

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

Section summary

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). As proposed by the United Nations, UHC could be called a practical expression of the right to health care for all. To achieve the goal of universality, there are measurable indicators to monitor. In the WHO African Region, even though great efforts have been made, by reaching only 46% of the population health care does not yet even cover every second citizen.

By 2021, reports were pointing out the deterioration in household financial protection, particularly because of falling incomes and rising poverty and inequality, meaning a movement away from UHC. In some low-income countries where services are very limited, the scope of health expenditure also is limited. The Abuja Declaration calls for the mobilisation of more resources from the government for the health sector in African countries.

The level of the family planning need among women aged 15–49 years satisfied with modern methods is one of the indicators of inequalities in reproductive health service coverage. It shows that in the Region only 56.3% of the women living in a couple or marriage relationship used family planning in 2020 compared with more than 75% on average in the rest of the world. For antenatal care and childbirth, families in urban and rural areas do not always have access to qualified health personnel, which compromises the well-being and future of children. Protecting the health of both newborns and adults requires immunisation, the coverage of which is declining worldwide and in Africa as well. This substantial decline of immunisation has been accentuated by the COVID-19 pandemic, which pushed back the targets to be reached and forced states everywhere to redouble their efforts to catch up on immunisation but with few resources available to them.

Tuberculosis (TB) treatment coverage, on the other hand, has shown an increase since 2014, although some countries are still lagging despite the free access to the drugs. In fact, only 57% of the affected patients are covered by treatment. 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 in the WHO African Region living with HIV had access to lifesaving antiretroviral drugs. But malaria continues to strike mainly pregnant women and children, particularly in Africa.

Significant progress has been made in the universal access to basic water supply, sanitation and hygiene services, but considerable gaps remain in the quality of the services provided and there are inequities between and within countries. The WHO African Region remains the Region with the lowest coverage of water, sanitation and hygiene services with only 23% 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.

The COVID-19 crisis has demonstrated that more needs to be done to prepare for the next pandemic and public health emergencies. The frequency and pervasiveness of epidemics, disasters and other public health emergencies in Africa require substantial investments in the preparedness capacity in all countries. But while investing in emergency and disaster preparedness should be guided by global frameworks such as the International Health Regulations (2005) (IHR (2005)), it is the responsibility of each government to fund its needs. What is inescapable is that these actions require collaboration between countries and regional economic communities; financial, material and effective human resources; multidisciplinary and intersectorality in approaches; and certainly good leadership. The WHO African Region experiences more epidemics than any other part of the world. Before the emergence of COVID-19, the top five causes of epidemics were cholera, measles, yellow fever, meningococcal meningitis and influenza.

The encouraging news in pursuing the goal of a healthier population in the Region is that the prevalence of stunting among under-five children has been dropping in the Region since 2000, though slowly. Almost 80% of the countries have a high or very high prevalence of stunting among under-five children. Undernutrition is responsible for about 45% of the deaths of children in this age group in the low-income and middle-income countries. Regional data show a decline in overweight levels from 6.04% to around 4.54% from 2000 to 2021. This clearly shows that the aim of reducing overweight levels by 50% by 2025 might not be realised if nothing is done about it.

Suicide remains one of the leading causes of death worldwide. Its 5.7% decline in the Region over 2015–2019 was better than the global average decline of 3.2%. In the WHO African Region, the suicide level seems to be alarming in southern Africa. While the link between suicide and mental disorders is well established, many suicides occur during a crisis for the victim that he or she lacks the ability to cope with.

Africa missed the SDG 3.6.1 target of halving the number of global deaths and injuries from road traffic accidents by 2020 and, furthermore, estimates show that the number of cars on the road will likely double between 2015 and 2030.

Consumption of beer has been rising globally and in 2019 it increased for the second year in a row, supported by strong demand in Asia and Africa alongside their economic growth. That year consumers in the African and Asian regions spent more on beer purchases than in the previous year, with an increase in Africa of 5.2%.

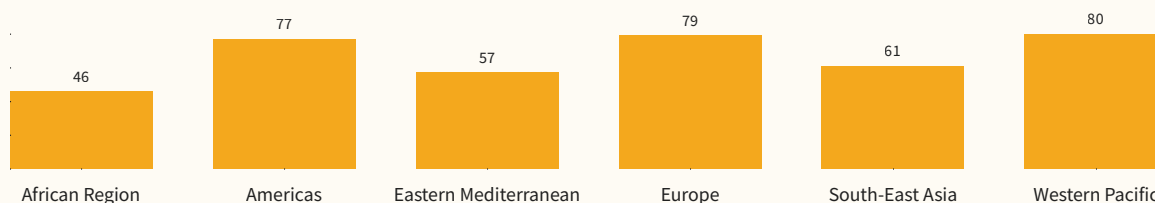
The global ambition of achieving net zero greenhouse gas emissions by 2050 is an added dimension for the energy sector. African countries are particularly well placed to take advantage of technological benefits from these efforts and attract increasing flows of green finance.

2.1 Universal health coverage

2.1.1 SERVICE COVERAGE

Service coverage index

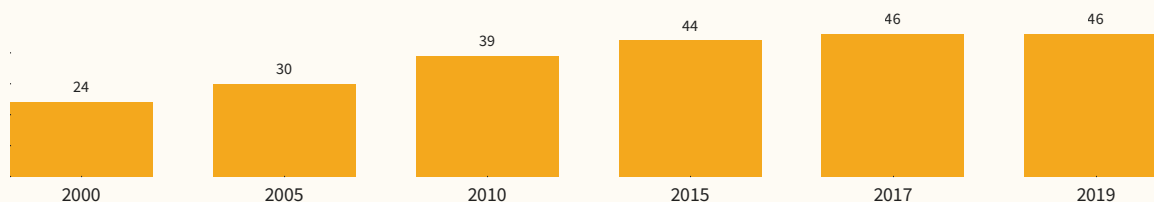
Figure 2.1.1.1. Service coverage index in the WHO regions, 2019, WHS2022



UHC means making quality health services available for all, ensuring that people are not pushed into poverty by health care costs. The construction of the UHC service coverage index (SCI) is based on 14 indicators extracted from various sources and organised into four broad categories of service coverage, namely reproductive, maternal, newborn and child health; infectious diseases; noncommunicable diseases; and service capacity and access. These indicators are meant to be indicative of the service coverage and should not be interpreted as a complete or exhaustive list of the health services or interventions that are required to achieve UHC.

During 2000–2019 substantial progress was made worldwide in the UHC SCI levels, especially in Asia and Africa.¹ In 2019 UHC SCI across the six WHO regions ranged from 46 to 80, with an average of 68. The WHO African Region, with an index of 46, is considered to have average UHC, as is the Eastern Mediterranean Region, with an SCI of 57. The regions of South-East Asia, the Americas and Europe with indices of 61, 77 and 79, respectively, are considered to have high UHC coverage. Only the Western Pacific Region, with an index of 80, is considered to have very high UHC.

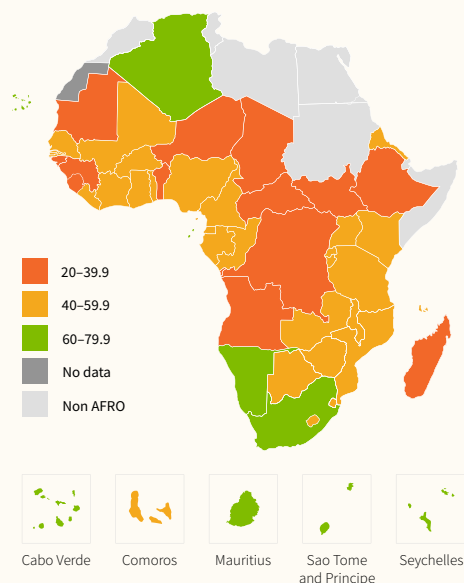
Figure 2.1.1.2. Service coverage index in the WHO African Region, 2000–2019, WHS2022



SCI rose from 45 to 68 globally between 2000 and 2019 and from 24 to 46 in the WHO African Region. The goal of the service coverage dimension of UHC is to help ensure that people in need of promotive, preventive, curative, rehabilitative or palliative health services receive them, and that the services are of sufficient quality to achieve potential health gains. Africa still has more than half of its population without access to quality health services and will have to increase its efforts in the face of the financial constraints, environmental challenges, wars and disasters, but also a growing population.

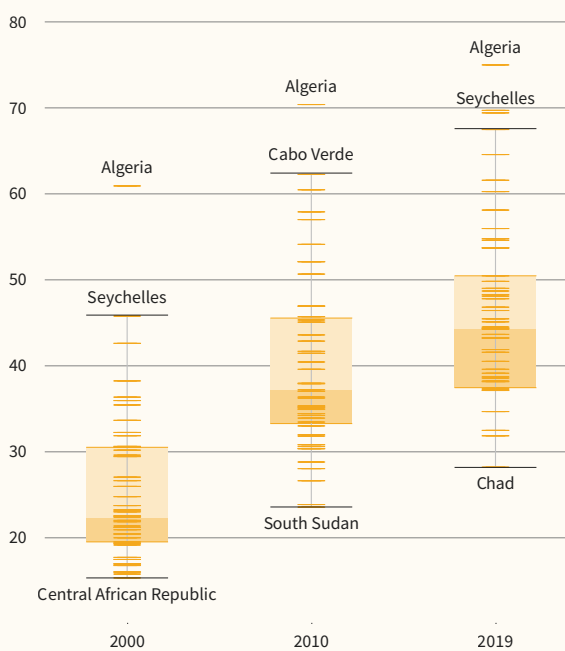
1 WHO and the World Bank; Tracking universal health coverage; 2021 Global Monitoring Report

Figure 2.1.1.3. Service coverage index in the WHO African Region, 2019, WHS2022



The relationship between SCI and GDP per capita suggests a link between income and the coverage of essential health services. The average SCI score observed in low-income countries seems to be lower than that in high-middle-income countries. Countries in southern and eastern Africa had better SCI scores than most other countries in 2019.

Figure 2.1.1.4. SCI box plot in the WHO African Region, 2000, 2010 and 2019, WHS2022

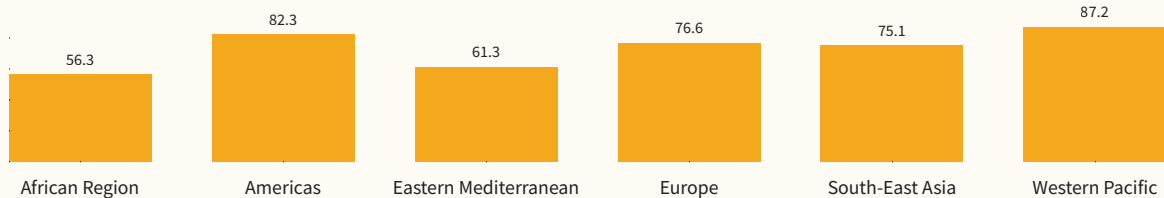


Analyses at the country level indicate that regional performances in 2019 and progress over 2000–2019 mask the considerable variations across the countries. Despite the progress made, the constraint of limited resources means that some countries fall short in fulfilling the requirements of the ambitions of UHC in some of its dimensions such as the size of the population covered, services offered etc.

The average SCI has improved compared to the 2000s, but the bottom quartile of the countries has widened, creating a disparity between this group of countries with a larger gap in service coverage index in 2019. On the other hand, countries with a higher index made more progress than those with a lower index. Seychelles and Algeria stood out from among the countries in the top quartile.

Need for family planning satisfied with modern methods among women aged 15–49 years who are married or in a union

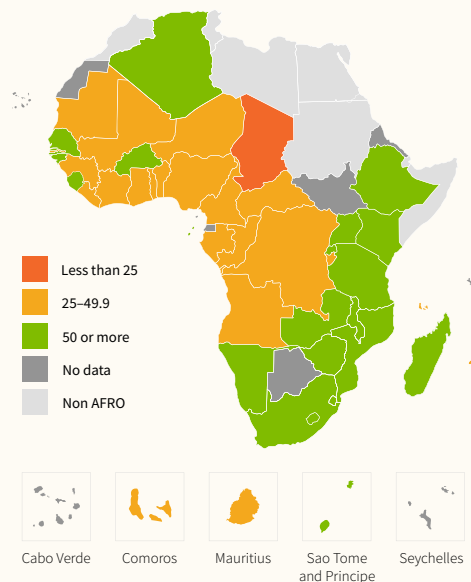
Figure 2.1.1.5. Need for family planning satisfied with modern methods among women aged 15–49 years who are married or in a union (%) in the WHO regions, 2020, WHS2022



The need for family planning satisfied with modern methods in women aged 15–49 years who are married or are in a union is one of the indicators of inequalities in reproductive health service coverage. Reproductive health, maternal health, child immunisation and management of childhood illnesses are part of a continuum of health services that is used in identification of inequalities between population subgroups.

In Africa, only 56.3% of the women living in a couple or are married used family planning in 2020 compared with more than 75% on average in the rest of the world. At the regional level, countries can be divided into three groups, with just Chad in the least advanced group in terms of family planning, almost the entire East and Southern Africa subregion, along with a few countries in West Africa, in the group with the highest rates of family planning, and the rest of the countries in Central Africa and a large part of West Africa in the intermediate group, in which 25–50% of the family planning needs of women of reproductive age and in a union are satisfied.

Figure 2.1.1.6. Need for family planning satisfied with modern methods among women aged 15–49 years who are married or are in a union (%) in the WHO African Region, 2012–2020, WHS2022



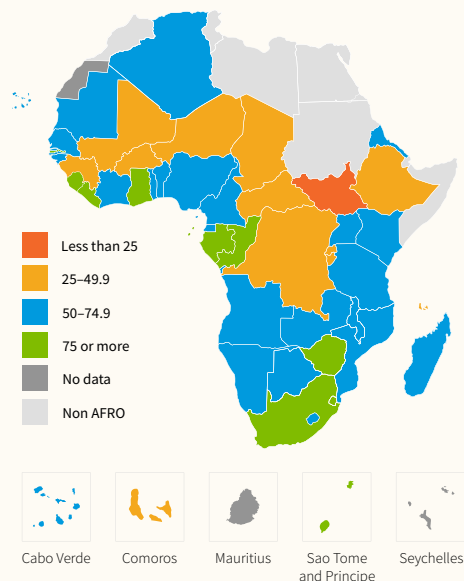
The prevalence of modern methods of contraception among married women of reproductive age has increased globally by just a little more than two percentage points over the past 10 years. The slowness of this increase is explained by the limited choice of contraceptive methods; limited access to services, especially for the young, poorest and unmarried people; fear or experience of side effects; cultural or religious barriers; low quality of available services; preconceptions of users and also providers against certain methods; and gender-related barriers to accessing services. Less than half of the family planning needs are satisfied in Central and West Africa.

There is no direct relationship between a country’s income level and the need for modern contraceptive methods among women aged 15 to 49 years. Family planning needs reflect regional patterns of nuptiality, with early marriage, universal marriage,

significant polygamy, extended families etc. as important in West Africa; late marriage, significant celibacy, little polygamy, more family nuclearisation etc. as important in southern Africa, and a combining of some of these factors as important in East Africa (Lesthaeghe et al., 1989; Tabutin and Schoumaker, 2004; Hertrich, 2007).

Antenatal care coverage

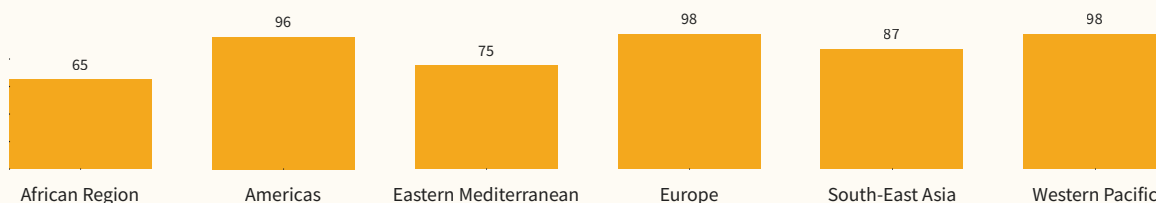
Figure 2.1.1.7. Antenatal care coverage (+4 visits), 2011–2017 in the WHO African Region, WHO/AFRO



Antenatal care coverage (+4 visits) is an important link in the continuum of care. Ensuring accessible and good quality continuity of care before and during pregnancy, at delivery and in the postnatal period reduces maternal and neonatal mortality. Major efforts are still needed in most countries in antenatal care, including ensuring an optimal number of visits, the minimum of which should be four. About 10 countries, most of which are located in areas of sociopolitical instability or war areas, do not have a reach of 50% coverage in their ANC needs. High-income and middle-income countries have better ANC coverage, although the high income and high ANC coverage relationship is not systematic for all countries at the different income levels.

