Progress Towards Universal Health Coverage and Health-System Performance in ECSAHC Member States (2015–2025): A Regional Comparative Analysis

Abstract

Universal Health Coverage (UHC) is a central indicator of health-system performance and equitable access to essential services. This paper assessed progress towards UHC across nine member states of the East, Central, and Southern Africa Health Community (ECSA-HC) between 2015 and 2025. We conducted a regional comparative descriptive analysis using secondary data from global databases and national surveys from the nine ECSA-HC member states.

Results indicate improvements in life expectancy, maternal and child health outcomes, and HIV treatment coverage, alongside steady economic growth in several countries. However, persistent challenges remain, including health workforce shortages, high out-of-pocket expenditures, and a rising burden of non-communicable diseases. Strengthening domestic health financing, workforce capacity, and integrated health services will be essential to accelerate progress toward UHC in the region.

Keywords: Universal Health Coverage, Health System Performance; East, Central and Southern Africa Health Community

Introduction

Universal Health Coverage (UHC), enshrined in Sustainable Development Goal (SDG 3.8), represents a central global health priority aimed at ensuring equitable access to essential health services without financial hardship. Globally, progress has been observed, with the UHC Service Coverage Index increasing from approximately 45 in 2000 to 68 in 2019, reflecting expanded access to key interventions across maternal health, infectious diseases, and selected non-communicable conditions. However, this progress remains uneven. The World Health Organization African Region (WHO Afro) continues to lag behind global averages, reporting a service coverage index of approximately 46 in 2019, indicative of persistent gaps in access to quality healthcare services across the region [1].

Improvements in service coverage have not been matched by gains in financial protection. In 2019, nearly one billion people globally experienced catastrophic health expenditure, with incidence rising from 12.6% in 2010 to 13.5% in 2019[2]. This trend underscores the ongoing vulnerability of households to financial hardship, particularly in low- and middle-income countries where out-of-pocket payments remain a dominant source of health financing, constraining access to essential services.

In Africa, progress towards UHC remains slow due to health system challenges including limited domestic financing, shortages of skilled health workers, and continued reliance on external assistance[3]. Consequently, catastrophic health expenditure affects an estimated 15–17% of households in several countries, highlighting persistent financial protection gaps[4].

The East, Central and Southern Africa Health Community (ECSA-HC) incorporates countries with diverse socioeconomic contexts and health system capacities, facing a dual burden of communicable diseases and rising non-communicable conditions. Assessing UHC progress in this region requires a multidimensional approach that integrates demographic, economic, and health system factors. This paper therefore evaluates health system performance and UHC progress across nine ECSA-HC member states from 2015 to 2025, focusing on socio-demographic characteristics, health financing, workforce capacity, and disease burden, while analysing country-level priorities for accelerating progress toward UHC

Methodology

This assessment employed a regional comparative descriptive design to assess health system performance and progress toward UHC across nine ECSA-HC member states: Eswatini, Kenya, Lesotho, Malawi, Mauritius, Tanzania, Uganda, Zambia, and Zimbabwe. The analysis covered the period from 2015 to 2025, with 2015 serving as the baseline to align with the commencement of SDG monitoring. The content in this paper was part of a regional review presented at the 76th Health Ministers Conference of the ECSA-HC held in Eswatini from 3 to 5 February 2026, where member states reviewed regional progress and shared country reflections on health system performance and UHC indicators.

