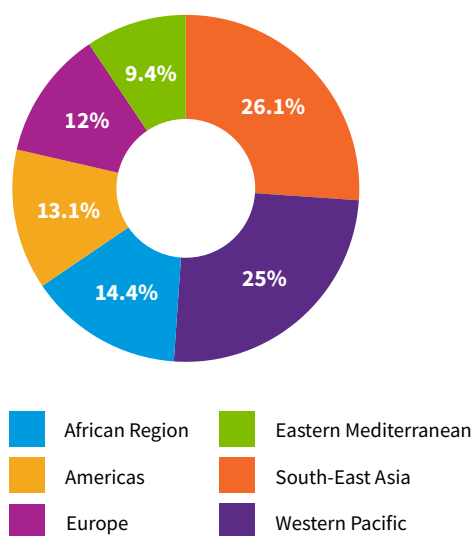
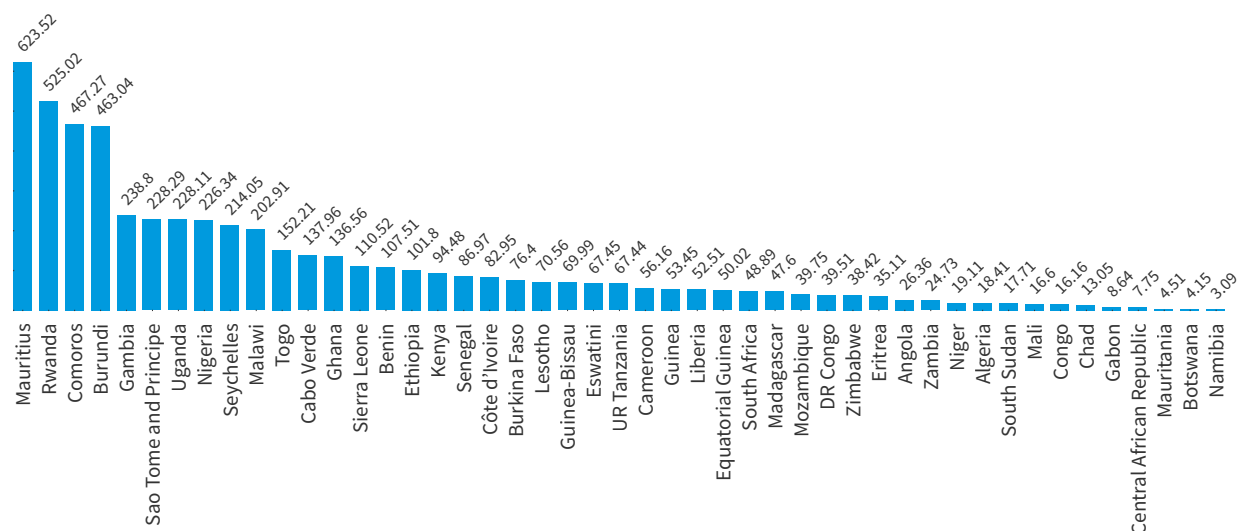


Figure 1.1.2. Population density in 2020 (persons per km²) in the WHO African Region, 2020, World Bank

Indeed, difficulties in accessing services, including those related to health, create and reinforce inequalities, which, added to deficits in education, gender, rurality or low socioeconomic status, constitute obstacles to poverty reduction. For example, cities with large populations (Lagos with 20 million inhabitants or Kinshasa with 14 million people) and with very high densities face enormous challenges which may be mitigated by holistic planning of the different sectors including health.

The concept of demographic dividend supports the theory that African countries could experience an acceleration of economic growth, with the decline in fertility, which would lead to a change in the structure of the population, and the age pyramid. The share of the active population becomes larger than the non-active population (those over 65 and under 18). It is at this tipping point that human capital will activate development. It is a real challenge and special attention in countries on the creation of jobs that will generate this development and activate economic growth.

1.2 Economic context

Gross domestic product is a reflection of the economic health of a country, an indicator that describes the level of development and reflects available resources. It also assumes access to services, including health. Gross domestic product (GDP) remains low for the Region and low for a number of countries. The annual GDP growth rate of African countries was 4.8% between 2011 and 2019. For the year 2022, it was reported to be 3.7%, while projections for 2023 place it at 4.0% based on growth projections according to the International Monetary Fund's World Economic Outlook Update released in July 2022. Globally, GDP growth projections are 3.2% and 2.9% for the years 2022 and 2023, respectively.

In countries of the Region in 2020, inflation rates remained high. They ranged from 0.4% (Mali) to almost 30% (South Sudan), excluding extreme values. For the year 2022, the Trading Economics website publishes figures for the Region, which range from inflation rates of 14% in Benin to 33.5% in Ethiopia, excluding Sudan and Zimbabwe, which have inflation rates of 149% and 285%. These double-digit inflation rates in most countries, due to soaring food prices, are putting food security objectives in jeopardy. The war in Ukraine and the energy and environmental crises do not offer prospects of an improvement, with countries' economies already strained by disputes over agricultural land and the COVID-19 crisis. According to the World Bank, if nothing is done, nine out of 10 poor people in the world will be Africans. Owing to the pandemic alone, an estimated 29 million people have fallen into extreme poverty. The human development index, the composite indicator, has shown enormous progress in several countries in terms of access to water, hygiene, quality of life, etc. This does not mean letting down the guard in many countries where such improvements could be reversible if governments do not structure their health and economic systems in a solid and sustainable way. By 2050, demographic changes and rapid urbanisation (more than 1.1 billion Africans will live in cities) will occur while Africa is caught in a poverty trap (160 million urban dwellers living in informal settlements and slums, nearly a third of the population without access to clean water, sanitation, energy or mobility facilities, and 200 million young people about to enter the labour market, with little hope of finding decent work).

1.3 Health system organisation structure

There are links between the size of countries or the number of regions they have, and the number of their health districts. However, this relationship is not direct, because a country like Gabon (9 inhabitants/km²), which is nearly twice as small as neighbouring Cameroon (58 inhabitants/km²), has the same number of regions as its neighbour, but with only one tenth of its population. Local and regional authorities (regions/states and the subnational level) are the first public authorities to deal with the consequences of situations arising from poverty and delays in the provision of infrastructure and basic services. The internal organisation of countries and the very diverse realities explain the creation of health districts. It is about the supply of health care services and their availability in the country and the level of income of the population. The United Cities and Local Government (UCLG) report highlights key actions to integrate local and regional authorities in the implementation of the SDGs. These include better management of urbanisation and the interconnection of villages, medium-sized cities and large towns; allocation of adequate financial resources, combining decentralisation of powers with decentralisation of resources; and the creation of a network of local authorities.

SECTION II

GPW 13 TRIPLE BILLION TARGETS – UHC, PROTECTION FROM HEALTH EMERGENCIES, HEALTHIER POPULATIONS

- 2.1 Universal health coverage
- 2.2 Protection from health emergencies
- 2.3 Healthier populations

The Thirteenth General Programme of Work (GPW 13) defines WHO's strategy for the five-year period 2019–2023; a resolution of the World Health Assembly validated its extension until 2025. It focuses on triple billion targets to achieve measurable impacts on people's health at the country level. The triple billion targets are to ensure that by 2023:

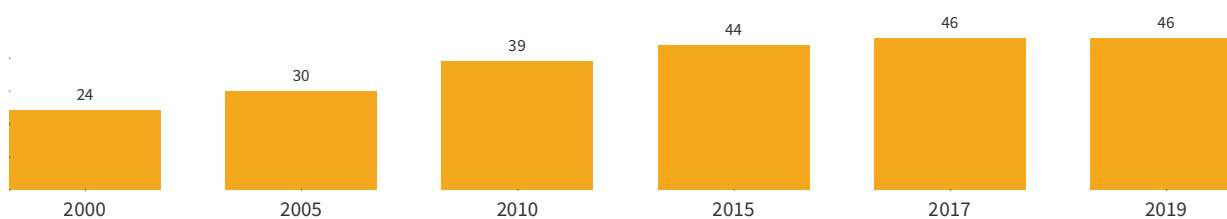
- **One billion more people are benefiting from universal health coverage;**
- **One billion more people are better protected from health emergencies;**
- **One billion more people are enjoying better health and well-being.**

Measurable impact is at the heart of WHO's mission to transform the future of public health.

2.1 Universal health coverage

Making quality health services available for all and ensuring people are not pushed into poverty by health care costs are the main objectives of universal health coverage (UHC). UHC represents a practical expression of the right to health care for all. In the WHO African Region, even though great efforts have been made, the service coverage index, one of the key indicators of UHC monitoring, remains at 46%.