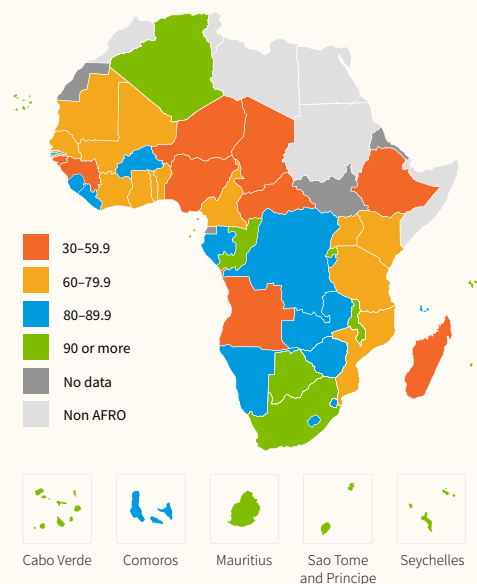
Skilled birth attendance

Figure 2.1.1.8. Proportion of births attended by skilled health personnel (%) in the WHO regions, 2015–2021, WHS2022



Despite the progress in the participation of skilled attendants during birth delivery in the WHO African Region, one third of births still do have skilled health personnel attending. The high cost of the services and the low availability of qualified health personnel are parts of the cause.

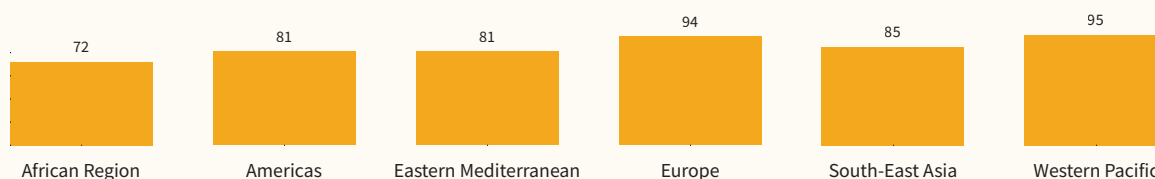
Figure 2.1.1.9. Proportion of births attended by skilled health personnel (%) in the WHO African Region, 2012–2021, WHS2022



Preventing childbirth deaths remains a huge challenge. In the United Republic of Tanzania, where 64% of childbirths have a professional attendant, 9000 women die each year from complications related to childbirth. In Kenya, a country in which professional attendants are present at 70% of the births, a maternity ward located near two of the largest slums in Nairobi helps around 27 000 mostly poor women under the age of 20 years to give birth every year. Nigeria has a health care professional present in 43% of births and is witnessing increasing cases of obstetric fistula at levels of 800 000 each year caused by problems during childbirth. About three quarters of the countries in the Region have a skilled birth attendant coverage above 70%.

DTP3 immunisation coverage for children aged 1 year

Figure 2.1.1.10. DTP3 immunisation coverage for children aged 1 year (%) in the WHO regions, 2020, WHS2022



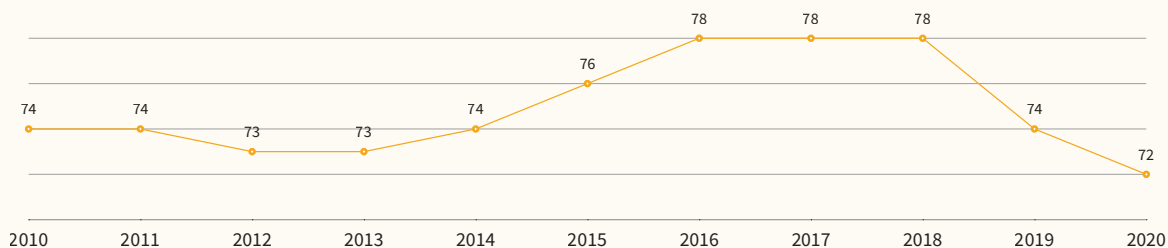
The minimum immunisation schedule recommended by WHO for all countries for DTP3 coverage of 90% at the national level and 80% at the district² level is far from being applied for all children in the WHO African Region. The oldest vaccines in the expanded immunisation programme such as BCG and vaccines against diphtheria, tetanus, whooping cough and measles benefit less than half of the children.

Globally immunisation coverage declined over 2019–2020 from 86% to 83%. It is estimated that 23 million children under the age of 1 year have not received basic vaccines, the highest figure since 2009. Of the 23 million children, more than 60% live in 10 countries that include Angola, the Democratic Republic of the Congo, Ethiopia and Nigeria, which are in the WHO African Region. In 2020, the number of completely unvaccinated children increased by 3.4 million.

The decline in vaccination coverage, particularly among children living in fragile environments where access to immunisation services is often difficult, is explained by the increase in misinformation and problems related to the COVID-19 pandemic such as disruption of services and the supply chain, reorganisation of resources and introduction of COVID-19 containment measures that have limited access to and availability of immunisation services. For UNICEF,³ this is a red flag for children’s health. It is the largest uninterrupted decline in child immunisation in a generation and it is not abating. It is imperative to make up for lost time for the millions of children who have not been immunised, or we will inevitably see more outbreaks of vaccine-preventable diseases, more sick children and more strain on health systems already under strain, and the consequences could be counted in human lives.

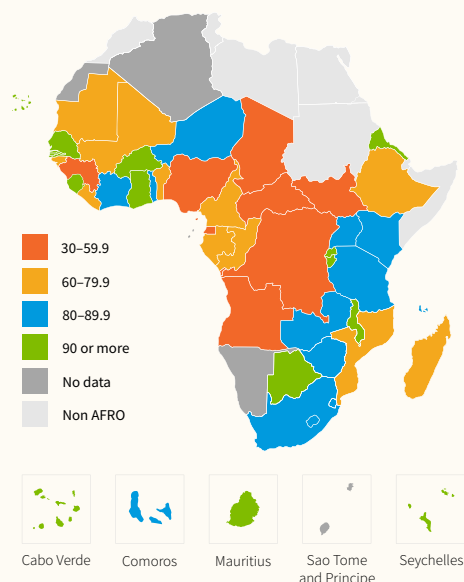
2 WHO/UA; Fulfilling the promise: ensuring vaccination for all in Africa; ministerial Conference on immunisation in Africa; 2016
 3 WHO-UNICEF Joint Statement, GENEVA/NEW YORK, 15 July 2022

Figure 2.1.1.11. DTP3 immunisation coverage for children aged 1 year (%) in the WHO African Region, 2010–2020, WHO/UNICEF



The lowest rates of DTP3 vaccination in 2020 were in the WHO African Region with 72% coverage for children under 1 year old. A total of 14 countries had coverage levels below this and three of them⁴ had lower than 50% coverage. DTP3 immunisation coverage in children aged 1 year has changed little over the past 10 years, although it has decreased slightly since 2018 and continued that way even with the COVID-19 crisis.

Figure 2.1.1.12. DTP3 immunisation coverage for children aged 1 year (%) in the WHO African Region, 2020, WHO/UNICEF



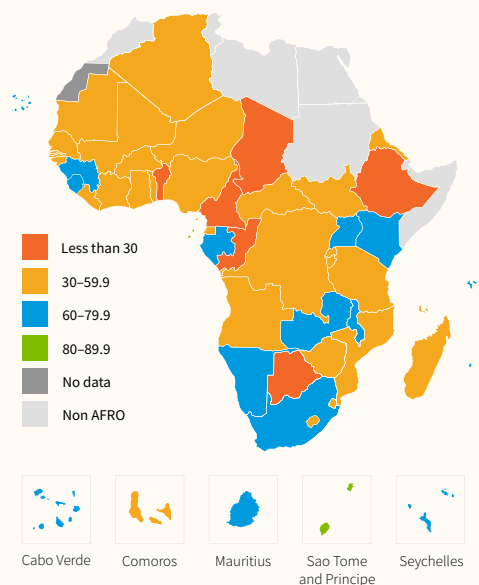
Disparities in DTP3 immunisation exist among the countries in the Region. The countries from the Central African subregion have the lowest coverage rates with the majority at lower than 60%. The Southern and Eastern African countries have the highest rates with most of them at more than 80% coverage. West African countries are in between, with diverse situations between countries.

Many countries need to intensify efforts to catch up with routine immunisation and expand outreach services in underserved areas to reach children who have missed out on immunisation and implement campaigns to prevent disease outbreaks.

4 Central African Republic, Guinea, South Sudan.

Care seeking for under-five children with suspected pneumonia

Figure 2.1.1.13. Care seeking for children with symptoms of pneumonia in the WHO African Region, 2010–2019, WHO



Pneumonia continues to be one of the leading causes of death in under-five children globally, even if the implementation of safe, effective and affordable interventions has reduced mortality from this disease.

In general, care seeking for children with symptoms of pneumonia is still quite low in the Region. Only about 10 countries in the Region have acceptable levels of care provision for children with symptoms of pneumonia, most of which are in Eastern and Southern Africa. Most of the countries in the Region are in the 30% to 60% range of coverage for care seeking for children with symptoms of pneumonia.

TB treatment coverage

Of the 10 million TB cases diagnosed worldwide each year, a quarter are in Africa. TB spreads faster in countries where the proportion of people living with HIV is high. Since 2014, the TB treatment coverage curve has shown an upward trend. Despite the free access of TB drugs, many countries are still lagging, with treatment covering only about 57% of the people affected by the disease.

Figure 2.1.1.14. TB treatment coverage (%) in the WHO African Region, 2010–2019, WHO

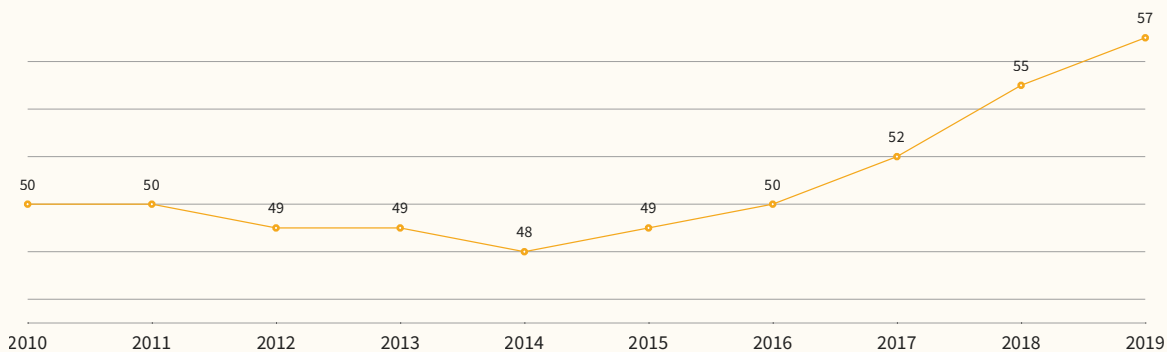
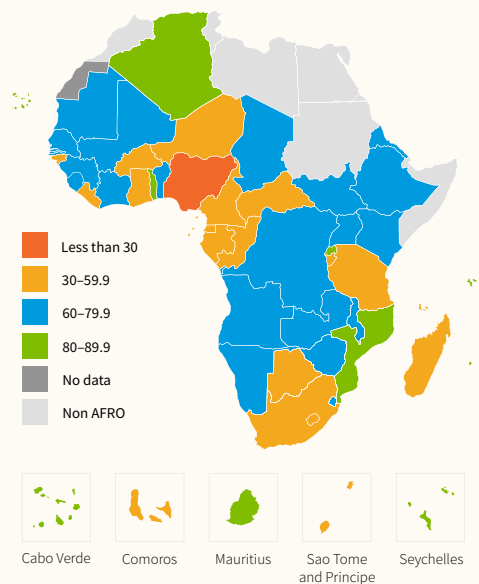


Figure 2.1.1.15. TB treatment coverage (%) in the WHO African Region, 2019, WHO

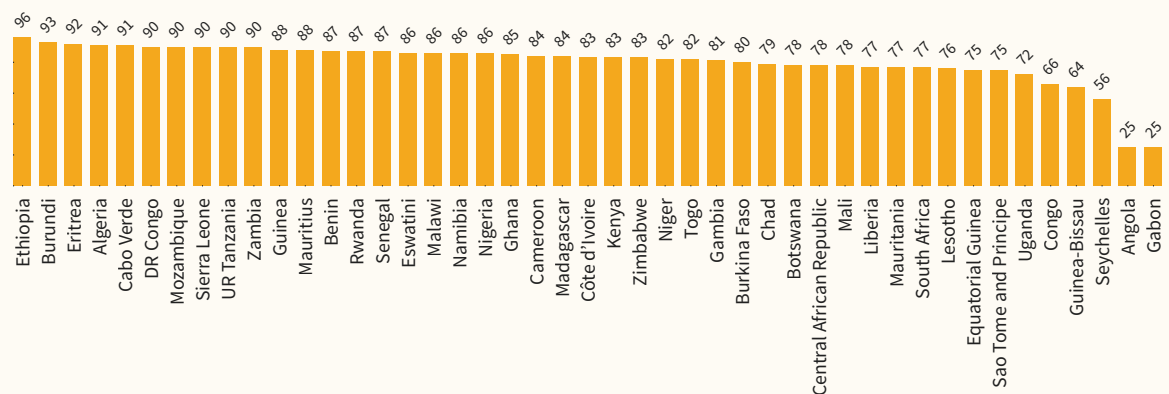


Africa accounts for 500 000 of the 1.2 million annual global deaths attributed to TB. The most affected countries are the Democratic Republic of the Congo, Nigeria and South Africa.

Countries with well-organised health care systems or good economic growth do not necessarily have good TB treatment coverage, meaning that other factors also play a role.

Only seven countries manage to treat eight out of their 10 patients affected by TB and another seven have lower treatment coverage than one out of two patients.

Figure 2.1.1.16. TB treatment success rate (%) in the WHO African Region, 2017, WHO

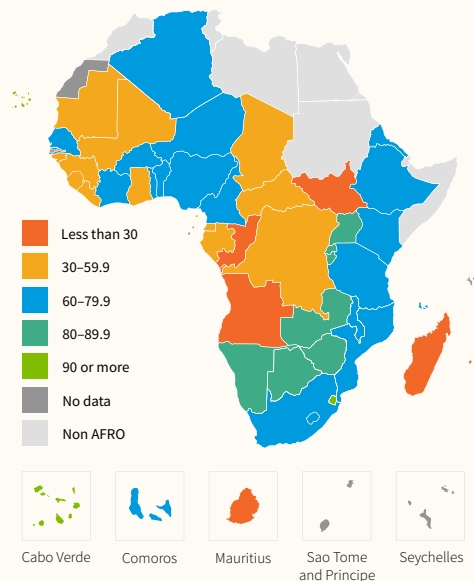


One of the targets of the SDGs is to end the epidemic TB. Africa has the highest per capita incidence of TB in the world. Consequently, the eradication of the disease in Africa will have a significant positive impact in achieving global eradication goals.

Fewer than half of the countries in the Region meet the 85% TB treatment success rate recommended by WHO. There seems to be no direct link between the TB treatment success and the economic growth of the countries. Indeed, countries with the best rates are in the lower-income or lower-middle-income groups.

HIV ART coverage

Figure 2.1.1.17. Coverage of antiretroviral therapy (ART) in the WHO African Region, 2019, UNAIDS



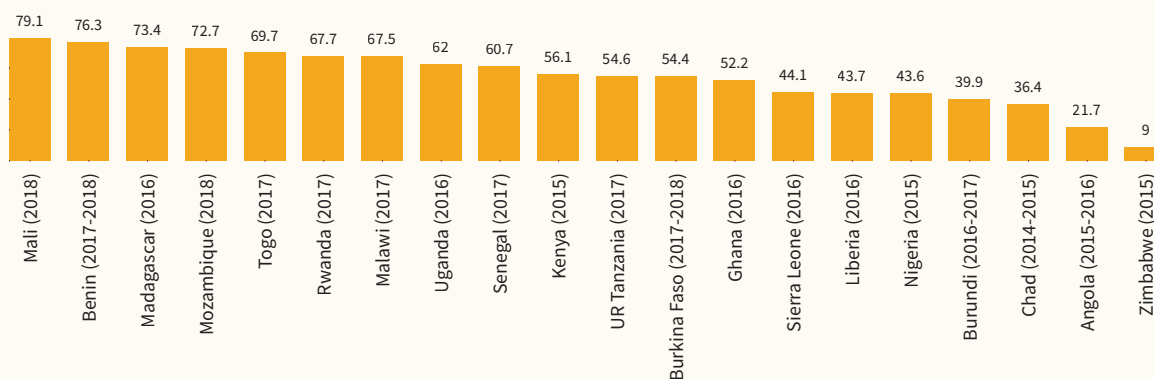
The global response to HIV/AIDS has produced noticeable effects in the WHO African Region. By the end of 2017, some 15.3 million people living with HIV in the Region had access to lifesaving antiretroviral drugs. This represented 70% of the world’s population with access to ART, then estimated to be 21.7 million. A total of 15 countries in the Region are at this coverage rate or surpass it, with two countries exceeding 90%. The countries in Central Africa have lower coverage rates than the other countries.

