From health systems to health sovereignty across Africa and the Eastern Mediterranean

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Recently, I attended the African Union Summit in Addis Ababa, which brings together Member States from both the WHO African Region (AFR) and the Eastern Mediterranean Region (EMR). The discussions highlighted a structural shift in global health: health systems are operating within the context of geopolitical fragmentation, prolonged crises and increasingly constrained and volatile external financing (*1*).

Official development assistance (ODA) for health is contracting sharply, decreasing by 9% in real terms in 2024, with the Organisation for Economic Co-operation and Development (OECD) projecting a further decline of 9–17% in 2025 (*2*). At the same time, structural dependence remains high: in half of the low-income countries in sub-Saharan Africa, external financing accounts for one-third or more of total health expenditure (*3*). In parts of the Eastern Mediterranean Region—particularly the conflict-affected settings—essential health services continue to rely heavily on externally financed humanitarian assistance (*4*). These realities heighten the urgency to strengthen national institutions while deepening structured cooperation between regions that share epidemiologic risks.

Health sovereignty, in this context, must be understood as institutional capacity. It is not confined to domestic production of vaccines or medicines. It encompasses the ability to finance and govern essential services sustainably, regulate medical products, maintain resilient supply chains, generate and share surveillance data, and respond to emergencies without systemic collapse. Sovereignty rests on durable systems.

The African and the Eastern Mediterranean regions are experiencing converging crises—conflict, displacement, climate shocks, economic strain and recurrent disease outbreaks, which unfold simultaneously rather than sequentially. In several EMR countries, prolonged conflict and large-scale displacement have placed extraordinary strain on health systems, and in such settings, hospitals and primary care facilities are not only providers of care but also anchors of social stability (*5*). When systems fracture, instability often follows.

The polio incidence illustrates the indivisibility of health security across regions. Although the African Region has been certified as free of wild poliovirus, circulating vaccine-derived poliovirus outbreaks continue in many of the countries (*6*). In the Horn of Africa and Yemen, for example, transmission has demonstrated clear epidemiological linkages between the 2 regions. Whenever cross-border coordination weakens—whether due to insecurity, population movement or immunisation campaign quality gaps—transmission resurges. Viruses exploit fragmentation. WHO has been supporting interministerial coordination across the Horn of Africa and Yemen to strengthen synchronised campaigns, improve surveillance quality and address persistent implementation gaps. Eradication will depend on urgency as well as on sustained improvements in campaign quality, shared environmental surveillance and collective accountability. In this context, cooperation will reduce collective risk while fragmentation will amplify it.

The same logic applies to malaria, neglected tropical diseases and waterborne disease outbreaks. Vector ecology, climate patterns, increasing biological threats, and human mobility do not align with administrative boundaries. In malaria-endemic corridors linking the Sahel, the Horn of Africa and parts of the Arabian Peninsula, cross-border coordination on policies, surveillance, integrated vector control, treatment protocols, and monitoring of drug resistance and biological threats is essential to move towards elimination and prevent resurgence (*7*). Sustainable progress requires embedding disease control within strong primary health care systems, reinforced water and sanitation programmes, effective surveillance, and community ownership and engagement. Vertical gains are fragile without system integration.

Primary health care is central to health sovereignty. For millions of people across AFR and EMR, primary health care remains the first—and often only—point of contact with the health system. Yet, services remain fragmented, with limited integration across the life-course, and there is uneven adoption of digital technologies (*8*). Strengthening primary care through integrated service packages, workforce development, streamlined referral systems and accountable data platforms creates shock absorbers that protect populations when crises converge.

WHO and the Africa Centres for Disease Control and Prevention (Africa CDC) are increasingly aligning support across surveillance, emergency preparedness, workforce development, and regulatory strengthening in countries connected by cross-border transmission—

particularly across the Horn of Africa, the Sahel and the Red Sea corridor linking AFR and EMR Member States. By coordinating across regions, the partnership reduces fragmentation and strengthens collective resilience against transnational health threats.

The ongoing negotiations on pathogen access and benefit-sharing (PABS) under the WHO Pandemic Agreement further illustrate the link between sovereignty and cooperation (9). AFR and EMR countries were among the hardest hit by the COVID-19 pandemic—in terms of health system strain and delayed access to vaccines, diagnostics and therapeutics. The pandemic exposed weaknesses in pathogen and genetic sequence data sharing and revealed profound inequities in access to countermeasures.

For AFR and EMR Member States, active and coordinated participation in the PABS negotiations is essential. The final framework must reflect the realities of countries with limited manufacturing capacity, fragile supply chains and recurrent disease outbreaks, linking rapid pathogen sharing to fair and equitable benefit distribution.

Ultimately, health sovereignty and interregional cooperation are mutually reinforcing. Sovereignty requires strong national institutions, skilled health workforces and accountable governance. Yet in an interconnected world, it is consolidated through deliberate collaboration across regions that share epidemiologic corridors and structural vulnerabilities.

AFR and EMR are not peripheral to global health governance; they are central testing grounds for its resilience. If health systems can withstand compound stress in these regions—conflict, climate shocks, displacement and infectious threats—then the architecture of global health is robust. If not, redesign is required. Health sovereignty can only be achieved through institutional strength aligned with structured and sustained inter-regional cooperation.

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