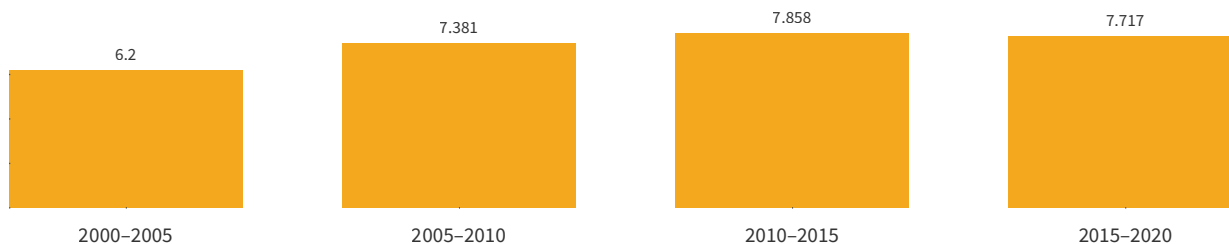
Figure 2.1.1. Service coverage index in the WHO African Region, 2000–2019, WHS2022



Family planning needs satisfied with modern contraceptive methods in women aged 15–49 is an indicator that reflects inequalities in reproductive health service coverage, and shows that 56.3% of women who are married or in a union used family planning in 2020 compared to an average of more than 75% in the rest of the world. For antenatal care and childbirth, families in urban and rural areas are not always attended to by qualified health personnel, thus compromising the well-being and future of the child. Protecting the health of both newborns and adults includes immunisation, the coverage of which is declining worldwide, as well as in Africa. This substantial decline has been accentuated by the COVID-19 pandemic, pushing back the targets to be reached and forcing States to redouble their efforts to catch up on immunisation everywhere, with scant resources available to countries. On the other hand, since 2014, the tuberculosis treatment coverage curve shows an increase. However, despite free access to drugs, many countries are still lagging behind. Treatment barely covers one out of two affected patients (57%). The global response to HIV/AIDS has produced noticeable effects in the WHO African Region. By the end of 2017, a total of 15.3 million people living with HIV in the WHO African Region had access to lifesaving antiretroviral drugs. In addition, pregnant women and children, particularly in Africa, continue to bear the brunt of malaria. Significant progress has been made in universal access to basic water supply, sanitation and hygiene services, but considerable gaps remain in the quality of the services provided. The African Region continues to have the lowest coverage of all regions with only 23% (two out of 10 people) of the population having access to at least basic sanitation. Tobacco is the leading preventable cause of death worldwide, and Africa could become a playground for tobacco companies.

By 2021, reports were pointing to a deterioration in household financial protection, particularly because of falling incomes, as well as rising poverty and inequality, taking the Region further away from UHC. Almost 7.8% of the population in the Region spends more than 10% of income on health expenditure. In fact, Africa and Asia represent 97% of the world's population that is impoverished by out-of-pocket health expenditure. The acceleration of the implementation of the "Abuja Declaration" for the mobilisation of more resources from the public sector for the health sector in African countries is more than ever necessary.

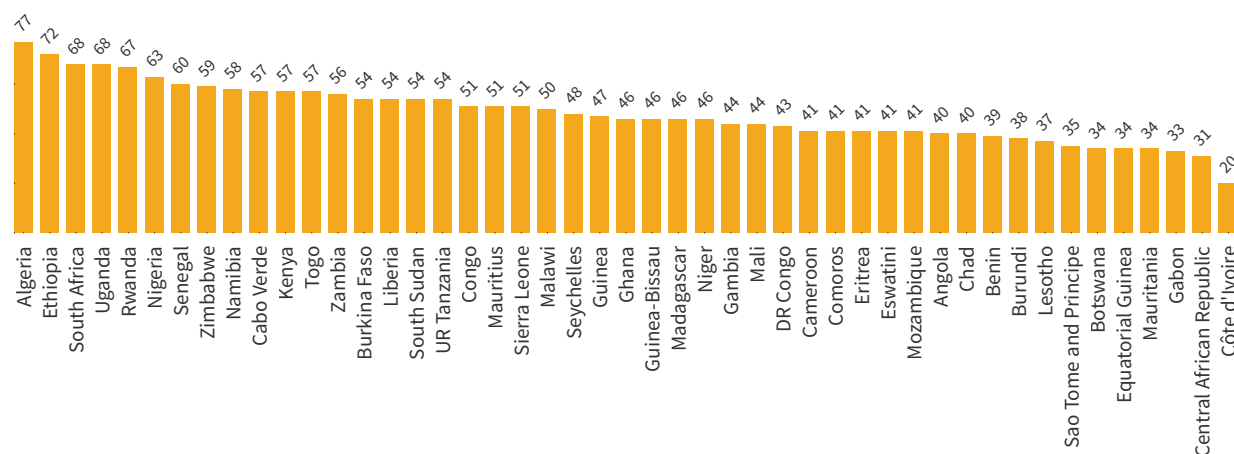
Figure 2.1.2. Proportion of the population spending more than 10% of household consumption or income on out-of-pocket health care expenditure (%) in sub-Saharan Africa, 2000–2020, World Bank



2.2 Protection from health emergencies

The COVID-19 health crisis has demonstrated that more needs to be done to prepare for the next pandemic and future public health emergencies. Indeed, the COVID-19 pandemic has revealed global differences in the response. Previous disparities in detecting, assessing, reporting and responding to international health emergencies led to the signing of the International Health Regulations in 2005 (IHR (2005)). The frequency and pervasiveness of epidemics, disasters and other public health emergencies in Africa require substantial investments in preparedness capacity in all countries. While investing in preparedness should be guided by global frameworks such as the IHR, it is the responsibility of each government to fund its needs.

Figure 2.2.1. Average of 13 IHR core capacity scores in the WHO African Region, 2021, WHS2022

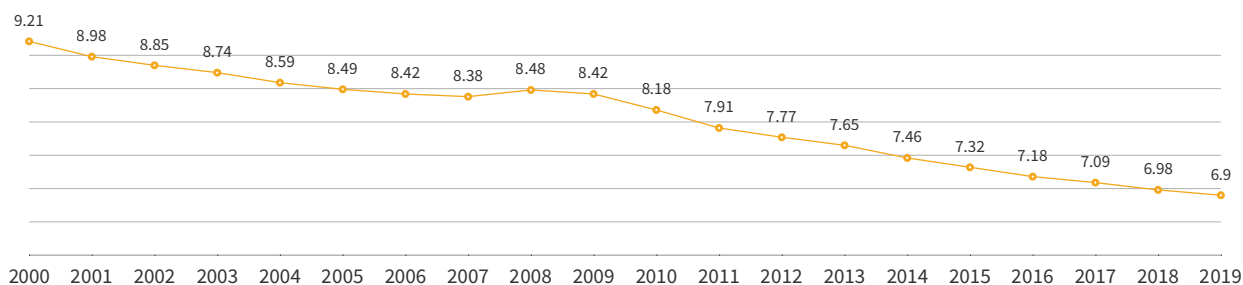


Preparedness and response require collaboration between countries and regional economic communities, but also financial, material and effective human resources, a multidisciplinary and intersectoral approach, and certainly real leadership. Before the emergence of COVID-19, the top five causes of epidemics were cholera, measles, yellow fever, meningococcal meningitis, and influenza, most of which are preventable by strengthening routine immunisation. Large-scale protracted outbreaks can be prevented through early detection, notification, and rapid control. The median time from detection to containment reduced from 418 days in 2016 to 51 days in 2018.

2.3 Healthier populations

In pursuance of the goal of a healthier population in the Region, prevalence of stunting among children under five years of age is dropping slowly, from 43.6% in 2000 to 31.7% in 2020. Almost 80% of the countries in the Region have a high or very high prevalence of stunting among under-five children. Undernutrition is responsible for about 45% of deaths of under-five children in low- and middle-income countries. Regional figures show a decline of overweight from 6.04% to around 4.54% from 2000 to 2021. That is a clear indication that the aim of reducing the prevalence of overweight by 50% by 2025 might not be reached, if nothing is done.

Figure 2.3.1. Crude suicide mortality rate (per 100 000 population) in the WHO African Region, 2000–2019, WHO



Suicide remains one of the leading causes of death worldwide. The suicide rate declined over the past 5 years (2015–2019) from 7.32% to 6.9% in the WHO African Region. However, the situation remains alarming in Southern Africa. While the link between suicide and mental disorders is well established, many suicides occur in a time of crisis and lack of ability to cope with the stress of life. Africa has missed the SDG target 3.6.1 of halving the number of global deaths and injuries from road traffic accidents by 2020. Death rates declined in other regions of the world between 2015 and 2019, except in North America and Africa, where they actually increased. The increase is greater in East and Southern Africa (3.0%) than in sub-Saharan Africa (2.2%) and West and Central Africa.

The global ambition of achieving net zero greenhouse gas emissions by 2050 sets a new direction for the energy sector. African countries are particularly well placed to take advantage of the technological benefits of these changes and attract increasing flows of green finance. WHO reports that Uganda and Namibia are leading in per capita alcohol consumption with an average of 11.8 litres of alcohol per year. The most abstinent countries in the WHO African Region are Mauritania and the Comoros with 0.2 litres of pure alcohol. Moreover, 80% of the 1.1 billion smokers in the world live in low- and middle-income countries. However, the smoking rate in the WHO African Region is the lowest of all WHO Regions. In addition, in a multicountry WHO study, 13–61% of women surveyed said they had experienced physical violence by a partner; and 6–59% said they had experienced sexual violence by a partner at some point in their lives.