Eastern and Southern African countries offer more access to antiretrovirals than does the rest of Africa. Effective tests, coupled with good therapeutic coverage, have made it possible to diagnose more than eight out of 10 people living with HIV, and one out of three people with HIV infection who know his or her serological status is on ART.

Some 52% of the people on ART have had their viral load suppressed. Furthermore, in the West and Central Africa subregions, 48% of people living with HIV have been diagnosed, 40% of the people with HIV who know their serological status are on ART, and 29% of the patients on treatment have had their viral load suppressed. WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) had a target of suppressing the viral load in 90% of the people living with HIV and on ART by 2020. The realisation of this ambitious goal has been compromised by the increase of the prevalence of HIV drug resistance.

Insecticide-treated net (ITN) use among people living in malaria endemic areas

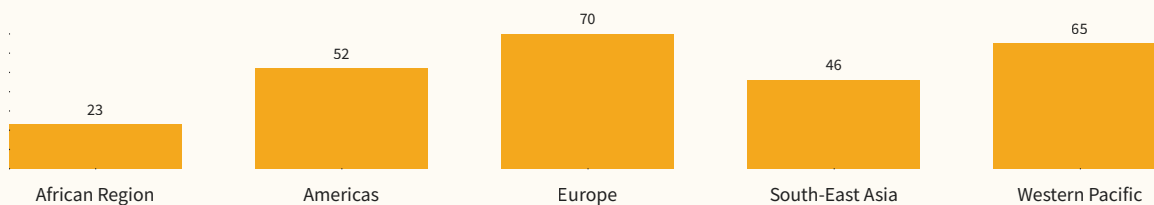
Figure 2.1.1.18. Use of ITNs in the WHO African Region, latest available data, MIS, WHO



Malaria continues to strike mainly pregnant women and children, particularly in Africa. The cases were estimated to be 241 million in 2020, with 627 000 deaths. While the global proportion of under-five children and pregnant women sleeping under ITNs increased from 3% to 49% between 2000 and 2020, for Africa there has been a decline since 2017. This is attributed to reasons such as the increasing investment needs in other humanitarian emergencies such as those on Ebola and COVID-19 diseases that affected the continuity of the services for malaria. However, the latest data indicate that a few countries⁵ in the Region have an ITN coverage rate of more than 70%.

Population access to basic sanitation

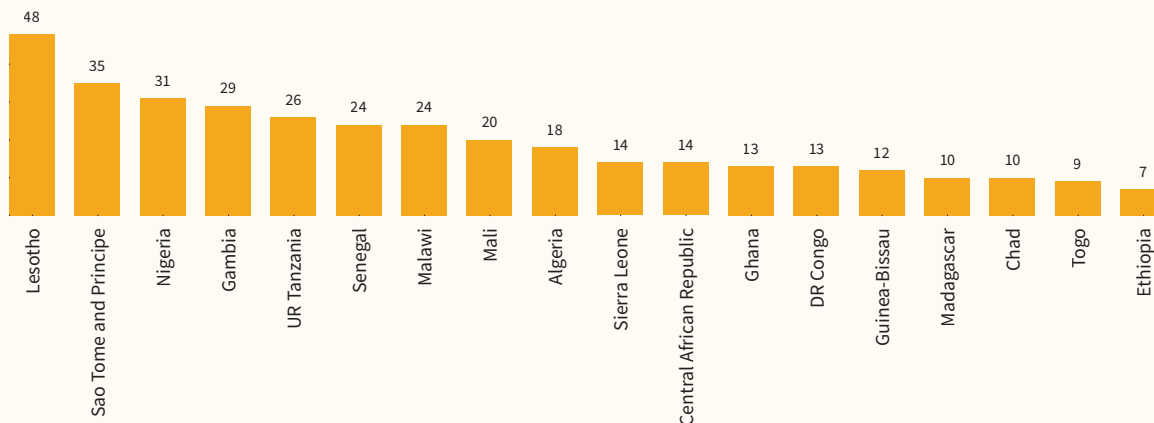
Figure 2.1.1.19. Population access to at least basic sanitation (%) in the WHO regions, 2020, WHS2022



The report on the inequalities in access to water, sanitation and hygiene reveals that more than half of the world’s population does not have safe sanitation services. Although significant progress has been made in the universal access to basic water supply, sanitation and hygiene services, considerable gaps remain in the quality of the services provided. It is estimated that 785 million people do not even have access to these basic services, that is one in 10 people. The data also show that in rural areas, eight out of 10 people are deprived of these services and that coverage of basic services is at least twice as high among socioeconomically advantaged groups than the poorest groups.

5 Burundi, Mali, Benin, Madagascar, Mozambique, Togo.

Figure 2.1.1.20. Population access to at least basic sanitation (%) in the WHO African Region, 2020, WHS2022

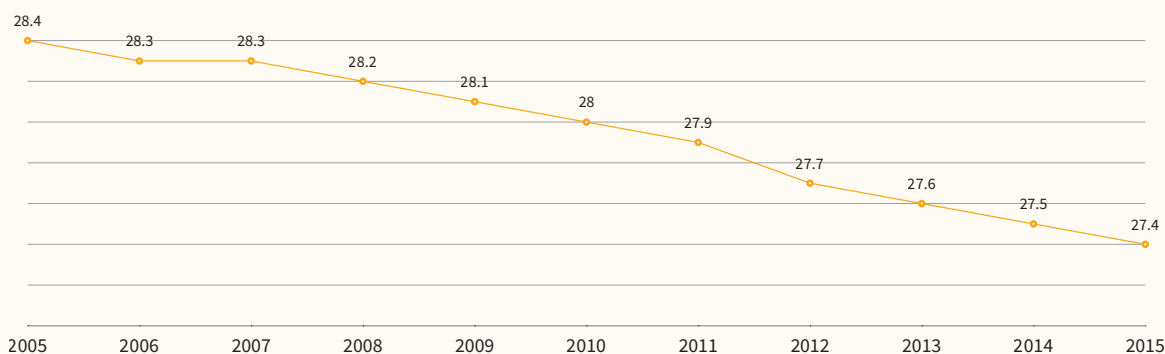


The WHO African Region has the lowest coverage of sanitation among the WHO regions, with only 23% of its population having access to at least basic sanitation. This level represents half of the coverage in South-East Asia and a third of Europe's. The socioeconomic level of countries is gauged by the universality of access by their citizens to basic services such as water supply, sanitation and hygiene.

If nothing is done to improve sanitation coverage, the goal of having universal access to basic sanitation services by 2030 will not be achieved and diseases such as diarrhoea, cholera, typhoid, hepatitis A and intestinal parasites that should have long been eradicated will continue to affect the population of the Region. It should be noted that few data are available for this indicator and those available might be underestimated.

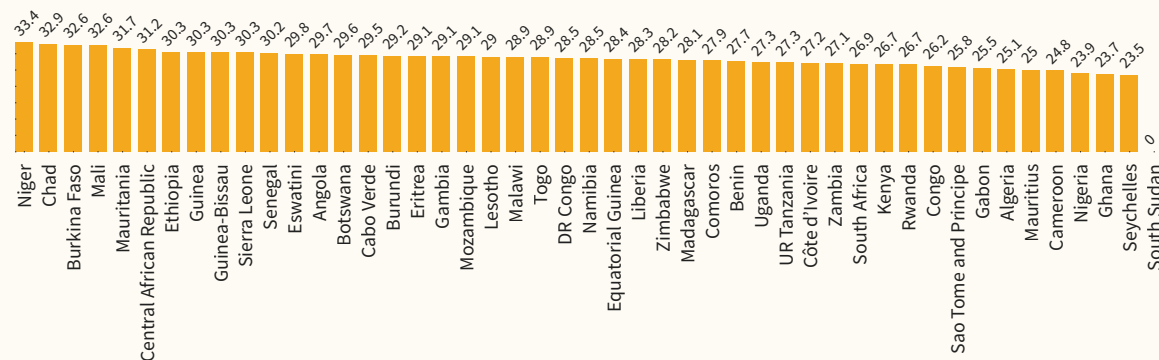
Prevalence of raised blood pressure in adults aged 18 years or older

Figure 2.1.1.21. Prevalence of raised blood pressure in adults aged 18 years or older (%) in the WHO African Region, 2005–2015, WHO



Hypertension affects 1.28 billion people worldwide, 82% of whom live in low-income or middle-income countries, including 580 million who are unaware of their condition, having never received a diagnosis. Hypertension is a major public health problem in developing countries and in Africa it affects women more than men. Both Hypertension rates for both men and women have gone down slightly over the last 10 years.

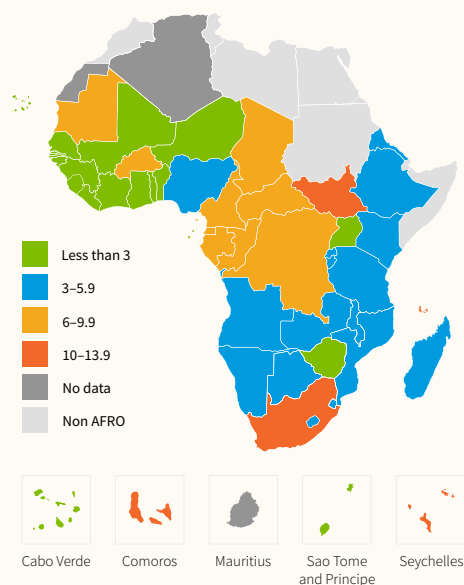
Figure 2.1.1.22. Prevalence of raised blood pressure in adults aged 18 years or older (%) in the WHO African Region, 2015, WHO



In the WHO African Region, as in all the other regions, there are differences in the prevalence of hypertension among countries, between men and women and by age. A link can be observed between the socioeconomic level of a country and its prevalence of hypertension (2015 data).

Mean fasting blood glucose in adults aged 18 years or older

Figure 2.1.1.23. Age standardised prevalence of raised blood glucose/diabetes among persons aged 18 years or older or on medication



Noncommunicable diseases (NCDs) are increasingly becoming the main cause of death in sub-Saharan Africa, where they were responsible for 37% of the deaths in 2019 compared with 24% in 2000. Their upsurge is mainly associated with weaknesses in the implementation of essential control measures such as prevention, diagnosis and care.

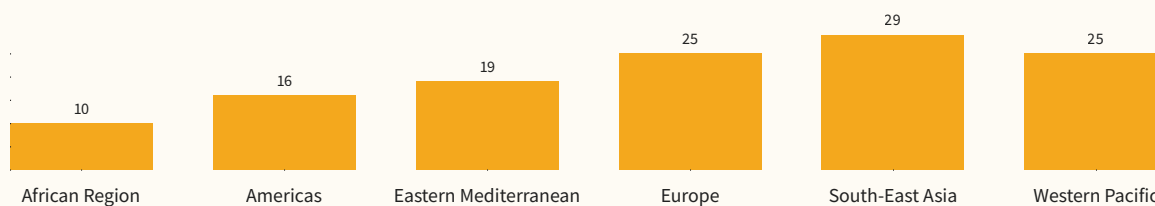
The growing burden of NCDs is a serious threat to the health and lives of millions of people in Africa and accounts for more than a third of the deaths, particularly among people under the age of 70.

In 2014, 8.5% of adults aged 18 or older had diabetes worldwide. In 2019, diabetes was the direct cause of 1.5 million deaths, to which must be added deaths due to higher than normal blood sugar levels leading to cardiovascular disease, chronic kidney disease, etc. In the WHO African Region, the number of people living with diabetes is expected to reach 47 million by 2045, up from 19 million in 2019.⁶

6 WHO Noncommunicable Disease Progress Monitor, 2022

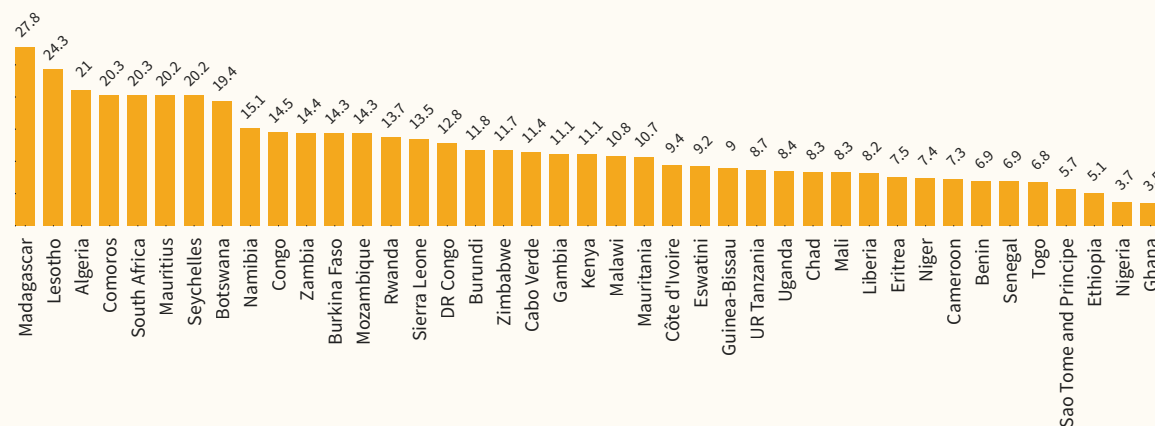
Tobacco use in the last 30 days among adults aged 15 years or older

Figure 2.1.1.24. Tobacco use in the last 30 days in adults aged 15 years or older (%) in the WHO regions, 2020, WHS2022



Tobacco is the leading preventable cause of death worldwide. Its control efforts aim to prevent young people from starting to use tobacco, to help current smokers quit and to protect non-smokers from exposure to second-hand smoke. Countries in the WHO African Region are experiencing increasing levels of tobacco use. The rapid population growth in sub-Saharan Africa and the increasing purchasing power of consumers mean that African markets are getting larger and more accessible. This is coupled with intensive efforts by the tobacco industry to develop African markets.

Figure 2.1.1.25. Tobacco use in the last 30 days in adults aged 15 years or older (%) in the WHO African Region, 2020, WHS2022

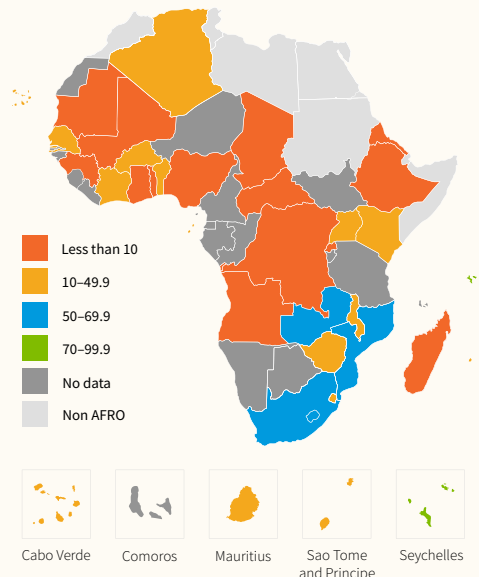


Tobacco use data from the month before the survey showed a low rate of 10% for the WHO African Region compared with the rates of 16% for the Americas and 29% for South-East Asia.

In the WHO African Region, smoking among people aged 15 years or older is highest in Madagascar (27.5%), then Lesotho (24.3%) followed by Algeria (21%). It is lowest in Ghana (3.5%), Nigeria (3.7%) and Ethiopia (5.1%). The highest income countries are in the top 10 with the highest proportions of tobacco users.