The analysis relied on secondary data obtained through a structured desk review of publicly available sources. Baseline information was obtained from regional progress reports and supplemented with internationally recognized databases, including the WHO Global Health Observatory, World Bank World Development Indicators,

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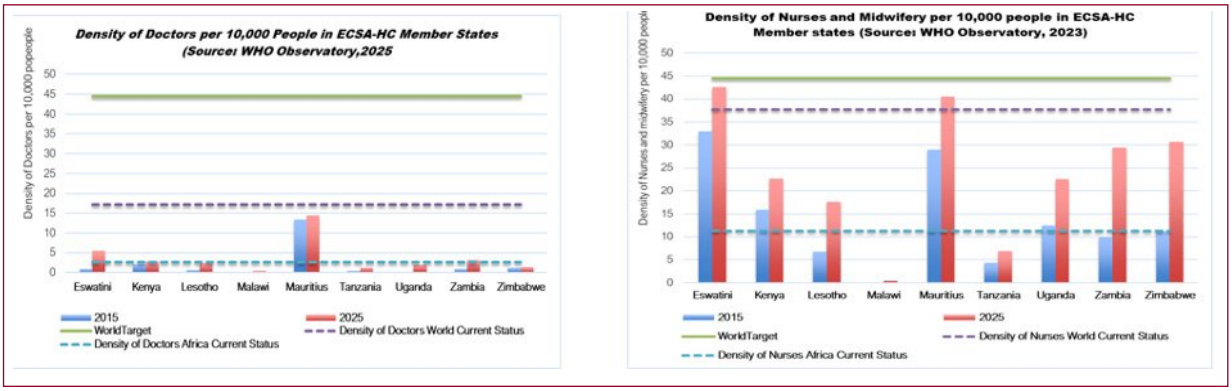
Figure 1: Human Resources for Health Doctors & Nurses and Midwives



UNAIDS databases, and the WHO International Health Regulations Joint External Evaluation reports. Indicators were selected to reflect key domains relevant to UHC and health system performance, including socio-demographic characteristics, health financing, human resources for health, reproductive maternal neonatal child and adolescent health, infectious diseases, non-communicable diseases, nutrition, and health security. Data were imported into Microsoft Excel and analysed descriptively to compare patterns and trends across countries. Data quality was strengthened through triangulation across multiple sources. Ethical approval was not required because the paper relied solely on publicly available aggregated data.

Results

Socio-demographic characteristics of the ECSA-HC member states

The nine ECSA-HC Member States cover 3.08 million km² with a combined population of 230–235 million, showing wide variation. Tanzania has the largest population (61.7 million) and Eswatini has the smallest (1.1 million). Annual population growth ranges from –0.12% in Mauritius to 2.87% in Tanzania. Fertility declined in Uganda (5.3–4.3) and Malawi (4.4–3.6), alongside reductions in crude birth and death rates. Life expectancy at birth increased in Eswatini (54.9–64.1 years). Economically, Kenya's GDP increased from USD 70 to over 100 billion and Tanzania's increased from USD 47 to nearly 80 billion, despite a temporary contraction in 2020 due to COVID-19.

Health status of the ECSA-HC members states

Health financing

Health financing indicators show wide disparities across ECSA-HC Member States. In 2022, Mauritius recorded the highest health expenditure per capita (>$1,000), while Tanzania and Malawi remained lowest (<$100) with minimal growth since 2015. Health expenditure as % of GDP was high in Lesotho and Eswatini (>10%) in 2024 but was lowest in Tanzania and Kenya (<5%). Out-of-pocket spending was highest in Mauritius and Uganda (>30%), and lowest in Eswatini, Malawi, and Lesotho (<15%).

Human Resources for Health

Most ECSA-HC countries remain below the recommended threshold of 44.5 skilled health workers per 10,000 population proposed by the World Health Organization (Figure 1). Mauritius reports the highest doctor density at approximately 13.4 doctors per 10,000 population, whereas countries such as Tanzania, Malawi, and Uganda report significantly lower densities. Nurse and midwife densities also vary widely across countries. Eswatini reports approximately 42.6 nurses per 10,000 population, while Mauritius reports around 40.5. In contrast, Tanzania and Malawi report substantially lower levels, highlighting significant workforce shortages.