SECTION III

HEALTH IN THE SDG TARGETS

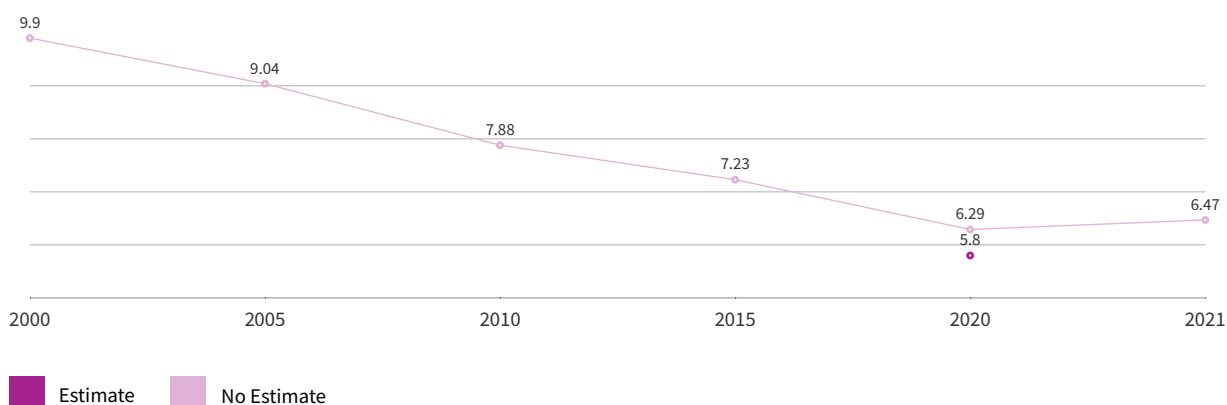
- 3.1 SDG 2 – No hunger
- 3.2 SDG 3 – Good health and well-being
- 3.3 SDG 4 – Quality education
- 3.4 SDG 5 – Gender equality
- 3.5 SDG 6 – Clean water and sanitation
- 3.6 SDG 7 – Affordable and clean energy
- 3.7 SDG 8 – Decent work and economic growth
- 3.8 SDG 11 – Sustainable cities and communities
- 3.9 SDG 13 – Climate action
- 3.10 SDG 16 – Peace, justice and strong institutions
- 3.11 SDG 17 – Partnerships for the goals

Health is well placed in the SDGs. **“Ensure healthy lives and promote well-being for all at all ages”** is a very broad goal that affects all sectors. The SDG statement emphasises that to achieve the overall health goal, **“we must achieve universal health coverage (UHC) and access to quality health care.”**

3.1 SDG 2 – No hunger

In 2019, nearly 690 million people were hungry, representing an increase of 10 million from the previous year. The number is rising in Africa, which is now the second continent most affected by hunger after Asia. People facing difficulties in accessing food increased from 52% to 59% between 2015 and 2019 in sub-Saharan Africa.

Figure 3.1.1. Prevalence of wasting among under-five children in the WHO African Region, 2000–2021, WHO



In 2020, the WHO African Region was the most affected by stunting, with more than a quarter (28.2%) of African under-five children affected. In contrast, only 4.2% of children are overweight, making Africa the second most overweight region for under-five children after South-East Asia. Since the beginning of the COVID-19 pandemic, an estimated 350 million more Africans have not had regular access to adequate food. Pregnant women and women of reproductive age are also affected by undernourishment, leading to a high prevalence of anaemia in the Region (39,6%), with more than half of the countries having an anaemia prevalence rate above 40%. However, some indicators show positive progress, such as the reduction of wasting among under-five children to less than 5% by 2025, and maintaining it at that level, for which the target could be reached if the current trend is preserved.

3.2 SDG 3 – Good health and well-being

Nearly 99% of maternal deaths occur in developing countries, with more than half in sub-Saharan Africa, where the rate stands at 525 deaths per 100 000 live births and 27 neonatal deaths per 1000 live births. Only three countries, Cabo Verde, Mauritius and Seychelles, fully achieve the internationally agreed target of 70 maternal deaths per 100 000 live births.

Current trends show that by 2030 the Region will still record 390 maternal deaths per 100 000 live births, very far from the target. The factors contributing to these deaths are numerous and include shortage of qualified health workers, which contributes to the low rate of skilled birth attendance (65%); the high prevalence of women of reproductive age with unmet need for family planning (44%), and a high adolescent birth rate among women aged 10–14 years which, at 102 births per 1000 women aged 10–14 years, is the highest in the world.

Figure 3.2.1. Maternal mortality ratio in the WHO African Region in 2017, UN MMEIG

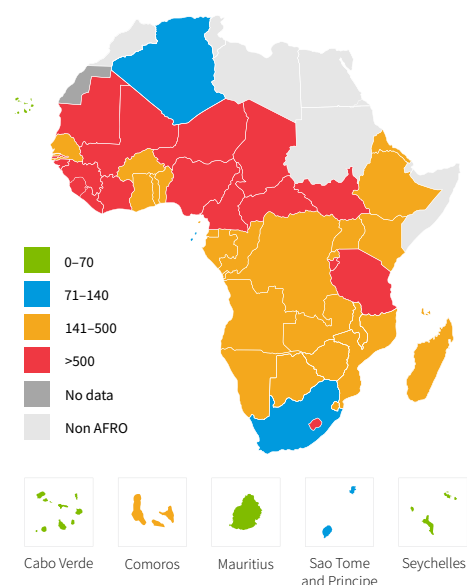


Figure 3.2.2. Prevalence of overweight among under-five children in the WHO African Region, 2000–2021, WHO



The continent remains subject to a number of threats such as tuberculosis, HIV, malaria, neglected tropical diseases, and noncommunicable diseases, which, despite their decline, remain well above the global average. Lifestyle habits (diet, smoking, alcohol and drug consumption, violence, suicide, etc.), medication abuse (especially antibiotics), and air pollution are also on the rise in this Region, and there is an increase in the mortality associated with them. Deaths due to road accidents, which was the target of SDG 3.6 that seeks to reduce them by half by 2020, could not be achieved, while the goal of "reducing overweight in under-five children to less than 5.6% by 2025" has been achieved and needs to be monitored. Following the COVID-19 pandemic, the WHO African Region is facing a re-emergence of certain vaccine-preventable diseases such as measles and polio, due to declining immunisation coverage.

3.3 SDG 4 – Quality education

The African Region has 60% of under-five children who are developmentally on track in terms of health, learning and psychosocial well-being, with 57% for boys and 62% for girls. Measuring and monitoring early childhood development (ECD) is critical to understanding what young children need and identifying those at risk of being left behind and not achieving their full developmental potential. Algeria has the most children whose development is on track with 77%, as opposed to the Central African Republic, which has only 36%. In 2020, about 85% of countries in the WHO African Region where data are available (27 countries) had more than 50% of their under-five children developmentally on track in terms of health, learning and psychosocial well-being.

3.4 SDG 5 – Gender equality

Women suffer the most from gender inequality and marginalisation on the continent. Indeed, in the WHO African Region, 34% of girls are forced into marriage before the age of 18, compared to 4% of boys. In addition, 33% of women are victims of partner violence, and 36% of women aged 15–49 are still victims of genital mutilation/cutting, that is, almost one in three girls in 2017. Many countries in the Region still do not have laws that guarantee the rights of these women. Although there has been a decline in such marginalisation, the COVID-19 pandemic has slowed actions against these practices over the past two years.

3.5 SDG 6 – Clean water and sanitation

The African population using basic drinking water services in 2020 was 32%, far from the 80% target to be reached by 2030, whose achievement is becoming more unlikely. The situation is similar to the use of basic sanitation services, for which only 23% of the population is covered. These water and sanitation shortfalls, in addition to poverty, are high risk factors for the faecal peril diseases that prevail in the Region.

3.6 SDG 7 – Affordable and clean energy

The quality of energy and technologies used are not modern and sustainable in the Region, especially in rural areas. This constitutes a challenge to ensure a living environment that meets the requirements of a healthy environment. Only 20% of the African population uses as first resort, clean fuels and technologies, which is the lowest rate among all WHO regions. The consumption of these energy sources is 39% in urban areas and 6% in rural areas.

3.7 SDG 8 – Decent work and economic growth

Most fatal injuries due to work accidents occur in Asia (65%) and Africa (17%). Men are more exposed than women to work accidents, regardless of whether they result in fatal or non-fatal injuries.

3.8 SDG 11 – Sustainable cities and communities

Sub-Saharan Africa's urban population is the fastest urbanising in the world. In the Region, 25 countries have a concentration of fine particulate matter (PM_{2.5}) over 40 µg/m³. Ambient air pollution-related deaths have been increasing, from 361 000 in 2015 to 383 000 in 2019, mainly in most highly developed countries. PM_{2.5} pollution was estimated to be responsible for 1.96 billion lost intelligence quotient points in African children in 2019.

3.9 SDG 13 – Climate action

The African Region is prone to natural disasters and was the second most affected region by disasters (622) after Asia (1 305) during the period 2010–2020. In 2019, most disasters over the 10 previous years (83% triggered by natural hazards) were caused by extreme weather and climate events such as floods, storms, and heat waves. In 2019, twenty million people were affected by disasters in Africa: Cyclone Idai in Mozambique, Zimbabwe and Malawi affected 2.8 million people; drought in Southern and East Africa (12 countries) affected 9.3 million people; Cyclone Kenneth in Mozambique and Comoros affected 2.7 million people.