Coverage of the national cervical cancer screening programme

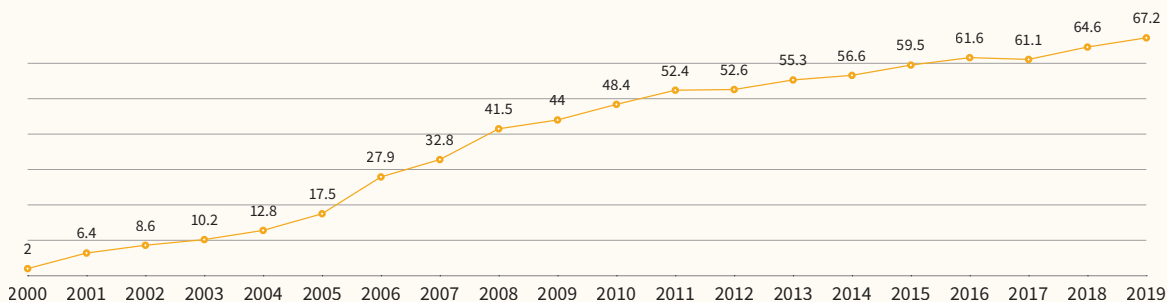
Figure 2.1.1.26. Coverage of the national cervical cancer screening programme in the WHO African Region, 2015–2019, WHO



The burden of cervical cancer weighs heavily on Africa in an inequitable way. It is on the African continent that we find 19 of the 20 countries most affected by the disease in the world. With cervical cancer rates up to six times higher in Africa than in North America, the disease is inequitable. The regional perspective has set as its guideline the suggested elimination threshold of less than four cases per 100 000 people per year, as well as the 90/70/90 targets. These targets intend that 90% of women should be fully immunised by age 15, 70% of women should be screened with high accuracy by age 35 and 90% of women with cervical disease should receive appropriate treatment and care.

Cervical cancer can be prevented by vaccinating girls aged 9 to 14 years, the age range at which the vaccine exhibits the highest immune response; by routine screening for cervical cancer for all women aged 30 to 49 years and by early treatment for those with precancerous lesions, as recommended by WHO.

Figure 2.1.1.27. Coverage of the national cervical cancer screening programme (%) in South Africa, 2000–2019, NHMIS

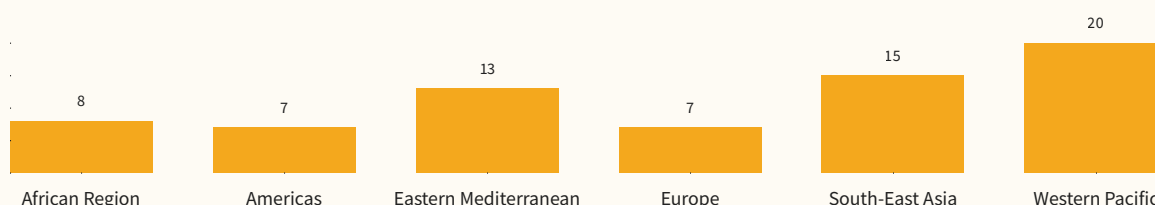


In South Africa, the national cervical cancer screening programme covered 67% of women in 2019 and has steadily grown since its establishment in 2000. The global strategy proposes that 90% of girls be fully immunised against the human papillomavirus (HPV) before the age of 15 years, that 70% of women be tested for efficient screening before the age of 35 and then again before the age of 45 years, and that 90% of women with cervical cancer receive treatment. Meeting these goals could reduce the median of the cervical cancer incidence rate of 42% by 2045, averting 300 000 deaths by 2030.

2.1.2 FINANCIAL RISK PROTECTION

Households spending over 10% of their expenditure on health

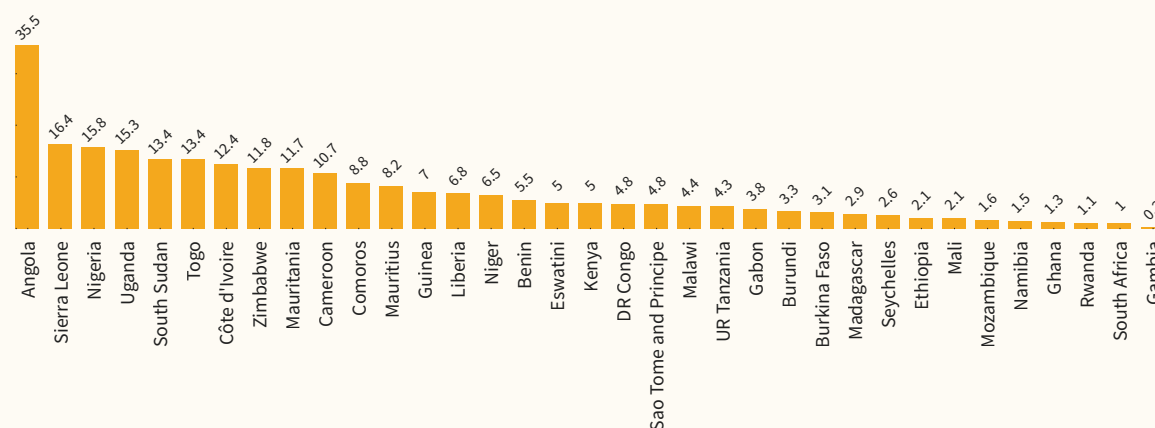
Figure 2.1.2.1. Proportion of population with the large household expenditure on health of more than 10% of the total household expenditure (%) in the WHO regions, 2017, WHS2022



According to the “Global monitoring report on financial protection in health 2015”, some 926.6 million people incurred out-of-pocket health expenditure exceeding 10% of their household budget (total amount of consumption or income) in 2015.

Between 2015 and 2017, the proportion of the population whose direct health expenditure exceeded 10% of their domestic budget rose from 12.7% (940 million people) to 13.2% of the population (996 million people). The 2021 edition of the report pinpointed a probable deterioration in the financial protection of households due to the drop in income and consumption and the increase in poverty and inequality. Health expenditure is still a big load for the people in the WHO African Region. The Region comes third after Europe and the Americas with 8% of its population incurring direct health expenditure exceeding 10% of their household budget in 2017.

Figure 2.1.2.2. Proportion of population with the large household expenditure on health of more than 10% of the total household expenditure (%) in the WHO regions, 2017, WHS2022

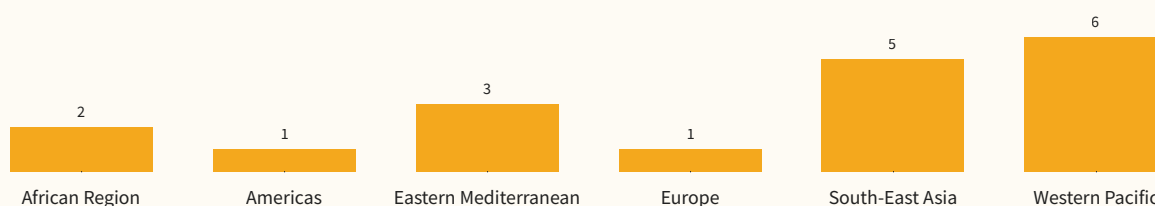


The world population with direct expenditure on health exceeding 10% of household expenditure increased by an average of 3.6% per year over 2000–2015. In that period, the WHO African Region experienced the highest increase in direct expenditure in terms of the number of people affected, averaging 5.5% per year.

Angola stands out with its rate of 35.5% for the population with direct health expenditure exceeding 10% of household expenditure. It is followed by Sierra Leone with 16.4%. There is a relationship between a country’s income level and the financial protection in health for its people, with implications on the number of its people with of out-of-pocket health spending exceeding 10% of household expenditure.

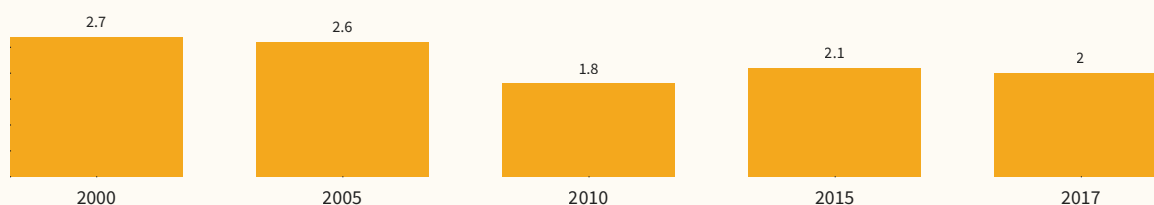
Households spending over 25% of their expenditure on health

Figure 2.1.2.3. Proportion of population with a large household expenditure on health of greater than 25% of the total household expenditure (%) in the WHO regions, 2017, WHS2022



All regions except North America have seen an increase in the number of people incurring expenses above the 25% threshold. The 2019 WHO and World Bank report on financial protection in health highlights the fact that more than 200 million people incurred out-of-pocket health expenditures that exceeded 25% of the household budget, that is the total amount of consumption or revenue. The proportion of households spending more than 25% of their income on health varies across regions, from 1% in the European and Americas regions to 6% in the Western Pacific Region.

Figure 2.1.2.4. Proportion of the population with a large household expenditure on health of greater than 25% of the total household expenditure (%) in the WHO African Region, 2000–2017, WHS2022

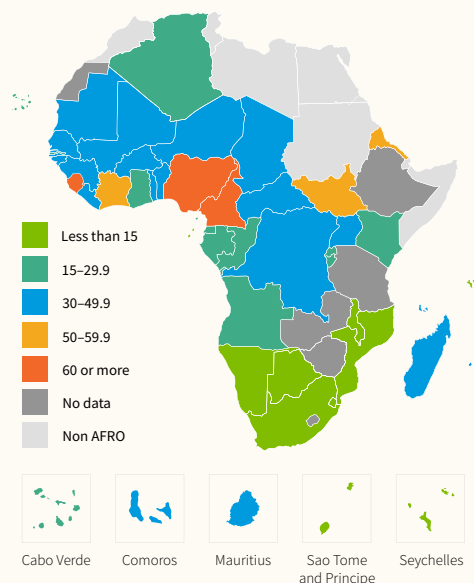


The proportion of households spending more than 25% of their household income on health declined in the WHO African Region between 2000 and 2017, going from 2.7% to 2%. Angola had the highest proportion of households (12.5%) with health expenditure exceeding the threshold of 25%, followed by Zimbabwe (7%).

According to the World Bank’s Operations Evaluation Department, Zimbabwe was affected by the civil service reform that reduced the number of government staff. At the same time the government was unable to control the budget deficit, which was financed by borrowing at high interest rates and for which the interest payments reached a quarter of all government revenue. Moreover, Zimbabwe had been more severely hit by the AIDS epidemic than any other country, according to UNAIDS.

Out of pocket spending as a percentage of the total health expenditure

Figure 2.1.2.5. Out of pocket spending as a percentage of the total expenditure in the WHO African Region, 2014, WHO



Experts recognise the difficulty of data comparison between countries, given the extreme differences in health systems and economic context. However, a certain number of parameters have been adopted on a global scale to assess the progress made towards UHC.

The global figures show that:

- Eight hundred million people devote more than 10% of their budget to health expenditure;
- One hundred million people fall into extreme poverty each year from having to incur excessive health care costs;
- Africa and Asia represent 97% of the world’s population impoverished by direct health expenditure.

Nigeria, Cameroon and Sierra Leone are the three African countries where in 2014 out-of-pocket health expenditure accounted

for the highest portion of the total household expenditure with levels above 60%.

Out of pocket spending as a percentage of the total health expenditure is an important indicator of the progress of UHC programmes, which aim specifically to reduce personal expenditure on health care in order to minimise the risks of impoverishment linked to health expenditure.

All countries in the WHO African Region have agreed to ensure that by 2030:

- All populations, regardless of individual income, expenditure or wealth, place of residence or gender, benefit from at least 80% coverage of essential health services;
- Everyone benefits from 100% coverage of the financial risk linked to direct payments for health services. But the question of funding remains crucial.

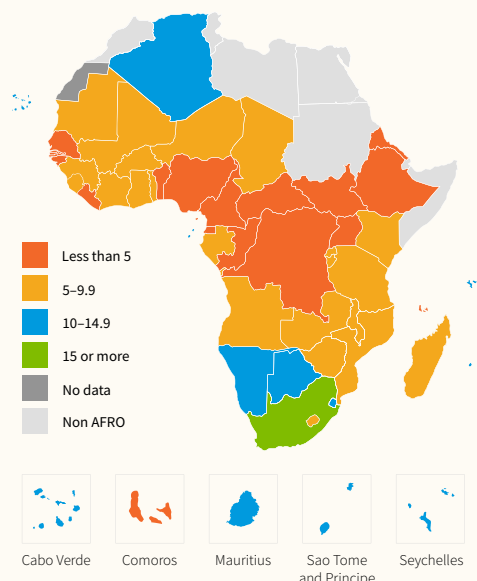
Government health expenditure as a percentage of total government expenditure

Figure 2.1.2.6. Government health expenditure as a percentage of the total government expenditure in the WHO regions, 2019, WHS2022



Public spending on health plays a central role in UHC, but there is no clear pattern in the priority accorded to health by African governments. The Abuja Declaration is a call for mobilisation of more resources from public coffers for the health sector, and African governments refer to this declaration in their health sector objectives and policy documents.

Figure 2.1.2.7. Government health expenditure as a percentage of the total government expenditure in the WHO African Region, 2019, WHS2022



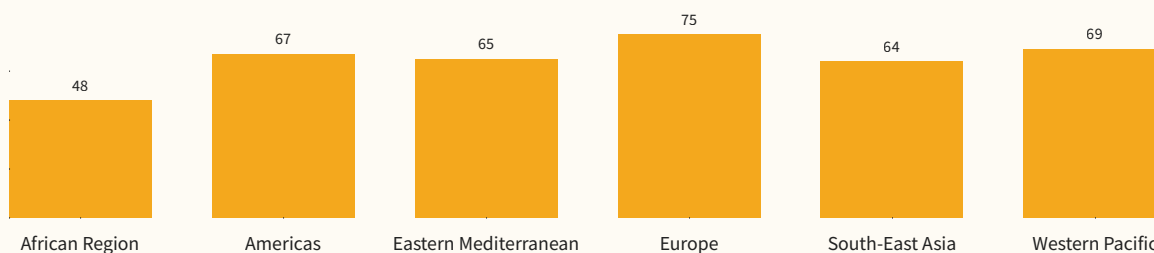
Although Africa has experienced better economic growth than other regions, it is known that when African countries get richer public spending on health does not automatically increase. In addition, development assistance for health has crowded out government resources and created donor dependency. The WHO African Region has the least government health expenditure as a percentage of total government expenditure compared with the other regions, and only one of its countries (South Africa) has attained the objective set by the Abuja Declaration to allocate at least 15% of the total government expenditure on health.

2.2 Protection from health emergencies

2.2.1 PREPAREDNESS FOR IHR CAPACITIES

IHR index

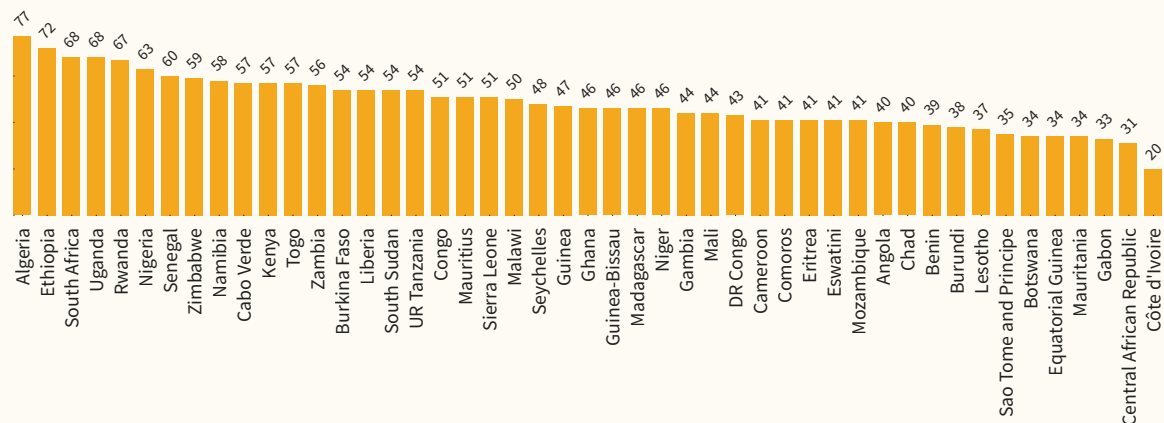
Figure 2.2.1.1. Average of 13 IHR core capacity scores in the WHO regions, 2021, WHS2022



IHR (2005) is an essential instrument for ensuring global health security. IHR capacities in the WHO African Region are reported through the “State party self-assessment annual report” and periodically using an independent joint external evaluation. In addition, the After action reviews (AAR) and simulation exercises (SimEX) are part of the IHR monitoring and evaluation framework to complement the “State party self-assessment annual report” and the joint external evaluation in the development and implementation of national action plans for health security. The WHO African Region has a lower score than that of the other regions (49%) and is far behind South-East Asia, the second one from the last, while Europe has real governance on the issue with a score of 75%.