Reproductive, Maternal, Neonatal, Child and Adolescent Health

Reproductive, maternal, neonatal, child, and adolescent health indicators show improvement but persistent disparities across countries (Figure 2). Neonatal mortality ranges from approximately 9.3 deaths per 1,000 live births in Mauritius to 29 deaths per 1,000 live births in Lesotho. Infant mortality follows a similar pattern, with Lesotho recording 49.7 deaths per 1,000 live births compared with 9.3 in Mauritius. Under-five mortality rates range from 52.8 deaths per 1,000 live births in Lesotho to 15.2 in Mauritius. Maternal mortality also remains high in several countries, with Lesotho reporting approximately 478 deaths per 100,000 live births compared with 65.9 per 100,000 in Mauritius.

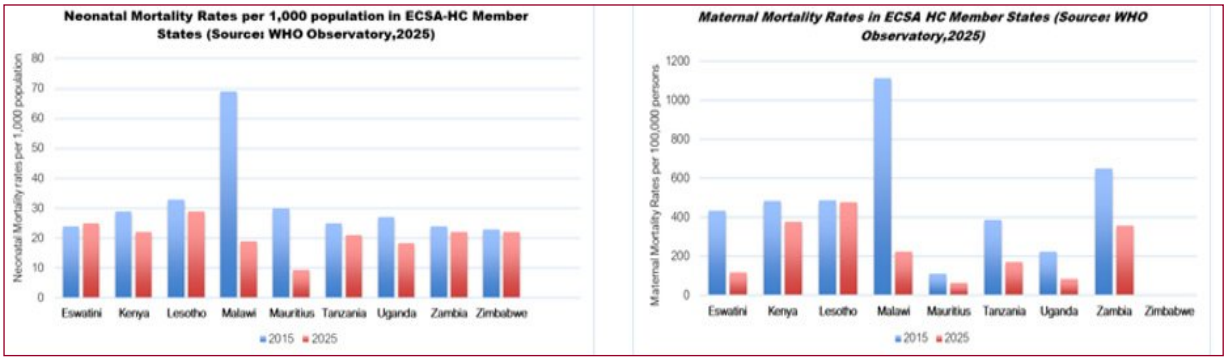
Non-communicable diseases

Non-communicable diseases are increasingly contributing to the regional disease burden. The probability of premature mortality from non-communicable diseases remains highest in Lesotho at 36.3%, followed by Eswatini at 32.3% and Zimbabwe at 31.2%. Hypertension prevalence is particularly high in Eswatini and Zimbabwe, exceeding 42%. Suicide rates are also elevated in Lesotho and Eswatini, while road traffic deaths remain high in Zimbabwe and Kenya

Nutritional status

Nutrition indicators reveal a complex double burden of malnutrition across the region. Anemia among women of reproductive age ranges from 23.5% in Mauritius to

Figure 2: Neonatal and Maternal Mortality Rates



38.9% in Tanzania. Stunting among children under five remains high, reaching 34% in Malawi and 31.8% in Lesotho. However, exclusive breastfeeding rates exceed 60% in several countries, including Zambia, Uganda, and Tanzania.

Communicable diseases

Communicable diseases remain a major public health concern across the region. Tuberculosis incidence ranges from 12 cases per 100,000 population in Mauritius to 664 per 100,000 in Lesotho. HIV incidence also varies significantly, with Eswatini recording the highest rate at 4.2 per 1,000 population while Kenya reports the lowest at 0.37 per 1,000 population. Malaria incidence is highest in Uganda at approximately 258.4 cases per 1,000 population, while Mauritius and Lesotho report no cases.

Health Security

Health security capacity across ECSA-HC Member States shows moderate but uneven performance. Scores for health emergency management (R1) range from approximately 1.25 to 3.75, with Uganda and Malawi demonstrating relatively stronger capacity. Workforce development (D3) averages between 1.3 and 3.3, indicating persistent human resource gaps. National legislation and policy (P1) remain low in several countries, ranging from 1 to 3, reflecting weak regulatory frameworks. Antimicrobial resistance (P4) scores vary between 1.5 and 3.4, suggesting inconsistent preparedness. Points of entry capacities range from 1 to 4, highlighting border health system disparities.