3.10 SDG 16 – Peace, justice and strong institutions

Africa is one of the most fragile and insecure regions in the world, with several ongoing conflicts. One third (35%) of the 464 000 homicides committed worldwide are in the Region, the majority of which are committed by men. Approximately 7 500 people lost their lives in armed conflicts in sub-Saharan Africa in 2020. These conflicts promote violence of all forms (sexual, physical, psychological). Studies show that more than half of African children are physically abused, and in some parts of the continent, four out of 10 girls are sexually abused before the age of 15 years. Civil registration in African countries is still a big challenge: 49% of under-five children (nearly 89.5 million children) in sub-Saharan Africa remain unregistered, a 2% decrease since 2008. If nothing is done, trends show that the number of unregistered children in Africa will continue to rise.

3.11 SDG 17 – Partnerships for the goals

Similarly, many countries do not perform well in terms of completeness of death registration and medical certification of cause of death, making data availability in this area a major challenge for civil registration and vital statistics systems. For both vital events (births and deaths), only seven African Region countries reached 90% completeness, which is a satisfactory level. Many countries have obsolete or inaccurate population data; only 20 countries have been able to conduct population censuses in the past 10 years. These data are essential for the development of policies.

Countries need to make additional efforts and adopt new strategies and laws to improve indicators for achieving the health-related SDGs by 2030. While most of the Goals are still under way, some have reached deadlines or are close to reaching them. Almost none of the latter indicators have reached their target and need to be updated. Experiences from other regions with significant progress or successful achievements can also be capitalised on and adapted to the WHO African Region to preserve gains and guarantee further significant progress.

SECTION IV

HEALTH INPUTS AND PROCESSES

- 4.1 Health financing
- 4.2 Health governance
- 4.3 Health information
- 4.4 Service delivery
- 4.5 Health workforce
- 4.6 Health infrastructure
- 4.7 Health products

Health care expenditures have never been higher, and medical costs are expected to continue to rise. This increase can be attributed in part to an ageing population and medical innovation. It is therefore more important than ever, to critically assess financial investments in health care and measure the importance of ‘inputs’, such as human resources and infrastructure in the health system.

4.1 Health financing

The proportion of public expenditure allocated to health reflects the priority given to the health sector. In 2019, the WHO African Region was ranked fifth out of six WHO regions, with 5.3% of its GDP spent on health. The average expenditure in sub-Saharan Africa tripled from US\$ 27 to US\$ 90 between 2002 and 2011, then began to decline around 2014–2016.

Figure 4.1.1. Government health expenditure as percentage of total government expenditure in the WHO African Region, 2019, WHO

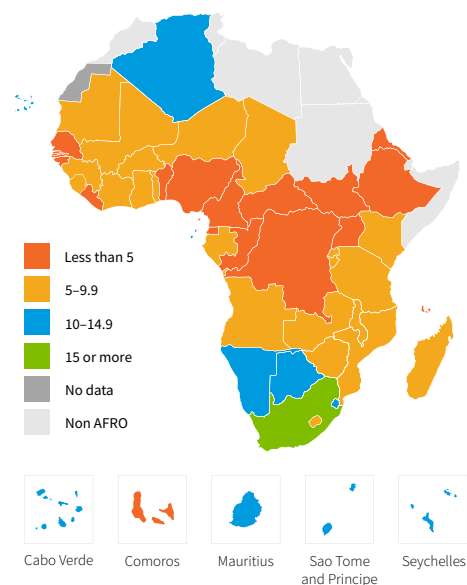
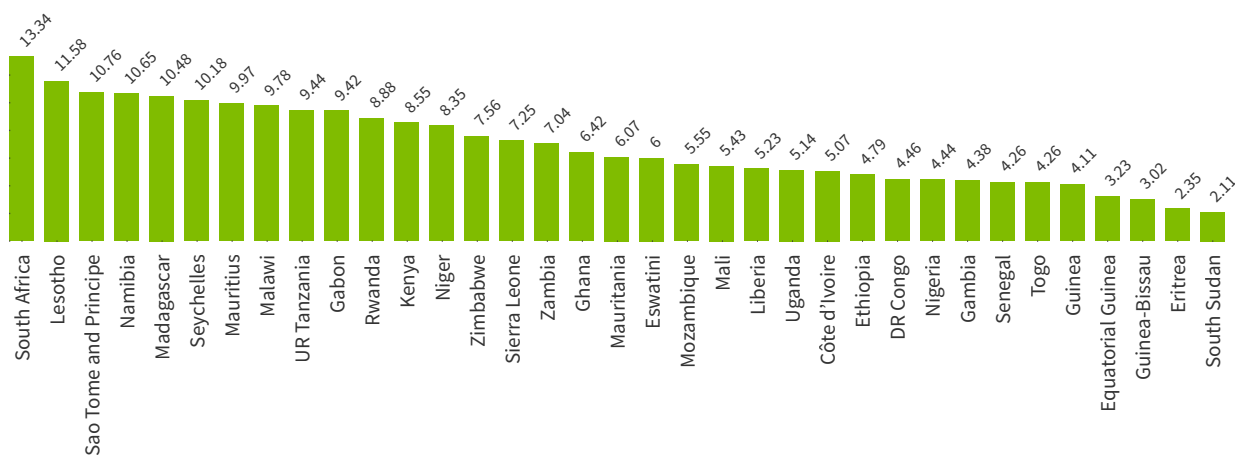


Figure 4.1.2. National budget allocated to health (%) in the WHO African Region, 2018, WHO



The African continent has made progress in improving some health indicators, but this progress needs to be sustained. In fact, health equity, value for money, and access to health services for all are all issues that still need to be addressed. It is not about spending more, but about spending more equitably. Weak budget execution and the reduction of resources available for health result in high expenditures and an inequitable health systems that ensures access only to those who can pay.

4.2 Health governance

In 2020, at least 33 countries in the WHO African Region had an updated health strategic plan with a monitoring and evaluation framework that defines the objectives, associated indicators as well as baselines and targets to be achieved per period. They also indicated the review periods of the plans, although many countries are not routinely conducting this exercise. In addition, the successful reorientation of health systems towards PHC depends on the recognition of the role of health facilities in this process. It is important at all levels of the health pyramid to equip the actors with “soft skills” to bring the health system to produce the expected results. Moreover, a detailed analysis of several other strategies developed for specific health problems revealed that they generally suffer from a lack of strategic alignment in monitoring and evaluation with the national health strategy. In fact, parallel data collection systems are created, which weaken the national system and in either case fail to produce quality information for decision-making.

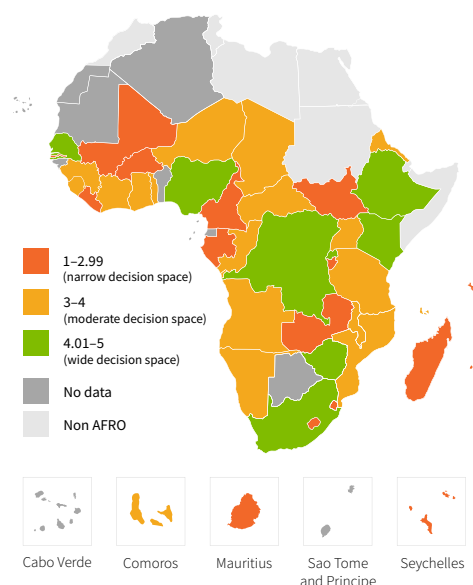
4.3 Health information

In almost half of sub-Saharan African countries, the legal time to register a birth is more than one month, while the legal time to register a death varies from 24 hours to one year. To improve health and reduce deaths and disabilities around the world and particularly in the WHO African Region, it is essential to regularly collect and analyse high-quality data on deaths and causes of death, as well as on disability. These aspects, which are nevertheless the “lifeblood” of public health, still faces many difficulties. In addition, several countries in the Region are using/piloting various patient data collection solutions and very few report on the percentage of facilities using patient records/unique patient ID numbers. There is need for countries to set up consolidated architecture to address data security as well as interoperability issues; only 2.77% of countries have digital health ecosystems that are fully interoperable. In fact, 76% of countries have developed their digital strategy/plan, while just 14.7% digital health projects have been implemented.

4.4 Service delivery

Service delivery is the part of a health system where patients receive the treatment and supplies they are entitled to. The services can vary greatly depending on the location (urban or rural); whether the patient is an outpatient or an inpatient; the patient's pathology; and the patient's financial capacity or sociocultural background. This reality runs counter to the goal of universal health coverage, the attainment of which is further compromised by inequalities caused by several challenges such as the COVID-19 crisis, conflicts and other disasters. One direct consequence is poor quality of care, which accounts for more than 15% of deaths each year in low- and middle-income countries, compared with 60% attributable to care conditions, and the remainder due to non-use of the health system. A WHO cross-sectional survey on service delivery in 10 countries shows that the public sector leads in providing health facilities, followed by the private sector and finally, traditional health practitioners. In urban areas, the private sector accounts for most services (55.9%) and, in peri-urban areas, traditional and spiritual healers account for 67.1% of health services. In Africa, outpatient care is still very hospital-centric and inaccessible for many. Outpatient services need to be strengthened and decentralised (including resources) to bring services closer to their users, but also to ensure affordability.

