Tracking implementation progress of AMR national action plans in the WHO African Region

Insights from the 2024 survey on human health

World Health Organization

African Region

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Abbreviations

AMC	antimicrobial consumption
AMR	antimicrobial resistance
AMS	antimicrobial stewardship
AMU	antimicrobial use
AST	antimicrobial susceptibility testing
ATC/DDD	anatomical therapeutic chemical/defined daily dose
AWaRe	Access, Watch, Reserve
CPD	continuing professional development
EML	essential medicines list
GAP-AMR	Global Action Plan on Antimicrobial Resistance
GLASS	Global Antimicrobial Resistance and Use Surveillance System
IPC	infection prevention and control
IPCAF	infection prevention and control assessment framework
KAP	knowledge, attitudes and practices
KPIs	Key performance indicators
lab	laboratory
M&E	monitoring and evaluation
NAP	national action plan
NEMLs	national essential medicines lists
PHC	primary health care
SDGs	Sustainable Development Goals
TrACSS	Tracking AMR Country Self-Assessment Survey
UHC	universal health coverage
UNGA	United Nations General Assembly
WAAW	World AMR Awareness Week
WASH	water, sanitation, and hygiene

Executive summary

Antimicrobial resistance (AMR) remains a critical global and regional health challenge, which threatens the achievement of the Sustainable Development Goals (SDGs), particularly those related to health, poverty alleviation, food security and environmental sustainability. In response to this growing threat, the World Health Assembly adopted the Global Action Plan on AMR (GAP-AMR) in May 2015 (WHA68.7), committing all WHO Member States to the development, implementation and monitoring of national action plans (NAPs) that reflect a One Health approach. At the regional level, Member States of the WHO African Region endorsed the Regional Strategy for Expediting the Implementation and Monitoring of NAPs on AMR (2023–2030) in August 2023. More recently in September 2024, global leaders reaffirmed their commitment to tackling AMR through the endorsement of the United Nations General Assembly's (UNGA) Political Declaration on AMR.

The annual TrACSS serves as a key monitoring tool to assess progress towards the implementation of NAPs and meet global and regional commitments on AMR. Drawing on data from the global TrACSS database, this report presents findings from the eighth round of TrACSS survey, conducted in 2024 across all 47 Member States of the WHO African Region. It offers strategic and technical insights to support prioritization, planning, policy-making, and advocacy efforts aimed at strengthening AMR responses in the Region. The 2024 findings highlight steady progress in several key areas of AMR response. Forty-five (95.7%) countries in the Region have developed AMR NAPs, and 35 of these plans endorsed by the government are now under implementation. However, only 22 (46.8%) countries have developed, costed and budgeted operational plans with established monitoring mechanisms, and none have yet secured dedicated national funding for AMR NAP implementation. Multisectoral coordination mechanisms have been established in 40 (85.1%) countries, but only 22 (46.8%) have formalized these structures with clear terms of reference, regular meetings, defined accountability systems and operational resources.

In terms of awareness-raising efforts 18 (38.3%) countries have launched nationwide, government-supported AMR awareness campaigns. Among these countries, only Algeria has reported implementing routine, targeted campaigns that are regularly monitored and evaluated. Training and professional education on AMR for human health professionals are being implemented in 32 (68.1%) countries. Nevertheless, no country has yet fully integrated AMR into pre-service or in-service training curricula at national level.

AMR surveillance capacity continues to be strengthened, with 27 (57.4%) countries now collating AMR data nationally for common bacterial infections, while 22 (46.8%) have established standardized AMR surveillance systems with designated national coordinating centres. Despite these gains, five countries still lack the capacity to generate or report AMR data, and none have linked AMR data with antimicrobial use (AMU) data in the human health sector. Monitoring of antimicrobial consumption (AMC) and use also remains limited, with 20 Member States (42.6%) lacking a national plan or system to monitor AMU in the human health sector.

Infection prevention and control (IPC) programmes exist in 43 (93.4%) countries, but implementation remains uneven. Only seven (15.2%) countries are implementing IPC programmes nationwide in accordance with the WHO core components, with Mali being the only country that regularly evaluates and publishes data on IPC effectiveness. With regard to optimizing the use of antimicrobial medicines, 23 (48.9%) countries have national guidelines for appropriate use of antimicrobials and are implementing antimicrobial stewardship (AMS) in some health care facilities, and three countries have scaled these efforts to most facilities nationwide. Still, 16 (34%) countries have no or weak policies to support appropriate AMU. Encouragingly, 31 (65.9%) countries have adopted the WHO Access, Watch, Reserve (AWaRe) classification of antibiotics into their national essential medicines lists (NEMLs), and four (8.5%) countries have further incorporated AWaRe into stewardship strategies, including treatment guidelines.

Overall, the 2024 status of the WHO African Region demonstrates notable progress towards achieving the targets set in both the Regional Strategy for Expediting the Implementation and Monitoring of NAPs on AMR (2023–2030) and the UNGA Political Declaration on AMR. However, intensified efforts are still required to fully meet these commitments, particularly in critical areas such as the establishment of national IPC programmes, surveillance of fungal AMR and the reporting of high-quality data on AMU.