Universal Health Coverage

The UHC Service Coverage Index demonstrates considerable regional variation. Mauritius approaches a coverage level of approximately 70%. Zambia, Eswatini, Zimbabwe, Lesotho, and Kenya perform above the sub-Saharan African average. In contrast, Tanzania, Malawi, and Uganda remain below 50% (Figure 3).

Discussion

Overall, the findings demonstrate measurable progress toward UHC across ECSA-HC member states over the past decade, particularly in maternal and child health outcomes, HIV treatment coverage, and life expectancy. However, persistent gaps remain in financial protection, workforce capacity, and the rising burden NCDs. Addressing these challenges requires sustained domestic investment, strengthened primary healthcare systems, and enhanced regional collaboration to promote equitable access to quality services [5–8].

High out of pocket expenditure continues to limit financial risk protection, exposing households to catastrophic health spending and reducing service utilization. Strengthening national health insurance systems, improving pooling mechanisms, and enhancing efficiency in resource allocation remain critical to advancing financial protection and achieving SDG target 3.8.2.

Despite increased investments in training, health worker densities remain below WHO-recommended thresholds across key cadres. Persistent workforce shortages constrain service availability, exacerbate inequities, and hinder progress toward UHC, highlighting the need for sustained workforce development and retention strategies.

Improvements in mortality indicators reflect the impact of interventions such as immunization, skilled birth attendance, and HIV programmes. However, mortality rates remain above global targets in most countries, underscoring the need to strengthen quality of care, referral systems, and continuity of services.

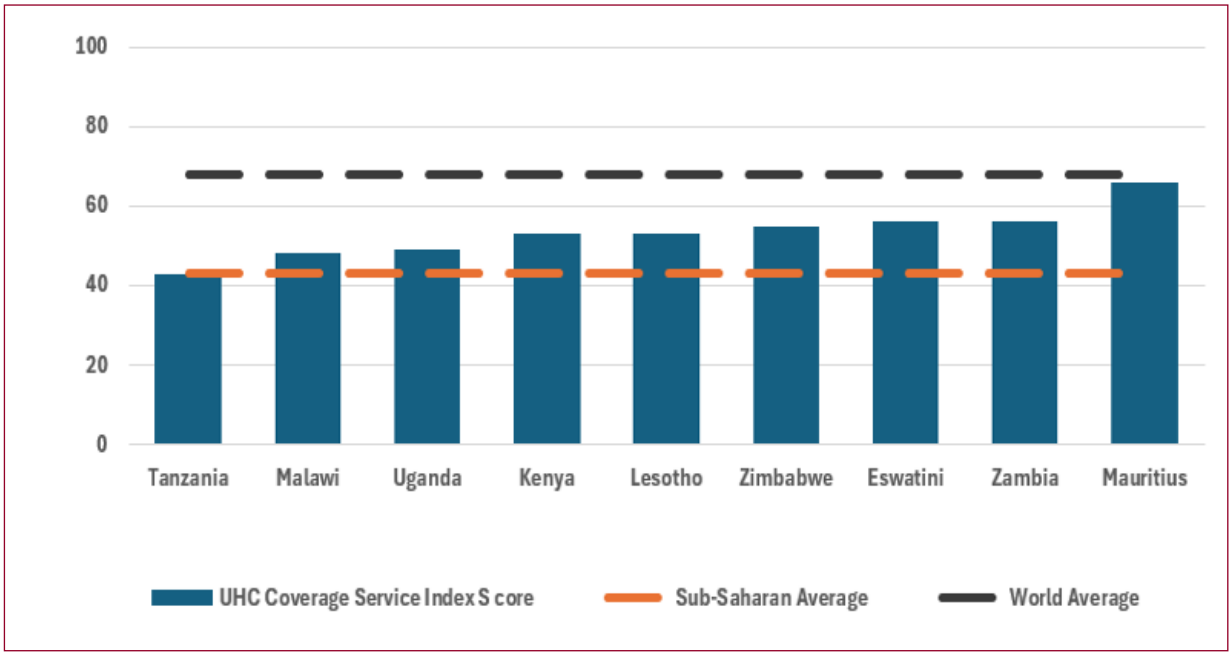
Nutritional outcomes remain mixed, with high prevalence of anaemia among women and stunting among children, largely linked to socioeconomic factors. While progress in exclusive breastfeeding is notable, addressing underlying determinants of malnutrition remains essential.