Figure 4.2.1. Subnational level decision-making space in the WHO African Region, 2022, WHO/AFRO

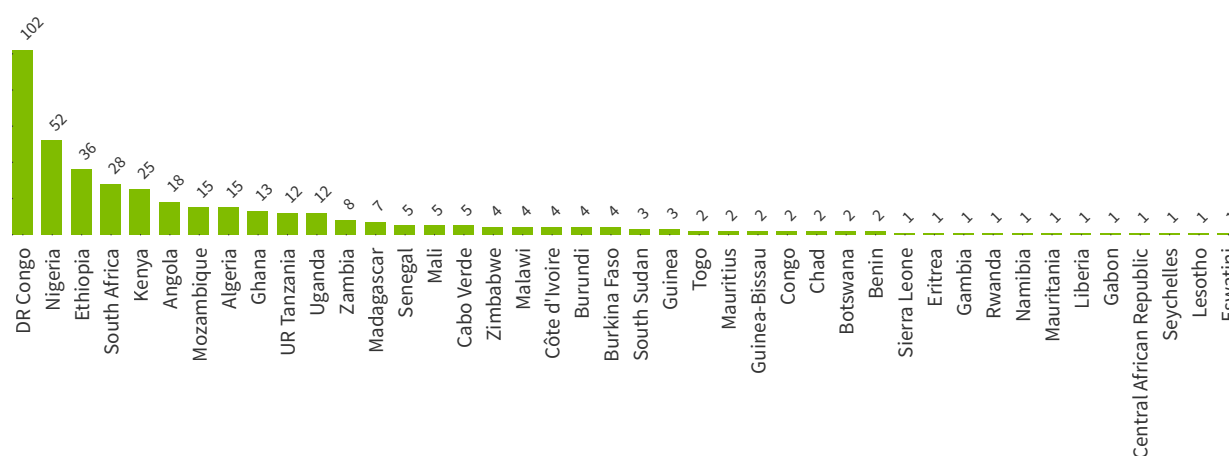


Overall Regional Average = 2.93 (out of 5)

| Area | Regional Average |
|------------------------------|------------------|
| Information systems | 3.48 |
| Government processes | 3.29 |
| Health products | 3.22 |
| Service delivery processes | 2.69 |
| Health workforce | 2.64 |
| Financial management systems | 2.64 |
| Health infrastructure | 2.56 |

4.5 Health workforce

Figure 4.5.1. Number of health training institutions in the WHO African Region (n=39), 2018, WHO/AFRO

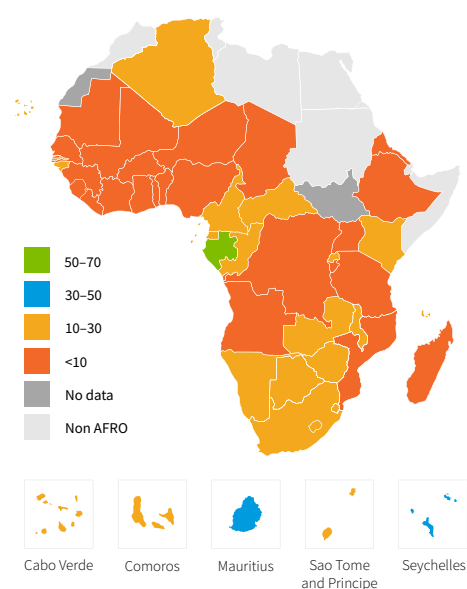


Reaching the level of performance necessary to achieve UHC and the SDGs might be compromised as long as the qualified workforce is insufficient or mismanaged. In 2018, thirty-one countries (79%) had an accreditation body for training institutions. Even though resources are being put into training health personnel, Africa had the lowest density of doctors (2.9 per 1000 population) compared to other WHO regions in 2020. Only 28% of the countries were above the regional average for doctors, excluding specialists (mostly higher income countries). The continent is facing a brain drain of locally-trained doctors to developed countries. The same shortage is observed for nurses and midwives: Africa has 12.9 nurses per 10 000 inhabitants, whereas Europe and America are at more than 80. So far, only four countries (Seychelles, Namibia, Mauritius, and South Africa) have reached or exceeded the SDG density target of 4.45 doctors per 1000 population.

4.6 Health infrastructure

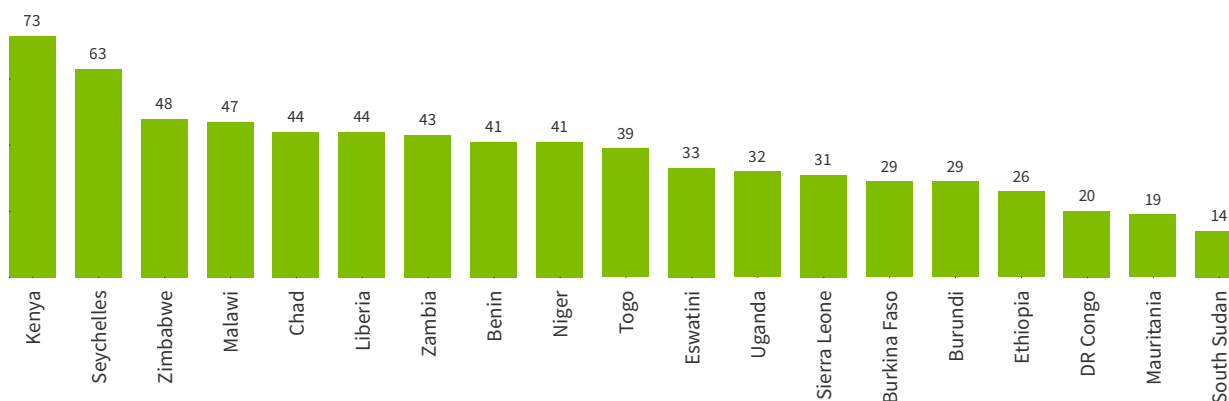
The density of the population goes together with the density of health services. Although there is currently no official standard for inpatient bed density per total population, the global average for inpatient bed density is 27 per 10 000, while the average for the WHO African Region is 10 beds per 10 000 population. The Service Availability and Readiness Assessment (SARA) suggests benchmarks of 18 and 39 inpatient beds per 10 000 population in low- and high-income countries, respectively. The availability of intensive care unit beds in public, private, general, and specialised hospitals that are regularly maintained and staffed by qualified and readily available personnel is more difficult to estimate for all the countries in the WHO African Region. This makes it difficult to determine the readiness to respond to a crisis or critical situation such as the COVID-19 pandemic.

Figure 4.6.1. Hospital bed density (per 10 000 population) in the WHO African Region, 2004–2017, WHO



4.7 Health products

Figure 4.7.1. Essential medicines readiness in the WHO African Region, latest available year, WHO/AFRO



WHO still estimates that more than half of the population of the WHO African Region does not have full access to essential medicines. For most countries, production scores for essential medicines remain low. With regards to stocks of essential products, many countries in sub-Saharan Africa are accustomed to shortages of medicines in hospitals and pharmacies. The readiness score of countries for health products, for those with available data, is very low. An analysis conducted by WHO during the COVID-19 pandemic showed that the WHO African Region had an average readiness score of 33% for COVID-19 vaccine deployment, which is below the baseline set at 80%. Innovative methods are necessary to improve supply chains, drug demand and ordering, communication between facilities and districts, and forecasting of future needs.

SECTION V

HEALTH OUTPUTS

- 5.1 Access
- 5.2 Demand
- 5.3 Quality
- 5.4 Resilience

The analyses included in this part situate the level of coverage of essential health services by determining the most effective interventions to fight against communicable and noncommunicable diseases and other health problems. Various constraints have been identified in the implementation of various interventions in the countries, in the context of the COVID-19 pandemic. The assessment of health system performance used four dimensions: (1) access to essential services; (2) quality of those essential services; (3) demand for essential services; and (4) resilience to shocks that interrupt service delivery. The overall health system performance for the Region is 52.9% of what countries can feasibly do, ranging from 34.4% to 75.8%.

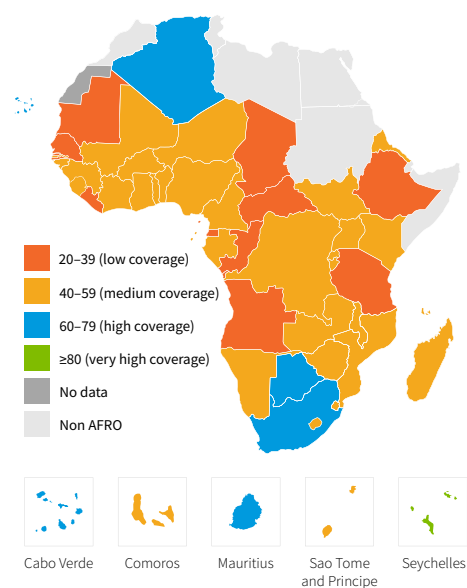


5.1 Access

On average, the systems in the Region are only able to assure 47.4% of potentially possible access to essential services.

Access to essential services is monitored through three vital signs, with the lowest score regionally being the vital sign of physical access (29.6), compared to financial (55.2) and sociocultural access (57.4). Populations are not able to get to facilities providing essential services. The Region needs to invest relatively more in interventions that will overcome physical barriers to services to have the greatest impact on access to services. These include investments to scale up the numbers of the health workforce, infrastructure and medical supplies targeting populations with no, or inadequate service provision units.

Figure 5.1.1. Access to health services index in the WHO African Region, 2020, WHO/AFRO



5.2 Demand

In general, the right to demand for health is distant from the consumption of health care. High demand indicates that health systems are providing the services that people need to ensure their health and well-being.