The COVID-19 pandemic health crisis has demonstrated that more needs to be done to prepare for and respond to public health emergencies, and one of the ways to do this is through strengthening the resilience of health systems. Moreover, capacity building and collaboration between countries are needed to strengthen global preparedness for epidemics.

Figure 2.2.1.2. Average of 13 IHR core capacity scores in the WHO African Region, 2021, WHS2022

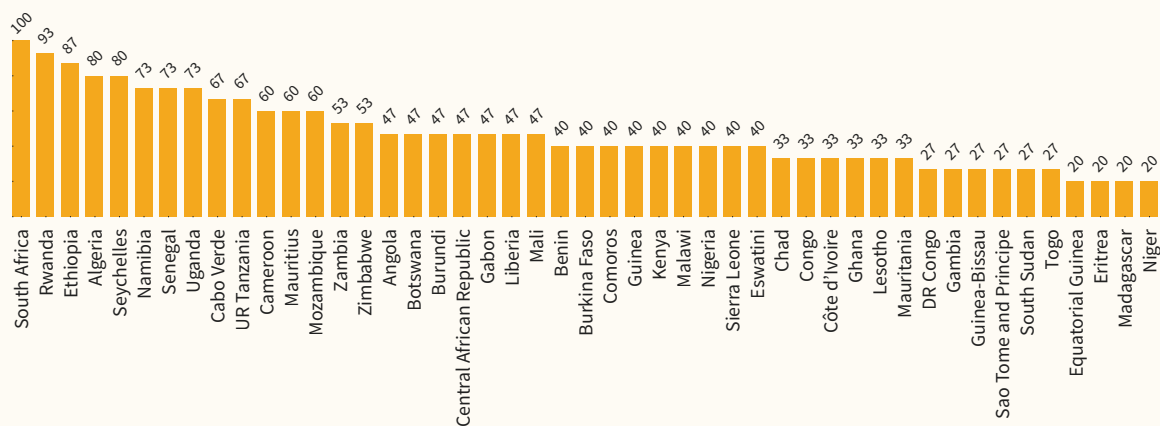


The COVID-19 pandemic revealed the global differences in response to health emergencies. Past disparities in detecting, assessing, reporting and responding to international health emergencies led to the signing of IHR (2005).

Almost all Member States in the Region are implementing IHR (2005) to strengthen national capacities and have submitted annual IHR self-assessment reports for 2017–2021, with the regional average score being 49. Only 13 countries had at least eight core capacities at the developed level or more advanced level in 2021. In addition, all Member States have completed joint external evaluations of their IHR capacities. The mapping of the 19 joint external evaluation technical areas to health systems building blocks reveals significant gaps in leadership and governance, medicines and technologies, as well as multisectoral collaboration, which is crucial, considering the importance of the One Health approach.

National legislation, policy and financing score

Figure 2.2.1.3. National legislation, policy and financing score in the WHO African Region, 2020, WHO



For about three quarters of the countries in the Region, the national legislation, policy and financing score was lower than 50 and only five countries had scores above 80. This points to the urgent need to develop the basic required elements to ensure appropriate preparedness, readiness and response to health emergencies in countries in the Region. The legal architecture⁷ related to the obligations of IHR (2005) has various gaps, and countries have largely failed to implement the required measures, particularly in the WHO African Region.

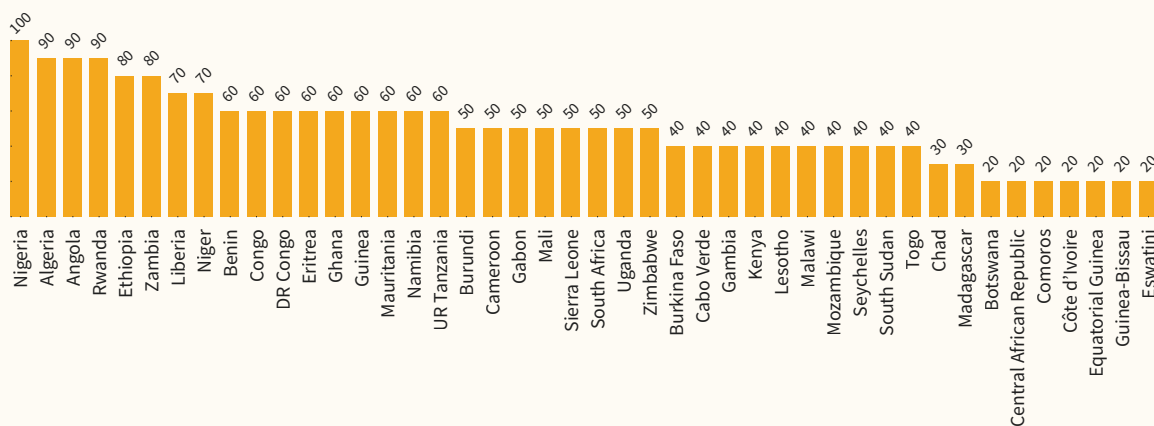
It is important to remember that almost 80% of WHO’s budget is from voluntary contributions and that much of the budget is in the form of earmarked funds, which impedes holistic preparedness efforts and hampers WHO’s ability to provide a global safety net. These characteristics suggest that there is limited international solidarity to help the weakest countries build capacity, and this was recognised in the 2015 “IHR Review Committee report”.

The “2019 state preparedness report” shows an inadequate level of preparedness for countries in the WHO African Region, with an average score of around 40. As a result, various informal structures were created to help address these concerns, such as the Global Preparedness Monitoring Board, composed of high level independent experts and supported by WHO. Other initiatives such as the Global Health Security Programme involve private actors and international organisations. The aim was to accelerate progress, raise awareness and improve the capacity of states to comply not only with IHR (2005) but also with other international treaties and standards, through a multisectoral approach.

⁷ Giulio Bartolin; The Failure of ‘core capacities’ under the WHO International Health Regulations; British Institute of International and Comparative Law; Cambridge University Press; 2020

IHR coordination and national IHR focal point function

Figure 2.2.1.4. IHR coordination, communication and advocacy score in the WHO African Region, 2020, WHO



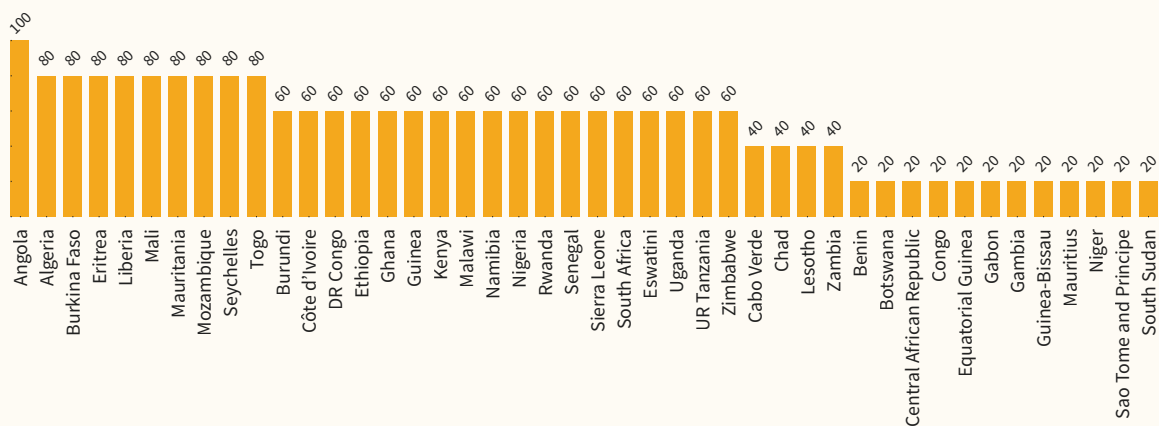
The national IHR focal point function has the responsibility to strengthen coordination, communication and advocacy regarding IHR, as well as its application, and consolidate and maintain in place a multisectoral and multidisciplinary mechanism for coordination and communication that is regularly tested and updated. The IHR coordination, communication and advocacy score shows that lots of effort is still needed in Africa. However, some countries such as Algeria, Angola, Nigeria and Rwanda are showing great achievements in that area.

To address the gaps identified, 39 Member States⁸ have developed a National Action Plan for Health Security (NAPHS), that, if funded and implemented, can significantly improve health security and health system strengthening. The Member States not in this initiative are in the process of developing their own plans. The resources needed to close the gaps have been costed in the national action plans for health security indicating that an average annual budget of US\$ 150 million per Member State is required.⁹

8 Except Algeria, Cabo Verde, Equatorial Guinea, Madagascar, Mauritius, Sao Tome and Principe, Seychelles and Togo.
 9 WHO (WHO). The investment case for public health emergency preparedness and response (Unpublished). WHO. 2019

Zoonotic events and the human–animal interface score

Figure 2.2.1.5. Zoonotic events and the human–animal interface score in the WHO African Region, 2020, WHO



Developing and applying operational frameworks in dealing with zoonoses, emerging and re-emerging infectious diseases, antimicrobial resistance threats and environmental risk factors using the One Health approach has shown the approach’s importance in tackling the latest and largest epidemics faced by Africa the last 10 years. Preparedness for such events is a priority, and Angola is top in the Region in this area with a score of 100. About one third of the countries in the Region have a score of less than 50.

The COVID-19 pandemic has shown that the study and understanding of emergencies in general requires (i) detailed analysis of the interdependence of the pertinent sectors with a transdisciplinary vision and (ii) both the production of upstream knowledge to understand the mechanisms of transmission and adaptation of a zoonotic pathogen to humans, and (iii) the development or improvement of surveillance and early detection tools downstream.

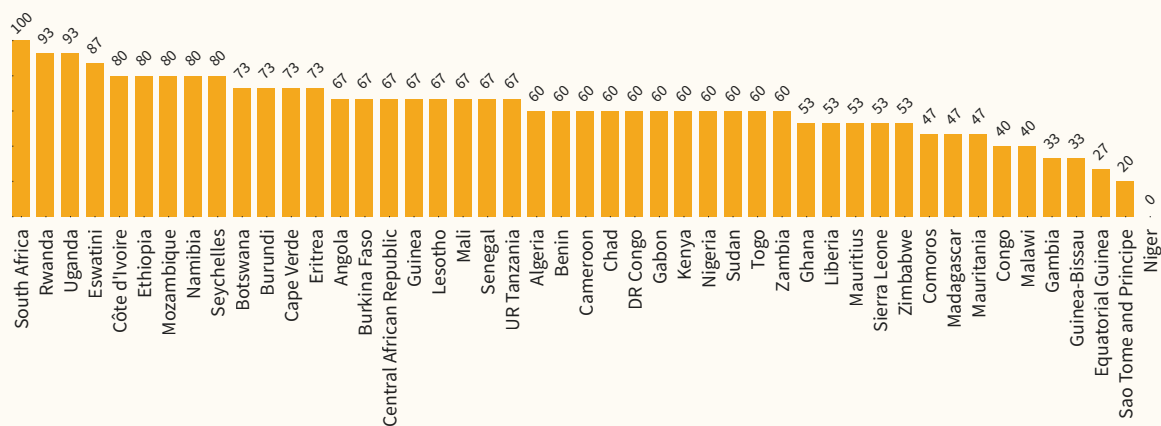
Zoonoses are one of the health risks where the deep interconnections of human, animal and environmental health are most visible. Around 60% of existing human infectious diseases are zoonotic and 75% of emerging infectious diseases, including Ebola, HIV, influenza and COVID-19 have an animal origin.¹⁰ Controlling zoonotic pathogens at their animal source is the most effective and economic way of protecting people from them.

Africa has a rapidly growing population with a need for animal-derived foods. Demographics are also pointing to increasing urbanisation and expansion of cities into wildlife habitat. Road, rail, sea and air links increase the risk of spreading zoonotic disease outbreaks from remote, sparsely populated areas to large urban areas.

10 <https://www.genevaenvironmentnetwork.org/>

Laboratory score

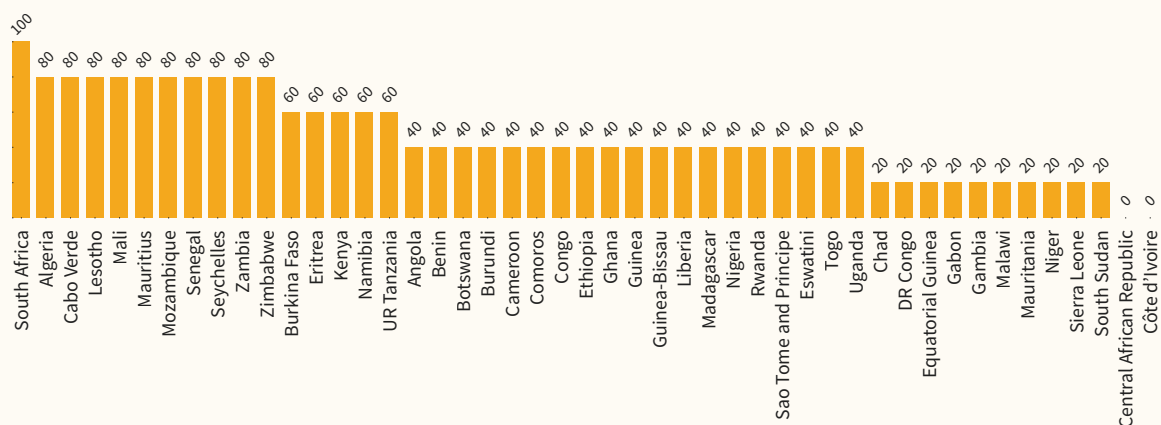
Figure 2.2.1.6. Laboratory score in the WHO African Region, 2020, WHO



The average laboratory score in the Region was 60 in 2020. The aim should be to strengthen national laboratory systems and networks for the detection, confirmation, further characterisation and monitoring of priority diseases and pathogens. Strengthening of the laboratory systems means building laboratory capacity, including through appropriate training, provision of reagents, twinning of laboratories for technology transfer and networking for sample referral. The response to COVID-19 has helped countries to develop their capacity for RT-PCR testing to detect SARS-COV-2 and also for genome sequencing of the SARS-COV-2 strains, which could help in the detection and surveillance of the integrated disease surveillance and response (IDSR) priority diseases.

Food safety score

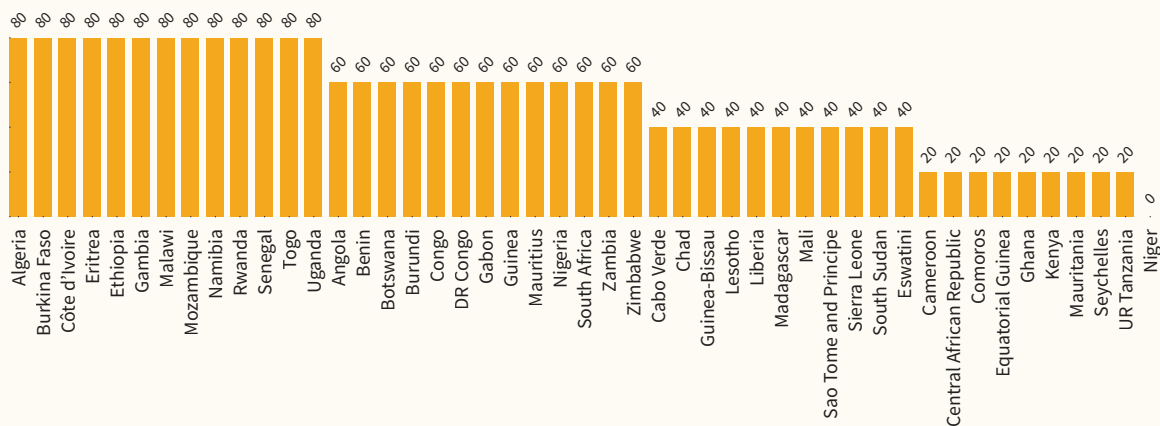
Figure 2.2.1.7. Food safety score in the WHO African Region, 2020, WHO



Less than one third of the WHO African Region countries have scores higher 50 for food safety. Major efforts still are needed in this area. Countries need to define their operational frameworks for food safety, and water quality monitoring is needed. Such frameworks might include the designation of food safety focal points in relevant sectors and the establishment of operational links between public health surveillance and officials specialised in emergency response, food safety and water, animal health and laboratories.