NCDs are increasing and contribute significantly to morbidity and mortality. High prevalence of hypertension and mental health conditions is driven by lifestyle changes, ageing, and socioeconomic factors, requiring strengthened prevention and control strategies.

Declines in HIV and tuberculosis incidence indicate progress, although substantial burdens persist. Malaria remains concentrated in selected countries, while near-elimination in others reflects effective control efforts, emphasizing the need for targeted interventions and integration.

There are improvements in emergency preparedness and workforce capacity, yet gaps remain in legislation,

Figure 3. UHC Service Index (%) in nine ECSA-HC Member States, 2025



policy, and border health systems. Strengthening surveillance, laboratory systems, and antimicrobial resistance responses is critical.

The low UHC coverage in Tanzania, Malawi, and Uganda highlight continuing gaps in service access and equity. Variations in UHC performance reflect disparities in financing and workforce capacity. Stronger investments in primary healthcare and governance are key drivers of improved service coverage.

Perspectives for the future

Institutionalize South–South cooperation and peer-learning platforms within ECSA-HC to facilitate systematic exchange of best practices, innovations, and lessons in service delivery, workforce development, and disease control, thereby improving efficiency and reducing duplication.

Expand domestic resource allocation to health, strengthen risk pooling mechanisms, and improve strategic purchasing to reduce out-of-pocket expenditure and enhance equitable access to essential services.

Invest in health workforce capacity, service readiness, and integrated service delivery to address evolving demographic and epidemiological transitions while improving system responsiveness to public health emergencies.

Conclusion

Achieving Universal Health Coverage and SDG targets in the ECSA-HC region requires sustained political commitment, increased domestic health financing, and strengthened regional collaboration. Prioritizing South–South cooperation and structured knowledge-sharing platforms can facilitate the exchange of best practices, enhance efficiency, and reduce duplication of efforts. Strengthening pooled financing mechanisms and increasing public investment in health are essential to expand equitable access, reduce out-of-pocket expenditure, and improve financial protection. These measures will support the delivery of comprehensive health services, enhance system resilience, and enable countries to better respond to demographic transitions and emerging public health challenges, ultimately accelerating progress toward UHC.

References

1. World Health Organization. Tracking universal health coverage: 2023 global monitoring report. Geneva: World Health Organization; 2023.
2. World Health Organization, World Bank. Global monitoring report on financial protection in health 2021. Geneva: World Health Organization; 2021.
3. World Bank. World Development Indicators 2024. Washington DC: World Bank; 2024.
4. Adam Wagstaff, Gabriel Flores, Justine Hsu, et al. Progress on catastrophic health spending in 133 countries: a retrospective observational study. Lancet Glob Health. 2018;6(2):e169–79.
5. Dean T Jamison, Lawrence H Summers, George Alleyne, et al. Global health 2035: a world converging within a generation. Lancet. 2013;382(9908):1898–955.
6. Ke Xu, David B Evans, Guy Carrin, Agnes M Aguilar-Rivera. Protecting households from catastrophic health spending. Health Aff. 2007;26(4):972–83.
7. World Health Organization. Global strategy on human resources for health: Workforce 2030. Geneva: World Health Organization; 2016.
8. David E Bloom, Elizabeth T Cafiero, Eva Jané-Llopis, et al. The global economic burden of non-communicable diseases. Geneva: World Economic Forum; 2011.