The demand score in the WHO African Region is relatively high compared to other performance measures. However, there is room for improvement, as the 52.8% score for effective demand, which is still low, fails to achieve effective performance. The demand for essential services is monitored through two vital signs, with the lowest score regionally being the vital sign monitoring individuals' healthy actions (47.9), compared to individuals' health-seeking behaviours (57.7). Many community-based interventions are primarily focused on taking services to the communities, as opposed to building community engagement and knowledge that is needed to generate strong service demand. The Region needs to invest relatively more in interventions that will improve individuals' healthy actions to have the greatest impact on demand for essential services.

5.3 Quality

The quality of care index shows that quality of care represents, in the Region, only 62.3% of what is possible. This index varied significantly from one country to another, from 39.7% to 84.7%. Namibia, Mauritius and Seychelles are above 80%. Quality of care is monitored through three vital signs, with the lowest score regionally being the vital sign monitoring user experience (54.9), compared to patient safety (61.0) and effectiveness of interventions provided (70.8). The Region needs to invest relatively more in interventions such as person-centred care initiatives that will improve overall user experience during the care process, to have the greatest impact on quality of care.

In the WHO African Region, the number of people on HIV treatment increased by 1.47 million in 2021 (compared to over 2 million in previous years). The largest increase was in Central and West Africa, while the increase in East and Southern Africa was lower than in previous years. Efforts must continue to eradicate TB. The percentage of reported TB patients with a conclusive HIV test result was 69% in 2019, a 5% increase from 2018. Overall, 88% of TB patients with known HIV infection were on antiretroviral therapy in 2020. Member States are on track to achieve the goal of eliminating TB in Africa by 2030 if resources are properly allocated and the organisation is well structured. Two of the key determinants of TB incidence identified in the Global TB Report 2020 are GDP per capita and undernutrition. The situation could be worsened by the economic impact of the COVID-19 pandemic.

Figure 5.2.1. Demand for health services index in the WHO African Region, 2020, WHO/AFRO

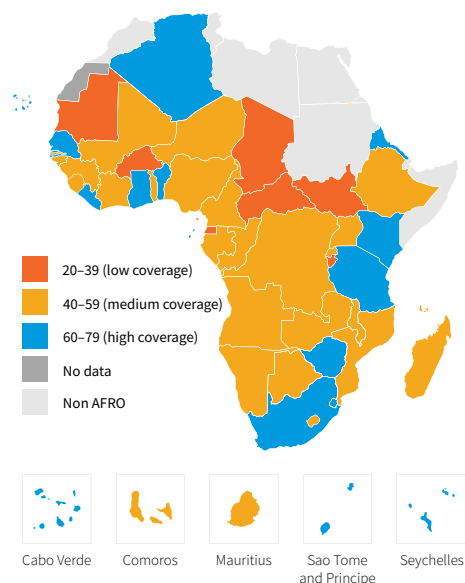
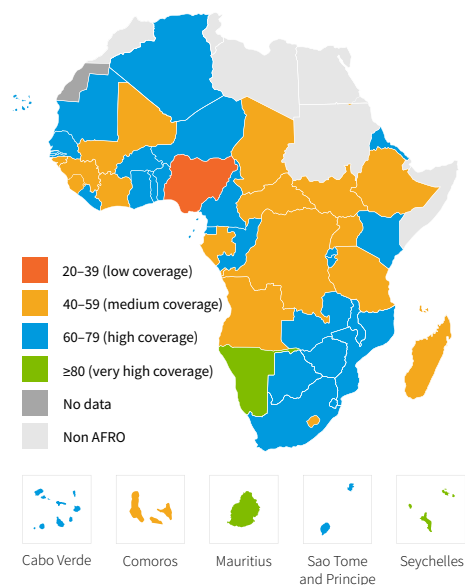


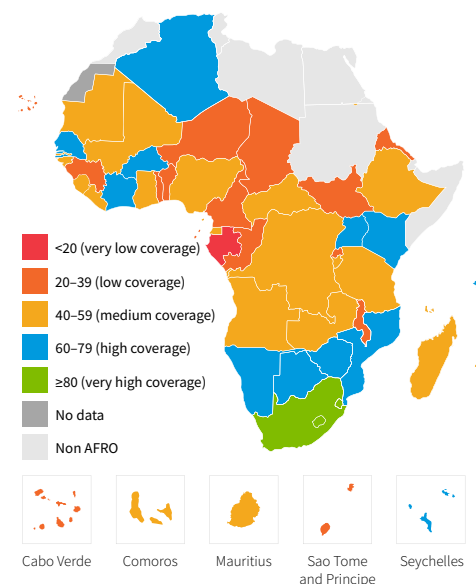
Figure 5.3.1. Quality of care index in the WHO African Region, 2020, WHO/AFRO



5.4 Resilience

Health system resilience presented a score of 51.9% in 2020. In fact, resilience describes a systemic approach that links emergency and development. Even though most countries have experienced various crises and shocks, some are not systemically equipped. Countries that experience shocks generally experience a significant decline in health service due to low resilience. Resilience is monitored through two vital signs: the inherent resilience that captures the inbuilt capacity to anticipate, absorb, and transform functionality due to a shock event; and the epidemic preparedness and response core capacity that captures the complementary capacity to respond to a shock event. The lowest score regionally is on inherent resilience (49.1), compared to the IHR core capacity (47.6).

Figure 5.4.1. Health system resilience index in the WHO African Region, 2020, WHO/AFRO



SECTION VI

HEALTH OUTCOMES

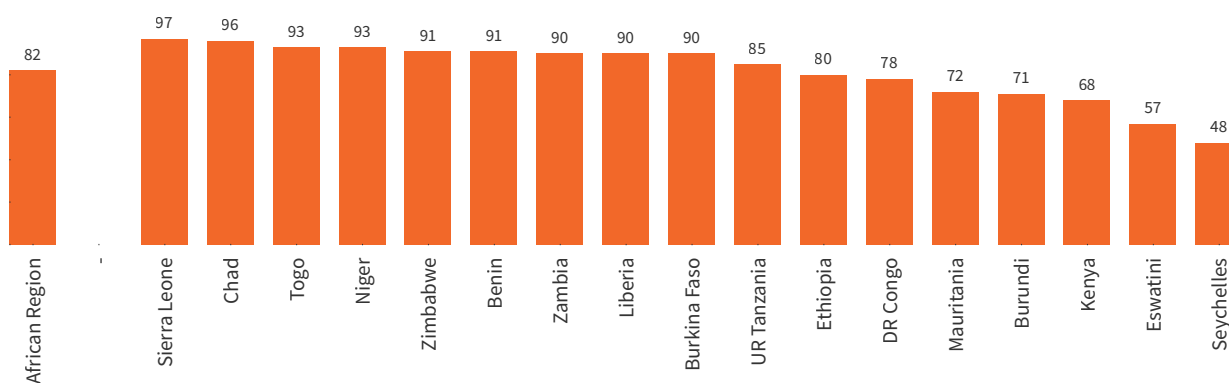
- 6.1 Availability of essential services
- 6.2 Coverage of interventions
- 6.3 Risk factors and behaviours
- 6.4 Health security
- 6.5 Financial risk protection

The state of health and well-being is a function of the levels of attainment of the dimensions related to outcomes – the health and health-related services desired by the population. For sustainable development, these services must cover all the populations, irrespective of their needs and locations. Outcomes in health consider the availability of health services, the coverage of the needs of the populations, the risk factors, health security and financial health protection.

6.1 Availability of essential services

The availability of essential health services throughout the life course is one of the pillars of universal health coverage. These include family planning, which addresses the goals of reducing child mortality, improving maternal health and promoting women's empowerment and gender equality. In the Region, 79% of health facilities offer family planning services, while 82% can offer antenatal care services. The offer of pregnancy-related services are decisive for the future of the mother and child.

Figure 6.1.1. Percentage of health facilities offering antenatal care services in the WHO African Region, 2012–2019, WHO/AFRO



Particular attention must be paid to early childhood services such as vaccination, growth development, but also curative care. In the Region, 68% of health facilities in countries with available data have comprehensive emergency obstetric and neonatal care services. On average, fewer than one in two pregnant women in Africa gives birth in the presence of skilled health personnel, and only 12% of those who need emergency care for themselves and their newborns actually receive it. In fact, nine out of 10 facilities offer the three essential preventive and curative care services for under-five children. Adolescents and youth (aged between 10 and 24 years) represent one third of the population in the Region. However, the availability of adolescent services is only 65%.

Among adults prone to noncommunicable diseases, services must be accessible and adapted. Management of hypertension was disrupted in 59% of countries, and management of diabetic complications in 56% of countries due to the COVID-19 crisis. Closing or slowing down services is likely to further worsen patients' underlying conditions, leading to more severe cases of noncommunicable diseases. It also exacerbates the susceptibility of people living with chronic diseases to COVID-19. Countries need to plan for more comprehensive essential health packages to ensure the availability of services for all.