Human resources score

Figure 2.2.1.8. Human resources score in the WHO African Region, 2020, WHO

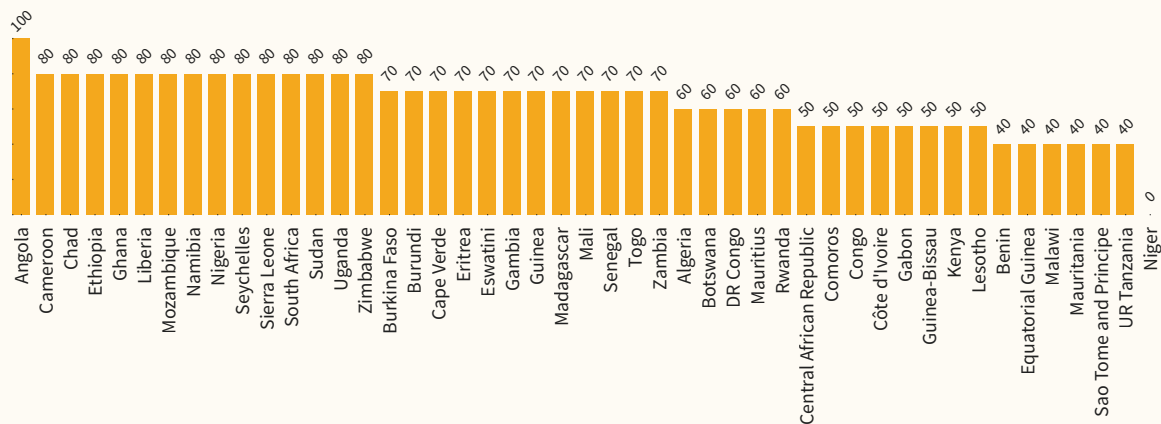


Mobilizing and retaining human resources to establish the core capacities required under IHR (2005) and to implement the disaster risk management strategy are important steps for preparedness and response. This will include training programmes in applied epidemiology related to human and animal health and designing an emergency public health workforce strategy.

Almost half of the countries in the Region have a score above 50 for human resources. That is an asset in promoting of south–south and north–south cooperation and in mobilizing regional and global health personnel who can be deployed in emergencies. Bringing more countries to a higher score will contribute to the creation of the envisaged database of African volunteer health corps.

Surveillance score

Figure 2.2.1.9. Surveillance score in the WHO African Region, 2020, WHO



The factors scored in strengthening IDSR for both event and syndromic surveillance were developing and maintaining interoperable, interconnected and electronic data management and reporting systems and improving the capacity to analyse and disseminate information and best practices.

On the onset of the COVID-19 pandemic, many African countries rapidly increased their diagnostic and surveillance capacity, allowing for better detection of events.

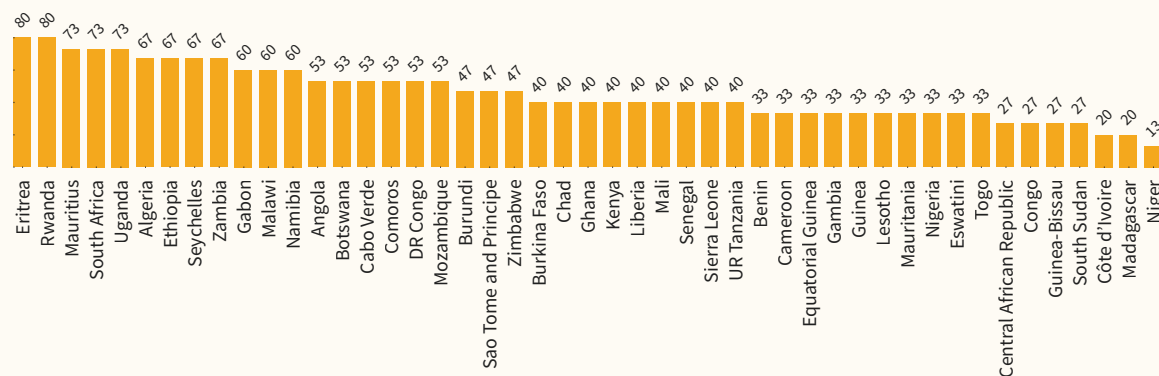
Most African countries were quick to adopt non-pharmaceutical interventions such as curfews and facility closures to limit COVID-19 transmission, but this compromised access to care. The WHO Regional Office for Africa considers the low testing capacity in the Region as likely to have contributed to the low detection rates for COVID-19 in Africa. Insufficient data reporting may result in the lack of meaningful representation. The intersection between public health and emergency management is illustrated by the emergency management cycle¹¹ whose complete model includes event prevention, preparedness, detection, risk assessment, response and recovery.

Many African countries have implemented the IDSR framework to meet IHR (2005) requirements and 15 countries have a score of 80 or more. A core function of the IDSR framework is data reporting at all levels of health system, which has been a challenge for many countries.¹² With this tool, examining national data reporting practices among African nations during the COVID-19 pandemic could reveal important insights for handling future pandemics.

11 Rose DA et al. The evolution of public health emergency management as a field of practice; American Journal of Public Health 107, S126–S133; 2017
 12 Wolfe CM et al. Systematic review of Integrated Disease Surveillance and Response (IDSR) implementation in the WHO African Region; PLoS ONE 16, 0245457; 2021

Health service provision score

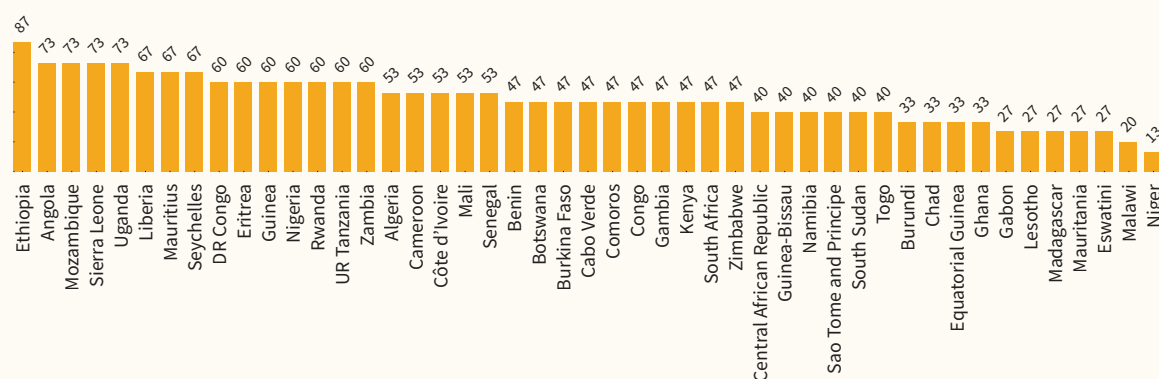
Figure 2.2.1.10. Health service provision score in the WHO African Region, 2020, WHO



Health service provision quality is low in most African Region countries. Surprisingly, the best three scores on service provision in 2020 were from low-income countries. Member States are urged to collaborate and invest in actions to prevent a repeat of the supply chain challenges encountered during the COVID-19 response. This may necessitate legislation to facilitate pooled procurement and purchasing, expediting of supply chain procedures during emergencies, mainstreaming of supply chain functions, inclusion of logistics content in training institutions' curricula and recruiting qualified logisticians and supply chain specialists in the health sector. The Region should establish and operate a regional logistics information system to ensure timely distribution of essential supplies from the regional depots and redistribution of surpluses from Member States.

National health emergency framework score

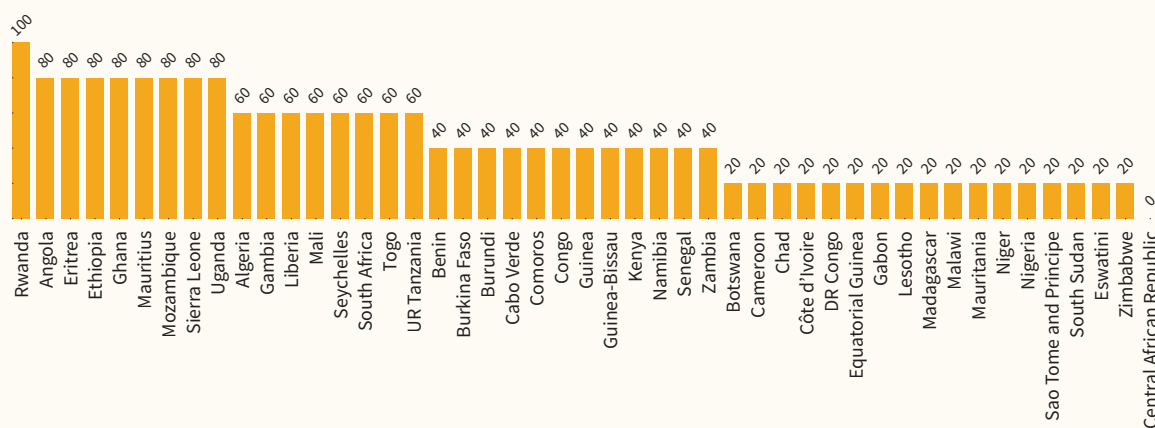
Figure 2.2.1.11. National health emergency framework score in the WHO African Region, 2020, WHO



In general, national health emergency frameworks exist in the countries but show limits. There is a need to update the emergency frameworks and ensure that they comply with international standards, considering each country's context and threats. The status in African countries clearly shows that it is the low-income countries that have high scores. Thirty-nine Member States have a national action plan for health security that, if funded and implemented, can significantly improve health security and the health system. The rest of the Member States are in the process of developing their plans. The resources needed to fill the gaps in the emergency frameworks have been costed in the action plans for health security.

Risk communication score

Figure 2.2.1.12. Risk communication score in the WHO African Region, 2020, WHO



The importance of risk communication has been demonstrated in the recent outbreaks of diseases with community transmission. But the Region needs to strengthen its capacity in this area.

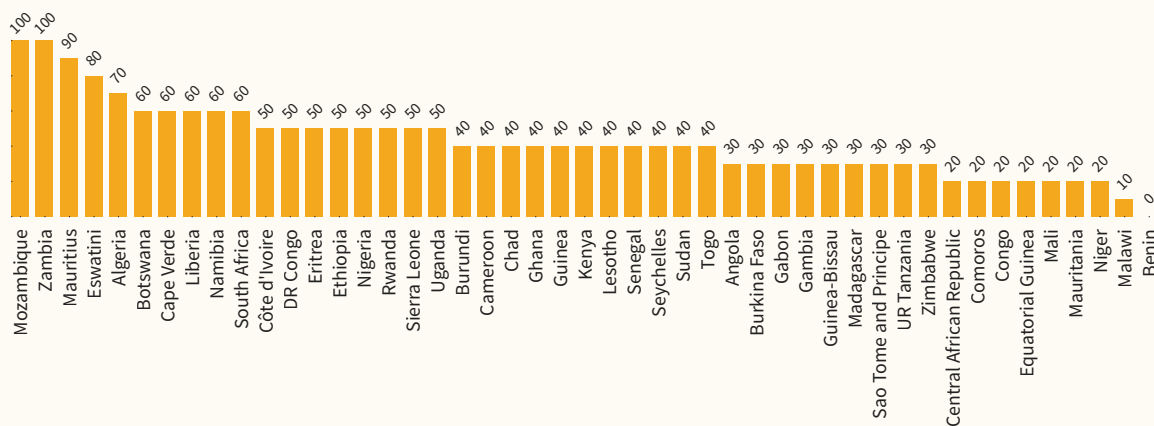
Public health data reporting and information sharing are critical at regional, national and international levels throughout the emergency management cycle. IHR (2005) require countries to report “all available essential information immediately to the appropriate level of health-care response” during health emergencies. Essential information according to IHR (2005) includes “clinical descriptions, laboratory results, sources and type of risk, numbers of cases and deaths, conditions affecting the spread of the disease and the health measures employed”. Moreover, the joint external evaluation highlights the need for “interoperable, interconnected, electronic real-time reporting systems” that could consider other sectors in the context of the One Health approach.

Globally, countries have used diverse methods to report data on the COVID-19 pandemic. A variety of systems have been employed to report COVID-19 data from African nations including online dashboard systems, national reporting systems for researchers, private and public channels for decision-makers’ communication with the public etc. Therefore, assessing publicly available national data can provide important insights on the data reporting practices of nations and identify gaps to be closed for mitigating of future pandemics.

Member States should be supported to develop risk communication and community engagement strategies and plans and to establish multisectoral mechanisms for their coordination at national and subnational levels. Such coordination mechanisms need to be linked to expert training and scientific resources on the science of risk communication and community engagement. There is also a need to develop frameworks and tools to engage communities as partners in emergency preparedness and response.

Points of entry score

Figure 2.2.1.13. Points of entry score in the WHO African Region, 2020, WHO

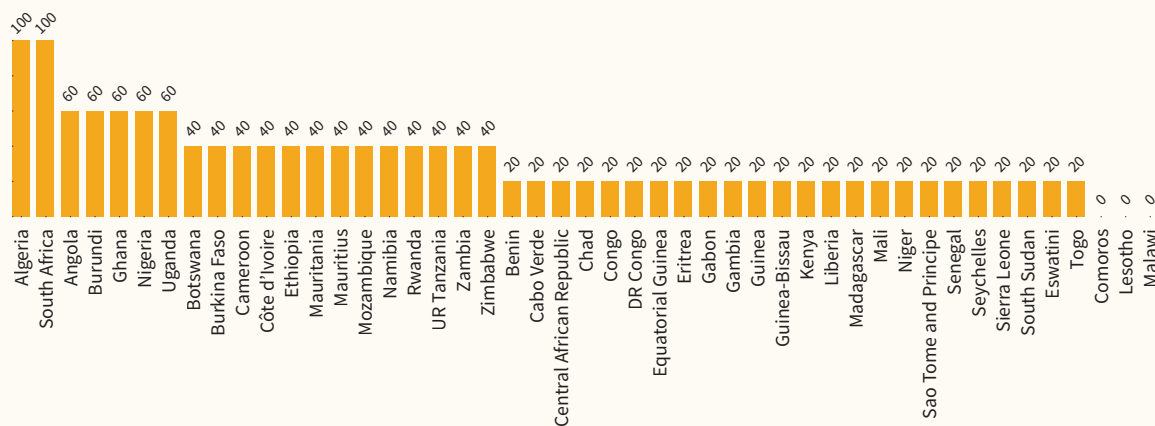


Following the joint external evaluation on the implementation of IHR (2005) that was conducted in 2018 on 19 technical areas and that revealed limited capacity and major gaps under the points of entry, together with WHO, the Southern African Development Community countries of Botswana, Eswatini, Lesotho, Mozambique, Namibia, South Africa and Zimbabwe, launched initiatives to strengthen their border health systems with the COVID-19 pandemic situation. This initiative pulls together local, national and regional levels to collectively agree on the approaches to build capacity at entry points and in border areas. It aims to identify and respond to public health events, strengthen regional public health information sharing and coordination and understand the patterns of population mobility and connectivity in the Region.

Countries should support data collection and analysis on population mobility and connectivity patterns in the Region, focusing on mutually identified priority geographic areas. Presumably, some of the countries initiating this effort have adapted their response and improved their points of entry score. Most countries still need to do that. Some 60% of the countries in the WHO African Region have not reached half of the score.

Radiation emergencies score

Figure 2.2.1.14. Radiation emergencies score in the WHO African Region, 2020, WHO



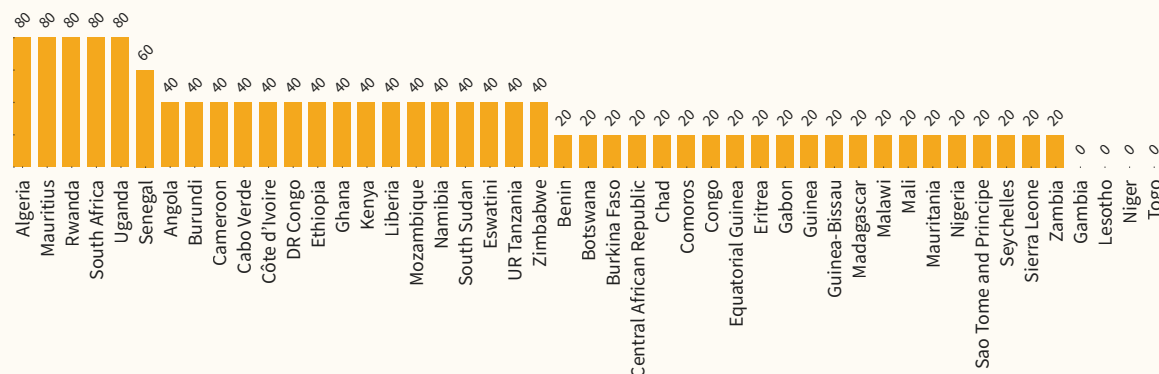
Data on radiation emergencies show that although countries like South Africa and Algeria are doing well, very few countries in the Region can claim a good score. This also applies to scores for chemical events, where a few more countries have good scores. Radiation emergencies can cause emotional and psychological distress, and people exposed to high doses of radiation could be at a greater risk than others of developing cancer later in life.