6.2 Coverage of interventions

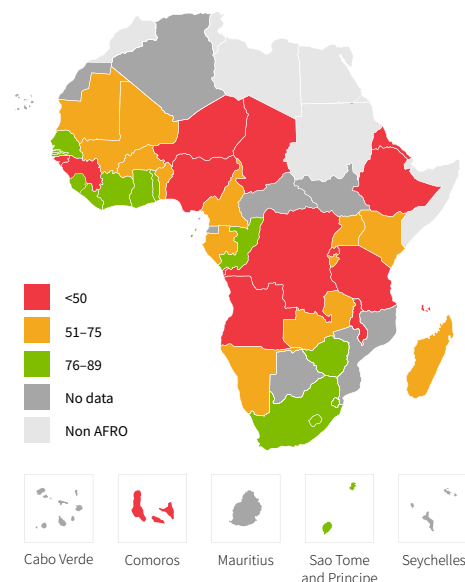
Coverage of interventions analyses the levels of utilization achieved for ‘traditional’ health services. Coverage of noncommunicable diseases and health promotion services is the lowest, while the coverage for communicable disease control interventions is the highest. Although progress has been made in recent decades in the area of contraception, contraceptive use remains low in sub-Saharan Africa. Across countries, the median contraceptive prevalence rate (CPR) among women of reproductive age was just 28% in 2017. Recent evidence indicates that increasing the frequency of antenatal visits in the health system for women and adolescents is associated with a lower likelihood of stillbirths, as these visits provide more opportunities to detect and manage potential problems.

In the Region, under-five children with symptoms of pneumonia who were taken to a health facility for treatment increased between 2016 and 2019 from 47% to 57%, and those with fever symptoms taken to a health facility for treatment increased from 57.2% to 60.0% in the same period. Due to limited access to safe water and adequate sanitation and hygiene, this age group remained the main victims of diarrhoea. Strategies to manage this disease reduced mortality to 437 000 deaths in 2018, which is three times less than in 2000.

People living with HIV who know their status account for 67% [of all persons living with HIV] in the Region, with a large variation across countries while the coverage of mother-to-child transmission is 87%. In order to stop maternal transmission of HIV, efforts are still needed, in particular to reduce even more drastically the number of infections through breastfeeding. Regarding the prevention of malaria, 38 African countries have adopted intermittent preventive treatment during pregnancy (IPTp) to reduce the burden of malaria during pregnancy. Coverage with three doses of IPTp (IPTp3) increased from 1% in 2010 to 16% in 2015 and 32% in 2020, but remains well below the target of at least 80%. In the Region, 31 countries had planned campaigns of insecticide-treated nets (ITNs), and indoor residual spraying (IRS) coverage stood at 5.3% of the entire population at risk of malaria in the WHO African Region in 2020.

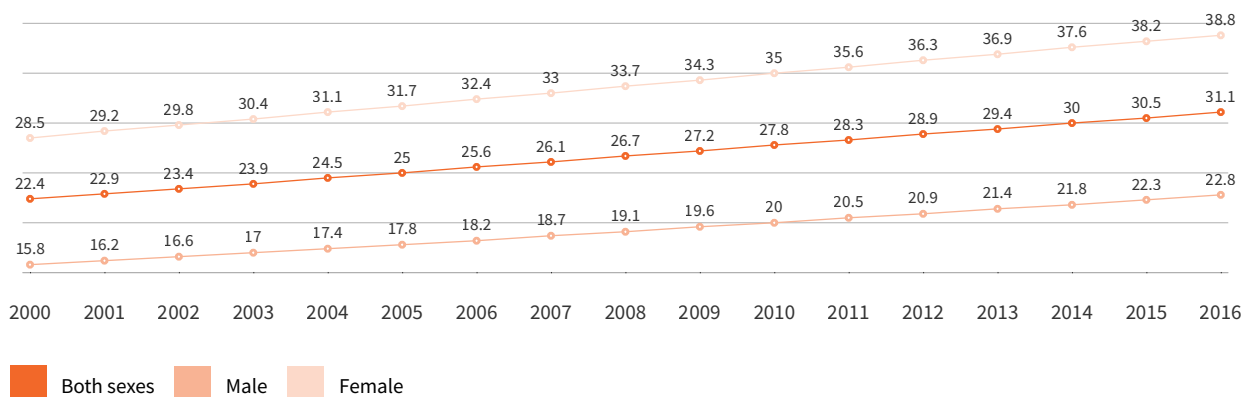
Concerning preventive chemotherapy for neglected tropical diseases, there was an overall decrease in coverage from 2018/2019 to 2020 in Africa: lymphatic filariasis (63.4% to 41.8%), onchocerciasis (from 73.8% to 47.1%), soil-transmitted helminthiasis (from 66.4% to 44.6%), trachoma (from 64.2 in 2019 to 23.8). This general decline might be due to the prolonged disruption in the supply of medicines, which was certainly accentuated by the COVID-19 crisis, resulting in resources being redirected and priorities being reviewed. This health crisis has put the spotlight on mental health, which has always been neglected in the WHO African Region. Indeed, there is one psychiatrist per 500 000 inhabitants, which is 100 times below the WHO recommendation. In fact, the coverage of services for severe mental health in the Region is 0.072 per 100 000 population.

Figure 6.2.1. Percentage of women who received postnatal (postpartum care) within 2 days of childbirth in the WHO African Region, 2015–2020, WHO/UNICEF



6.3 Risk factors and behaviours

Figure 6.3.1. Prevalence of overweight and obesity among adults (%) in the WHO African Region, by sex, 2010–2016, WHO



Risk factors induce health-promoting behaviours and lifestyles in terms of diet, physical activity, etc. The prevalence of exclusive breastfeeding of children up to 6 months for the Region is 45.7%. This means that less than one in two children under the age of six months was exclusively breastfed in the Region between 2010 and 2018. Early breastfeeding is essential for the survival of the newborn and for the establishment of long-term breastfeeding. In fact, three out of five newborns are not breastfed within an hour of birth.

The African Region has the highest rates of anaemia in children aged 6–59 months (60.2%), and the second highest rate of anaemia in women of reproductive age (40.4%) after the South-East Asia Region in 2019. The prevalence of insufficient physical activity in adults over 18 years of age shows an overall average of 22.10% lack of physical activity among adults. It is a leading risk factor for NCDs. Moreover, women (25.63%) are less physically active than men (18.4%) in the Region. This can explain why women (38.8%) suffer more from overweight and obesity than men (22.8%). This condition is on the increase in the Region with time and health consequences (NCDs).

6.4 Health security

Health security is a key measure in the WHO African Region, given the devastating effect of epidemics and health emergencies on health and well-being. In order to strengthen and sustain prevention, preparedness and response capacities for health security, the global community and particularly African Member States, should accelerate building and investing in critical elements of health systems. Although IHR capacities are necessary, they are insufficient on their own to prevent, detect and respond to public health events. In many settings, health systems have not been at the centre of national efforts to implement the IHR. The effectiveness of such a mechanism must be based on strong, resilient and responsive systems capable of preventive measures, absorbing shocks, adapting to disturbances and responding to the changing needs and contexts created by public health events, while ensuring the continuity of essential health services.

6.5 Financial risk protection

Financial risk protection focuses on the level of financial barriers hindering the utilization of essential services; it is characterised by low levels of social security and pooling of health resources in the WHO African Region. In fact, 7.72% of the African population spend more than 10% of household income on health care expenditure. This proportion ranks the Region after North America and Europe and Central Asia. the global average is 12.67% of the population spending more than 10% of household income on health care.

SECTION VII

HEALTH IMPACT

- 7.1 Life expectancy and fecundity
- 7.2 Morbidity
- 7.3 Mortality by cause
- 7.4 Mortality by age

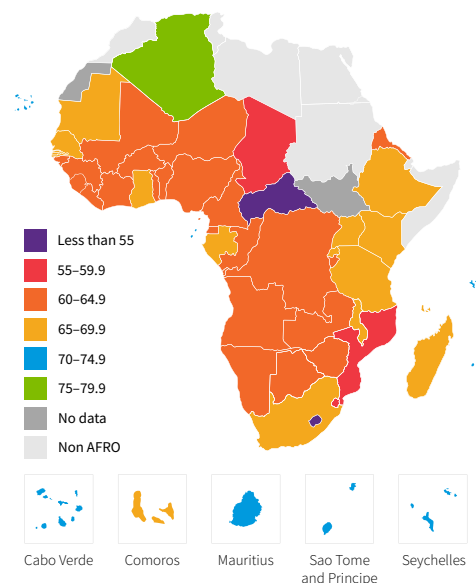
There are wide variations between the levels of performance of State-owned health systems, both in terms of investment and results achieved. Similarly, performance ranking is not always consistent with health impact. This suggests that countries are not well equipped to capture health investments and health-related outcomes. Furthermore, the focus on system performance in countries represents the best area of focus to move the slider towards the adoption of healthy lifestyles and well-being.

7.1 Life expectancy and fecundity

Life expectancy at birth increased from 52.7 years in 2000 to 64.5 years in 2019. By 2030, one in six people in the world will be 60 years of age or older. Moreover, the trend in average adjusted life expectancy in good health increased in the WHO African Region, from 46.7 to 56.5 years, over the period 2010–2021. This evolution shows a clear improvement in the health and well-being of the Region's populations. Over time, women have a longer healthy life expectancy than men; 57.1 years versus 55 years respectively in 2019.

Early childbearing, or pregnancy and delivery during adolescence, can derail girls' healthy development into adulthood and have negative impacts on their education, livelihoods and health. Many pregnant girls are pressured or forced to drop out of school, which can impact their educational and employment prospects and opportunities. Complications of pregnancy and childbirth are the leading causes of death for girls aged 15–19 years worldwide, and low- and middle-income countries account for 99% of maternal deaths worldwide among women aged 15–49 years. In addition, the total fertility rate is declining in all regions. In the WHO African Region, it remains high with 4.5 children per woman in 2017. However, the rate has declined over the past 30 years, from an average of 6.6 to 4.5 children per woman in the Region between 1980 and 2017.

Figure 7.1.1. Life expectancy at birth (years) in the WHO African Region, 2019, WHO



7.2 Morbidity

The Region is regularly faced with an upsurge of vaccine-preventable disease outbreaks. The mobility of people in the Region, including displacement due to conflict and other natural disasters, coupled with climate change which is changing the ecology and spread of infectious disease vectors, increases the risk of outbreaks of yellow fever, cholera and malaria. Between January and March 2022, nearly 17 500 measles cases were reported in the WHO African Region, representing a 400% increase over the same period in the previous year. Countries need to achieve and maintain a 95% immunisation coverage to eliminate measles. In 2021, thirteen countries reported yellow fever outbreaks in Africa, compared to nine in 2020. As of December 2018, a total of 168 out of 194 countries had introduced rubella vaccine, and global coverage was estimated at 69%. However, it is not enough in Africa and South-East Asia where rates of congenital rubella syndrome are the highest.

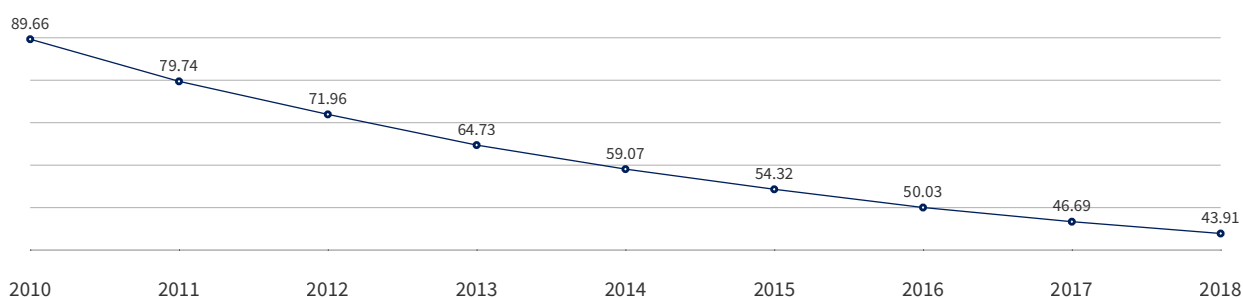
In 2021, Africa accounted for two thirds of people living with HIV worldwide. The incidence of HIV infections globally declined by 39% between 2010 and 2020, far less than the 75% target agreed to by the General Assembly in 2016. Measures to slow the spread of COVID-19, along with the added pressures on health systems, have disrupted HIV services. About 70% of the world's hepatitis B cases are concentrated in Africa, while 28 African countries now have a national hepatitis programme. Hepatitis strategic plans have been developed in 21 countries, while 17 countries have treatment and testing guidelines aligned with WHO guidelines. Every day, more than one million people worldwide contract a sexually transmitted infection (STI). The African Region is particularly affected by the high prevalence of these infections, which have an impact on the health and quality of life. The WHO African Region continues to pay the highest price for malaria. In 2020, it recorded 228 million malaria cases (95% of all cases) and 602 000 malaria deaths (96% of all malaria deaths). Eighty per cent of all malaria deaths in the Region are of children aged below 5 years of age.

The risk for a sub-Saharan African woman to develop cancer by the age of 75 years is 14.1%, with breast cancer (4.1%) and cervical cancer (3.5%) together accounting for half of this risk. The growth and ageing of the population, urbanisation and lifestyle changes are contributing to a rapid increase in the incidence of cancer. Actions need to be taken to address the absence of preventive measures, the delay in diagnosis, the lack of trained health workers, the lack of dedicated facilities and equipment.

Birth anomalies are among the leading causes of child mortality, chronic morbidity and disability. These diseases and anomalies may be present at birth or acquired later. The prevalence of low birth weight among newborns measured at birth in sub-Saharan Africa was 9.76%. Among the 10 countries with the highest rates of preterm births per 100 live births were eight African countries in 2016. Most stillbirths (84%) occur in low-income and lower-middle-income countries. In 2019, three out of four stillbirths occurred in sub-Saharan Africa or South Asia. Most stillbirths are due to poor care during pregnancy and childbirth. Despite progress in health services to prevent or treat the causes of child deaths, progress in reducing the stillbirth rate has slowed (2.3% decrease per year over the last 20 years).

7.3 Mortality by cause

Figure 7.3.1. AIDS-related mortality rate (per 100 000 population) in the WHO African Region, 2010–2018, WHO



Each year, more than 500 000 people die from TB in Africa, although TB-screening and treatment is free in all countries. Around 44 per 100 000 people died from AIDS in 2018. Meanwhile, the maternal mortality ratio remains very high with more than 525 deaths per 100 000 births. Despite its very high maternal mortality rate, sub-Saharan Africa has seen a substantial reduction in the maternal mortality rate of about 38% since 2000. The highest burden of malaria is in Africa with 96% of all malaria deaths in 2020.

In 2021, COVID-19 killed 113 102 people on the continent, giving an official figure of more than 300 deaths every day. Current projections are of 23 000 deaths – or about 60 a day – for the whole of 2022. The (official) milestone of 12 million people infected (4 million in South Africa alone) was passed in the first quarter of 2022, while the number of deaths now exceeds 254 000.

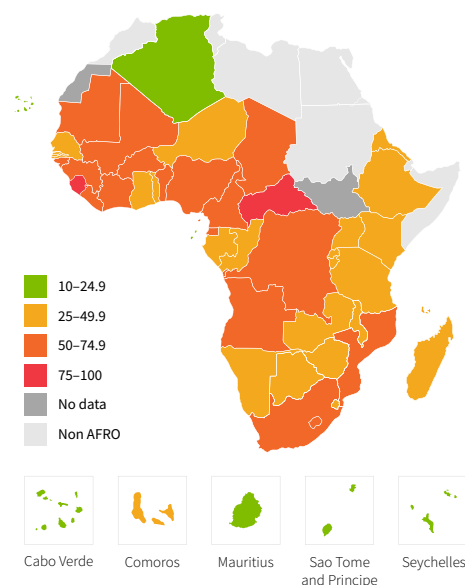
7.4 Mortality by age

To reach this level of life expectancy, the babies who are born must be able to survive. Most stillbirths (84%) occur in low-income and lower-middle-income countries. It is estimated that nearly 2 million babies are stillborn each year (three quarters of that figure occurs in sub-Saharan Africa or South-Asia). In 2020, the mortality rate among children under the age of one year in Africa was around 41.6 deaths per 1000 live births. Infant mortality on the continent decreased significantly compared to 2000, when approximately 81 newborn infants per 1000 died before one year of age.

Nearly one in 10 children still dies before reaching their fifth birthday in sub-Saharan Africa (95 deaths per 1000 live births). Malaria and malnutrition particularly affect under-five children in certain regions. Between 2010 and 2016, the rates per 100 000 adolescents fell from 235.0 to 211.8 for young men and from 223.4 to 196.0 for young women. There is a difference in adolescent mortality rates between countries. And, within countries, differences equally exist in mortality rates between men and women. For example, Nigeria's adolescent mortality rate ranks fourth for women and 15th for men.

Adult mortality also decreased by 14.5% over seven years (from 324 to 277) from 2010 to 2016 in the WHO African Region. In the Region as well as globally, the data describe excess male mortality in almost all countries. Mortality data, as well as birth rate data and other aspects of civil status, must be improved in most countries to for the best lessons to be learnt and the most effective preventive measures implemented. In the absence of effective civil registration systems, deaths often must be estimated from imperfect data.

Figure 7.4.1. Infant mortality rate (per 1000 live births) in the WHO African Region, 2019, WHO



Conclusions and key considerations

The health statistics for the WHO African Region in 2021 showed a varied profile, with countries at different stages of achievement of the target indicators. In general, progress has been observed in almost all areas. The health emergencies that the Region has faced recently, particularly the COVID-19 pandemic, have shown us that although the Region was not prepared for this particular disease, the response was appropriate and the pandemic was contained with the fewest possible deaths. However, the statistics also revealed a disruption in the continuity of health service delivery, leading to a degradation of some indicators and slowing down progress towards achieving UHC and the SDGs. The improvement of health information systems has had an impact on the monitoring of health indicators, although some key data are still not available. In the same line of good practice and effective action, health promotion programmes using all types of media and community mobilisation have improved population health indicators, as well as morbidity and mortality control. All of these aspects must now be integrated into structured, operational, and reliable monitoring and response systems.

Despite considerable advances in terms of life expectancy and improved access to health care in the WHO African Region, many challenges remain. Universal health coverage is one of these objectives that must be prioritised and to which financial, infrastructural and human resources must be allocated. Areas such as NCDs, health systems (including service delivery, health information systems, financing, health workforce and infrastructure) need to be strengthened. This also includes well-being, as well as maternal and child health.

Countries of the Region should prioritise the revision of health policies and/or strategies with targeted interventions to achieve the 2030 goals, including strengthening intersectoral collaboration (One Health), as well as advocacy and partnerships focused on country priorities. The Abuja 2001 target must also be considered a top priority in governments' agenda, with more endogenous resources for health, while resilience of the health system should be made effective at all levels of the health system pyramid.