An emergency exercise to prepare to effectively respond to radiation emergencies and plan for recovery was organised by Botswana with the support of the International Atomic Energy Agency (IAEA). Some 23 experts from 21 other African countries attended the exercise and experienced first-hand how radiation emergency exercises are organised and executed. The African experts involved realised that the challenges they faced in their home countries were similar, the main issue being the difficulty of bringing all relevant organisations together. The exercise allowed the comparison of the national response procedures of the countries represented.

The International Atomic Energy Agency develops standards and guidelines and works to define and promote common approaches to harmonise emergency response between countries. It carries out its work under the Convention on Early Notification of a Nuclear Accident, also known as the Early Notification Convention.

Chemical events score

Figure 2.2.1.15. Chemical events score in the WHO African Region, 2020, WHO



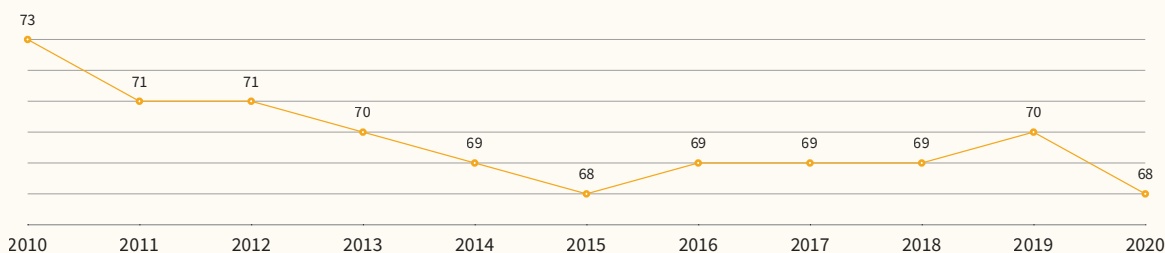
The strategic approach to international chemicals management provides a framework for action on chemical safety around the world. The management of chemical accidents and emergency situations requires a multidisciplinary and multisectoral approach that expects the health sector to play an influential complementary role, or even the leading role, at different stages of the management process.

A chemical release can be caused by a natural phenomenon. When it is the result of a technological accident, it is called a Natech (natural-technological) phenomenon. As the African continent is highly exposed to natural disasters, it would be important to develop plans to deal with such events and secondary technological disasters.

2.2.2 DISEASE PREVENTION

Immunisation coverage for measles

Figure 2.2.2.1. Immunisation coverage for measles (%) in the WHO African Region, 2010–2020, WHO/UNICEF

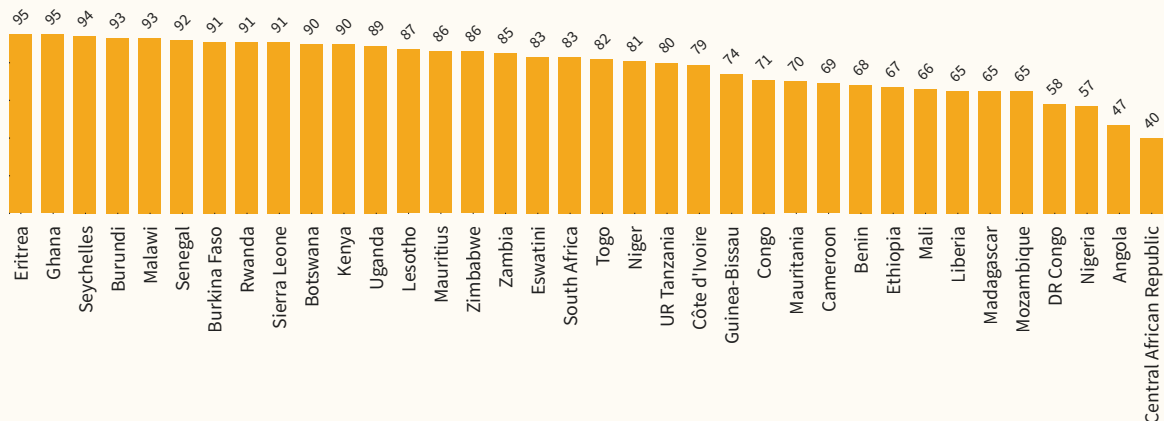


Despite the major efforts and variety of means deployed in immunisation in the WHO African Region, the coverage of measles vaccination remains at 68%, the lowest level among the WHO regions. Only six countries have attained the full coverage level of 80% for the two doses, with Seychelles and Rwanda as the only countries to have a coverage of above 90%.

The WHO African Region experiences more epidemics than any other part of the world. 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 immunisation¹³.

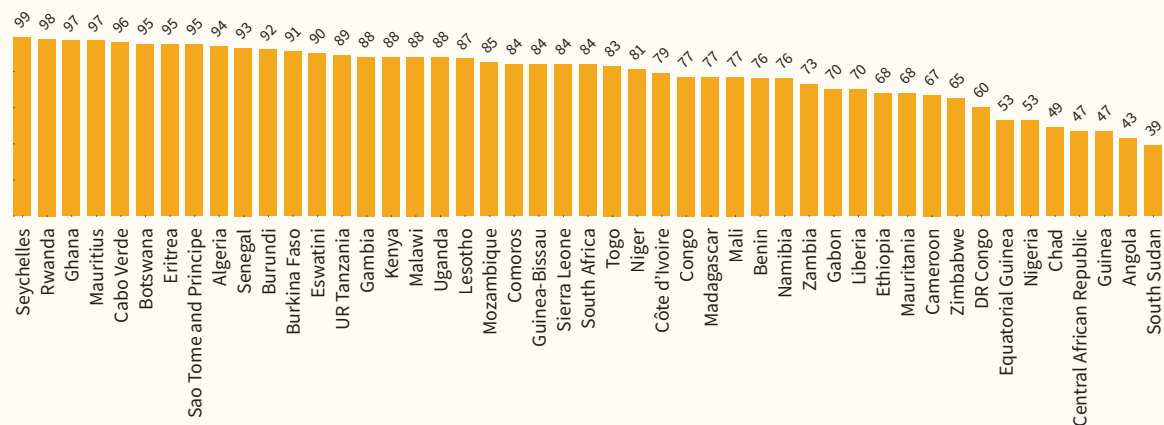
13 Talisuna AO, Okiro EA, Yahaya AA, Stephen M, Bonkougou B, et al. Spatial and temporal distribution of infectious disease epidemics, disasters and other potential public health emergencies in the WHO African Region, 2016–2018, Global Health. 2020

Figure 2.2.2.2. Measles-containing-vaccine second dose immunisation coverage (%) in the WHO African Region, 2020, WHS2022



Immunisation coverage for polio

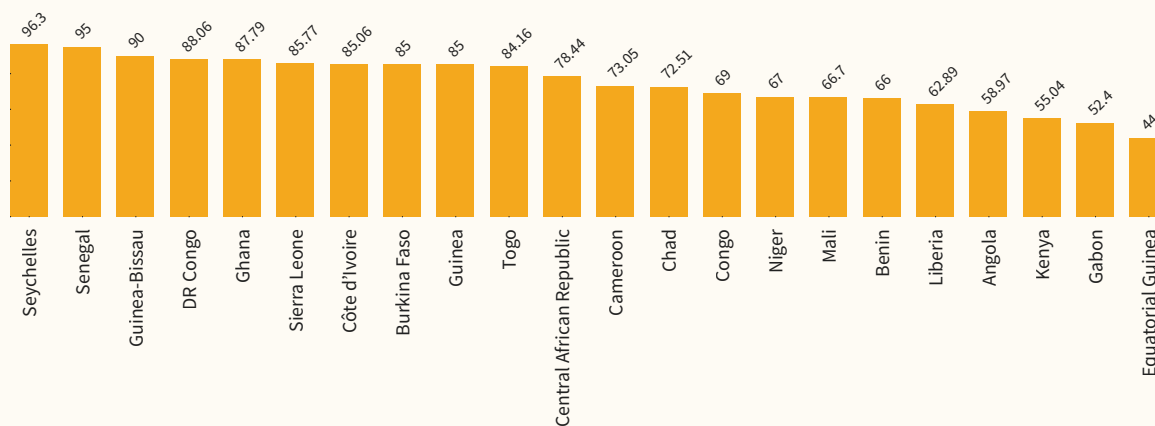
Figure 2.2.2.3. Immunisation coverage for polio in the WHO African Region, 2019, WHO/UNICEF



In general, immunisation coverage for polio in the Region is good. The countries in the Central African subregion have lower than average coverage rates. The strategy should ensure sustained and predictable investments, leverage the current favourable political will and enable the repurposing of resources from polio eradication and COVID-19 to support strategic investments in systems and tools for health emergencies. Aligned with the efforts to achieve universal health coverage, the health-related SDGs and efforts to build resilient health systems, the new strategy will accelerate the use of contemporary evidence and innovations.

Immunisation coverage for yellow fever

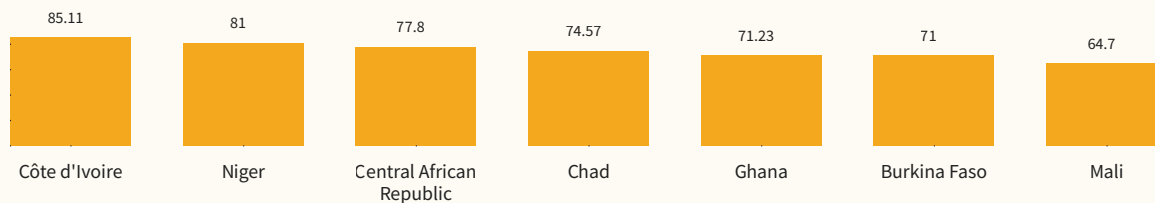
Figure 2.2.2.4. Immunisation coverage for yellow fever in the WHO African Region, 2020, WHO/UNICEF



Yellow fever is endemic in more than half of the countries in the WHO African Region. However, yellow fever vaccination coverage remains relatively unsatisfactory. Only 10 countries have above 80% vaccination coverage and only three of these have achieved more than 90% coverage. Countries like Angola, which in 2016 experienced one of the most devastating yellow fever outbreaks of the past 10 years, has a coverage of only 59%.

Immunisation coverage for meningitis

Figure 2.2.2.5. Immunisation coverage for meningitis in the WHO African Region, 2020, WHO/UNICEF



In Africa, 26 countries located in the zone called the meningitis belt, which extends from eastern Ethiopia to western Senegal, are the most affected by meningitis and experience regular epidemics of the disease. However, immunisation coverage for meningitis in the Region is still unsatisfactory.

2.2.3 DETECTION AND RESPONSE

Large-scale and protracted disease outbreaks can be prevented through early detection, notification and rapid control. Despite all the gaps identified in the capacities required for health security, it is only now that reforms in health emergency programmes are beginning to produce results. Responses to health emergencies are now faster, better coordinated and more effective. The median time from detection to containment was reduced from 418 days in 2016 to 51 days in 2018.¹⁴ Nevertheless, health emergencies continue to exact a heavy toll on health systems and economies, threatening to erase decades of hard-earned gains. Many countries in the WHO African Region continue to experience recurrent disease outbreaks. Lessons gained from each outbreak response have helped to improve the response to subsequent outbreaks, the reason for the reduction in the time taken to end the COVID-19 pandemic. The low levels of human resources for controlling outbreaks of vaccine-preventable diseases compared with foodborne or waterborne disease outbreaks may reflect the challenges associated with vaccine acquisition, uptake and access, particularly in hard to reach areas. National and international stakeholders should continue to support Member States in strengthening their capacity for early detection, notification and rapid control of epidemics. It is equally necessary to support Member States to enable them to track key milestones systematically for continuous measurement of outbreak response performance.

2.3 Healthier populations

Prevalence of stunting among under-five children

Prevalence of stunting among under-five children has been dropping slowly in the WHO African Region since 2000, however, from 2000 to 2020, the Region dropped from second to first place with the worst prevalence of child stunting among the WHO regions. Almost 80% of the countries in the Region have a high or very high prevalence of stunting among under-five children and only Algeria and Seychelles have a prevalence of less than 10%. This seems to be linked to the country's economic wealth.

Prevalence of malnutrition among under-five children

Of the global population of under-five children, 52 million are wasted, 17 million are severely wasted and 155 million are stunted, while 41 million are overweight or obese. While undernutrition is responsible for about 45% of deaths of under-five children in low-income and middle-income countries, the rates of overweight or obesity among children are on the rise. It is expected that there will be 15.4 million cases of acute malnutrition in under-five children, a third of them severe, in West and Central Africa in 2020 if adequate measures are not put in place now. This represents a 20% increase over the January 2020 estimate, according to an analysis on the impact of food insecurity combined with COVID-19 on acute malnutrition in 19 countries in the Region.

Trans-fats policy

Industrially produced trans-fats are formed when fats and oils are modified using industrial processing techniques. Limiting trans-fat content in foods through legislation has been shown to generate the greatest reduction in trans-fat in the food supply.

In the WHO African Region, the rules on trans fats differ among the countries. In the South African legislation the trans-fat content of any oils and fats should not exceed 2 grams per 100 grams. Products with higher trans-fats levels are prohibited from entering or being sold in the country. Kenya is considering adopting an East African regulation on trans-fats to promote NCD prevention and control. Uganda and the United Republic of Tanzania are also working to adopt this regulation with the aim of establishing an effective regional regulatory mechanism for the elimination of industrially produced trans-fats within the food supply in the East African Community, in line with WHO's recommendation.

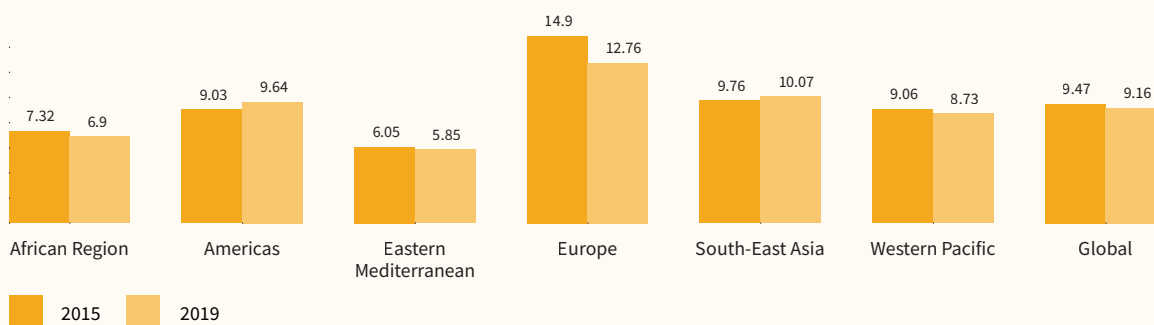
14 Impouma B, Roelens M, Williams GS, Flahault A, Codeço CT, Moussana F, Farham B, Hamblion EL, Mboussou F, Keiser O. Measuring Timeliness of Outbreak Response in the WHO African Region, 2017–2019. *Emerg Infect Dis.* 2020 Nov;26(11):2555–2564. doi: 10.3201/eid2611.191766. PMID: 33079032; PMCID: PMC7588517.

Obesity

The number of overweight or obese adults worldwide is 1.9 billion. The five voluntary global diabetes-related targets for 2025 include to halt the rise in diabetes and obesity. Regional figures show a decline in overweight levels from 6.04% to around 4.54% from 2000 to 2021. That clearly shows that reducing overweight levels by 50% by 2025 will not be possible if nothing is done. Focusing on the most affected countries, a cross analysis¹⁵ of data confirms that obesity is rising fastest in emerging economies, where also the double burden of malnutrition prevails.

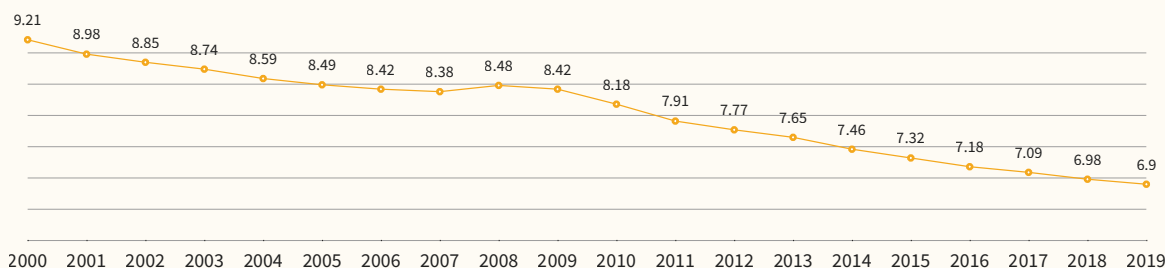
Suicide mortality

Figure 2.3.1. Crude suicide mortality rate (per 100 000 population) in the WHO regions, 2015 and 2019, WHO



Suicide remains one of the leading causes of death worldwide, according to the latest WHO estimates published in “Suicide worldwide in 2019”. In 2019, more than 700 000 people committed suicide, that is one in every 100 deaths. Suicide is not happening just in high-income countries, it is a global phenomenon. In fact, more than three-quarters of suicides in 2019 occurred in low-income and middle-income countries. This reality has led WHO to develop new guidance to help countries improve their suicide prevention and management approaches.

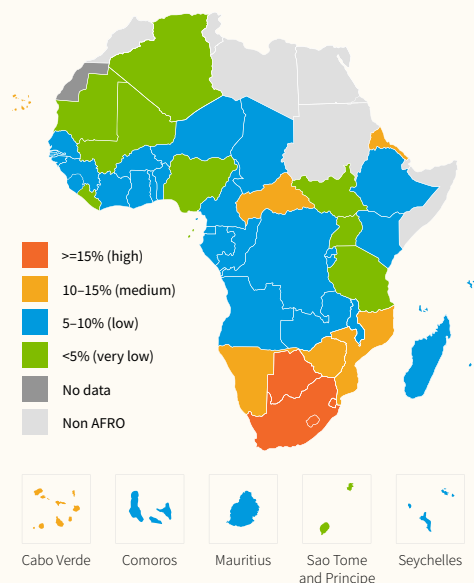
Figure 2.3.2. Crude suicide mortality rate (per 100 000 population) in the WHO African Region, 2000–2019, WHO



The decline in suicide levels in the Region of 5.7% during 2015–2019 was better than the global average of 3.2%. After Europe, where the suicide rate decreased by 14.4% in the 5 years, Africa has the most favourable rate. The other regions have seen their suicide rates increase over the 5 years, by 6.8% in the Americas and 3.2% in Western Pacific. Globally, the suicide rate is declining, and during the 20 years from 2000 to 2019, the decline was 25% in the WHO African Region, but this was lower than the global average of 36%.

15 WHO discussion paper, Draft recommendations for the prevention and management of obesity over the life course, including potential targets; Version dated 19 August 2021

Figure 2.3.3. Age standardized suicide mortality rate (per 100 000 population) in the WHO African Region, 2019, WHO

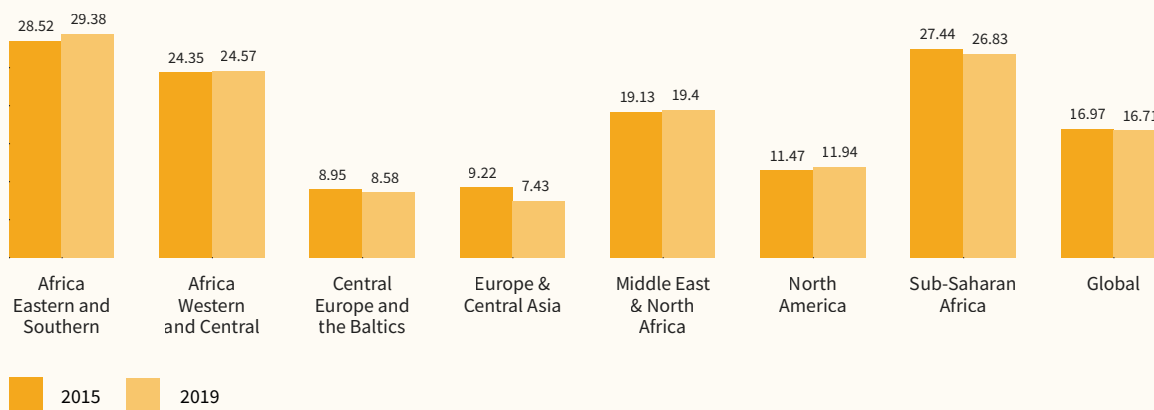


For the WHO African Region, the suicide situation seems to be alarming in Southern Africa. In fact, six countries there and Cabo Verde and the Central African Republic had rates above 12 per 100 000 in 2019.

While the link between suicide and mental disorders is well established, many suicides occur in a time of crisis and when the victim lacks the ability to cope with life stresses. In addition, conflict, disaster, violence, abuse or grief and feelings of isolation are strongly associated with suicidal behaviour. Suicide rates are also high in groups facing discrimination such as refugees, migrants and people in prison, or people whose sexual orientation can be source of discrimination. Many countries do not collect data on suicide owing to taboos surrounding this type of death. This results in its underreporting.

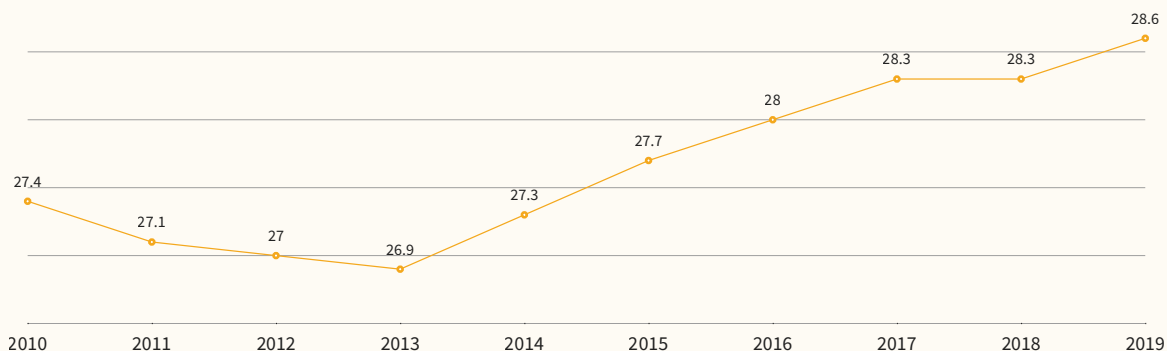
Death due to road traffic injuries

Figure 2.3.4. Mortality caused by road traffic injury (per 100 000 population) in the WHO regions, 2015 and 2019, WHO



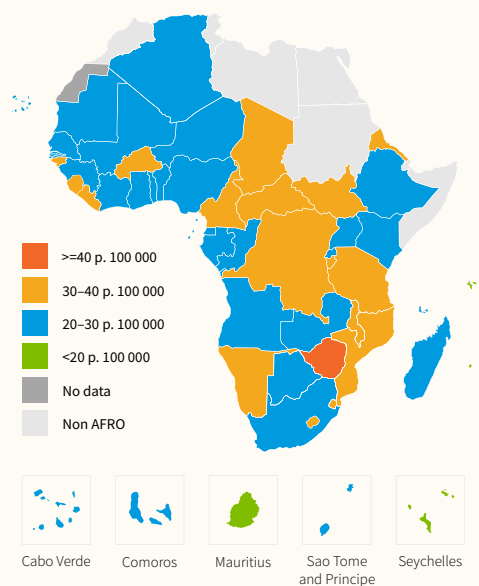
Road crashes result in approximately 1.3 million deaths per year and up to 50 million injuries, and many of the victims remain disabled from their injuries. About 93% of road deaths occur in low-income and middle-income countries, which have only about 60% of the world’s vehicle fleet. Road traffic fatalities were expected to be 16.3 per 100 000 worldwide in 2019 and 28.6 in the WHO African Region. Death rates due to road accidents declined across the world between 2015 and 2019 except in North America and Africa, where they rose. The increase in the WHO African Region is greater than for Eastern and Southern Africa (3%), sub-Saharan Africa (2.2%) and West and Central Africa.

Figure 2.3.5. Mortality caused by road traffic injury (per 100 000 population) in the WHO African Region, 2010–2019, WHO



The WHO African Region had an increase of 3.2% in the rate of mortality due to road accidents between 2015 and 2019. These data confirm that Africa missed the SDG 3.6.1 target of halving the number of global deaths and injuries from road traffic accidents by 2020. Further, estimates reveal that between 2015 and 2030 the number of cars on the road is likely to double. New targets need to be defined and strong and sustainable measures need to be taken stem the carnage from road accidents.

Figure 2.3.6. Mortality caused by road traffic injury (per 100 000 population) in the WHO African Region, 2019, WHO



The differences in mortality rates between the countries are relatively large. There is a huge gap of 11.3 deaths per 100 000 population between Zimbabwe and Seychelles. Zimbabwe has the highest rate of traffic deaths in the WHO African Region of 41 people per 100 000 population, and even in the world, according to a United Nations report. The number of road transport fatalities recorded by the authorities increased by 34% between 2011 and 2019, according to the “Road safety performance review report” produced by the Zimbabwean authorities in collaboration with the United Nations Economic Commission for Africa.

Population using safely managed drinking-water services

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Achieving the SDGs on water, sanitation and hygiene in Africa will require a dramatic acceleration of the current progress, according to a UNICEF/WHO Africa-focused special report. On the continent, 418 million people still lack basic drinking-water services, 779 million lack basic sanitation services and 839 million lack basic hygiene services. If current trends continue, very few countries would achieve universal access to safe drinking-water and sanitation or basic hygiene services by 2030. The WHO and UNICEF joint monitoring programme's report, "Progress on household drinking water, sanitation and hygiene 2000–2020" has a number of recommendations for the future. It shows that some progress has been made towards achieving universal access to basic water, sanitation and hygiene services but that this is insufficient.

Population using safely managed sanitation services

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Part of the goal of SDG 6 is to ensure that everyone has access to safely managed sources of drinking-water such as piped, borehole or protected well source. The sources must be close to the home and provide uncontaminated water throughout the day. In 2017 this criterion was met for 71% of the households or 5.3 billion people, up from 61% in 2000. Ensuring water is safe is a demanding standard. For many low-income and middle-income countries, the priority is still to expand access to basic services. In many countries the poorest households have the least access to sanitation services. Sub-Saharan African countries have a concentration of the lowest rates of access to basic hand hygiene including the Democratic Republic of the Congo, Liberia, Lesotho and Rwanda, which have rates of less than 5%.

Population with primary reliance on clean fuels and technologies

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Africa has the most to gain from the transition to clean energy. Of its people, 600 million do not have access to electricity and 970 million do not have access to clean cooking fuels, with disastrous consequences for health, particularly for women and children, hindering economic and social progress and with significant environmental impacts. The global ambition of achieving net zero greenhouse gas emissions by 2050 has set 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.

Air pollution level in cities

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The WHO Global Ambient Air Quality Database collects air quality information from 4 387 cities and towns in 108 countries, including 10 in sub-Saharan Africa. Dakar in Senegal and Johannesburg in South Africa are reported to be among the five most polluted cities in the world. Data are difficult to compare owing to factors such as the differences in the location of the measuring stations and the methods and quality of the measurements, and seasonal variations. The database includes only cities that submit data to WHO.

Alcohol consumption among people aged 15 years and older

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In 2017, WHO reported that Uganda and Namibia led in alcohol consumption with an average of 11.8 litres of alcohol per year. The most abstinent countries in the WHO African Region were Mauritania and the Comoros with a consumption rate 0.2 litres of pure alcohol per year. South Africa led the continent's most beer consuming countries and was ranked 12th in the world with a volume 3.62 million kilolitres, an increase of 5% from the previous year. In 2019, consumers in the African and Asian regions spent more on beer purchases than the previous year with the increase for Africa being 5.2%. Global beer consumption in 2019 increased for the second year in a row, supported by a strong demand in Asia and Africa associated with their economic growth.

Age-standardised prevalence of current tobacco use among persons aged 15 years and older

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According to the WHO, tobacco use will explode in Africa by 2025 if nothing is done to stem it. The African continent is now affected by the damage caused by smoking. About 80% of the 1.1 billion smokers in the world live in low-income and middle-income countries. However, the smoking rate in the WHO African Region is the lowest among all WHO regions. About 18% of men and 2% of women in the Region smoke, but there is a lot of variation between countries. The highest smoking rate among men is in Lesotho (53%) and the lowest in Ghana (7%). Among women, the highest rate is found in Namibia (9%), and rates below 1% are common in West African countries.

Kenya, Mauritius, Senegal, Seychelles and Uganda have the most ambitious tobacco control policies in the WHO African Region. Senegal is the only country on the continent that has implemented tobacco addiction treatment programmes to facilitate smoking cessation. Although tobacco production is driving economic growth in some countries like Zimbabwe, many countries have introduced measures to over-tax cigarettes, such as Mauritius, Seychelles and Madagascar where taxes constitute between 70% and 80% of the selling price of cigarettes.

Under-five children who are developmentally on track

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Developmental health has been defined as physical and mental health, well-being, coping and competence of human beings (Keating, 1999) and is the combination of health and developmental outcomes. Many different factors can positively or negatively affect developmental health. Fewer than half of infants under 6 months of age are exclusively breastfed in two thirds of the countries with data. Fewer than half of the young children in one third of the countries with data receive the benefits of early stimulation by adults in the home. More than three quarters of the children between the ages of 1 year and 4 years' experience violent discipline from their caregivers. In half of the countries with data, less than three quarters of the children aged 36–59 months are developmentally on track in at least three key domains of development, that is literacy numeracy, physical, social-emotional and learning.

Early child development usually follows a sequence, as the child needs to master one skill before he or she can acquire the next, although all children develop at their own rate. The development areas are growth, nutrition, feeding skills, dental health, sleep, perceptual development, character development, etc. The “On track guide” encourages professionals to connect children and their families to community resources and, if needed, to appropriate services.¹⁶ Many countries still lack data on key indicators of early childhood development.¹⁷

16 On track, Supporting Healthy Child Development and Early Identification in the Early Years

17 UNICEF/UN, A Resource for Monitoring and Action: Country Profiles on Early Childhood Development; Countdown to 2030 Women's, Children's & Adolescent's health

Intimate partner violence prevalence

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It is estimated that 36.6% of women in the WHO African Region have experienced physical and/or sexual violence from an intimate partner resulting in immediate or long-term physical, mental or sexual health problems. In a multi-country WHO study, 13–61% of women surveyed said they had experienced physical violence from a partner and 6–59% said they had experienced sexual violence from a partner at some point in their lives.

Africa has the highest proportion of ever-partnered women and girls aged 15–49 years who are subjected to physical and/or sexual violence by an intimate partner in 2022. Among the African subregions, Central Africa leads with 24%, particularly the Democratic Republic of the Congo with 36%. The prevention and response to intimate partner violence and sexual violence against women initiative identified several barriers to programme implementation at the country level, including:

- Insufficient financial resources and infrastructure, particularly in rural areas;
- Lack of training of actors, particularly health professionals;
- Weakness of coordination between different sectors;
- Limited availability of comprehensive and quality data;
- Lack of evaluation of interventions, with a perspective of scaling up good practices.

Violence against children

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African children are exposed to various forms of physical and psychological violence, sexual abuse and exploitation, neglect and child labour. In a context of urbanisation, armed conflict, displacement and globalisation, they also face threats to their survival and well-being from the effects of technology and humanitarian crises such as attacks on civilians.

The estimated economic value of disability-adjusted life years resulting from violence against children is 4.3% of a country's GDP. Significant efforts are being made to end violence against children in Africa. There is a strong continental legal and policy framework on children's rights that addresses violence against them. The widely ratified Convention on the Rights of the Child and its optional protocols and the African Charter on the Rights and Welfare of the Child are the cornerstones. The adoption of Agenda 2063, Agenda 2040 and the SDGs reinforces the efforts of these legally binding instruments to address violence against children.

Progress has been uneven, fragmented and too slow. Some countries have made remarkable progress while others have stagnated or, worse, regressed. Establishing programmes to end violence against children that focus on its prevention by addressing its causes provides additional protection for the most vulnerable children such as street children, child domestic workers and children in conflict and humanitarian emergencies. Children's participation in decision-making on such programmes should be promoted.

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