To accelerate measurable progress under financial constraints and limited staffing, the report proposes to Member States, WHO and partners a set of practical and scalable interventions to support countries, particularly those at Levels A and B with limited capacity in moving towards Levels C to E, which aim for nationwide implementation of most indicators by the end of 2027.

Introduction

The annual TrACSS is a key tool in monitoring and evaluating the NAPs and Global Action Plan on Antimicrobial Resistance (GAP-AMR). It aims to review and summarize country progress in implementing NAPs to address AMR and to encourage national-level review and prioritization of interventions for the next steps, including advocacy and resource mobilization. TrACSS is a joint Quadripartite initiative coordinated by WHO, which assesses countries' capacities and progress across multiple sectors, including human and animal health, food production and the environment. The survey results inform national, regional and global reporting, including monitoring the implementation of the Regional Strategy and the UNGA Political Declaration, and guide future actions to combat AMR. As shown in Fig. 1 below, participation in TrACSS across the WHO African Region has steadily increased, from 27 countries in 2017 to 47 in 2024, thereby providing more comprehensive data to evaluate progress and support the planning and implementation of evidence-based interventions. The TrACSS questionnaire and individual country reports are available at: https://new.amrcountryprogress.org/.

This report outlines the African Region's results of the eighth round of TrACSS, administered from April to July 2024, with a focus on the human health sector, and assesses regional progress towards AMR-related regional and global commitments. The report is structured in two main parts.

The first part outlines progress across eight key components of NAP implementation: (1) development of AMR NAPs; (2) multisectoral and One Health collaboration and coordination; (3) training and professional education on AMR; (4) national AMR surveillance systems; (5) monitoring of AMC and use; (6) infection prevention and control; (7) optimizing AMU; and (8) integration of the WHO AWaRe antibiotic classification into NEMLs.

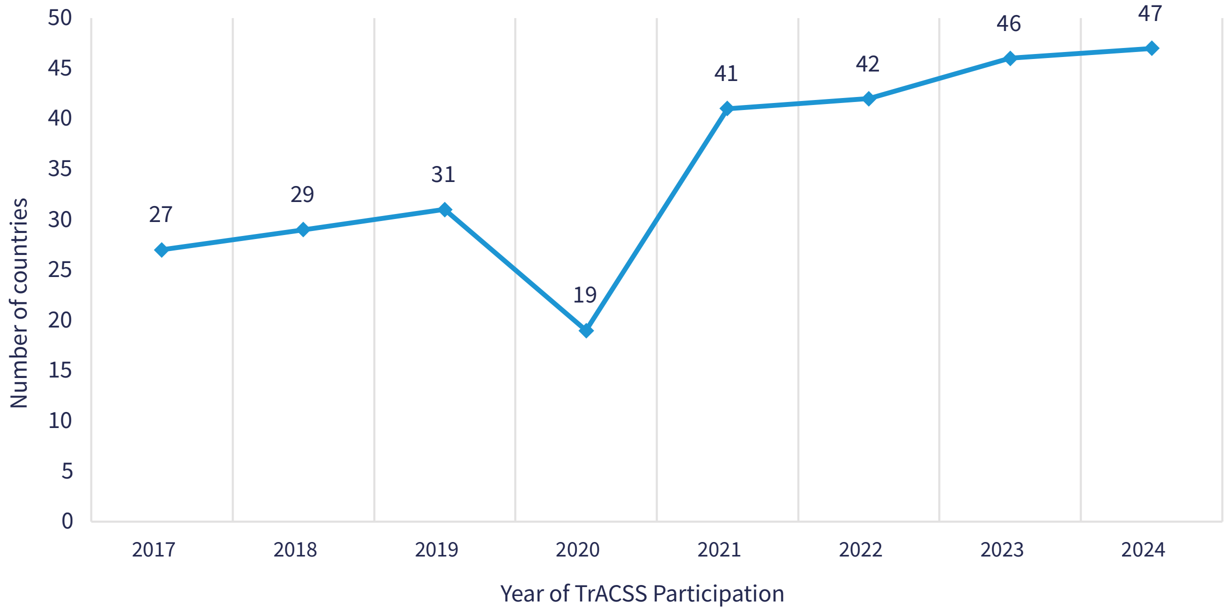
TrACSS rates country progress on a scale from A to E, where A represents no capacity and E represents sustained capacity, the most advanced level. Each section of the survey includes a legend explaining the criteria for each level. Progress is cumulative, meaning that a country assessed at level E has already met the requirements for the preceding levels. The TrACSS detailed questionnaire is attached as annex to this report.

The second part of the report uses TrACSS data to assess regional progress towards two major AMR-related commitments: (1) the Regional Strategy for Expediting the Implementation and Monitoring of NAPs on AMR (2023–2030) in the WHO African Region; and (2) the 2024 United Nations General Assembly (UNGA) Political Declaration on AMR.

Each section in both parts begins with a brief background to outline expectations for a well-functioning system or the specific targets set by the UNGA Declaration. This is followed by a summary of country-level progress. To support evidence-based planning and decision-making, each section concludes with proposed next steps.

The report concludes with a regional synthesis and a set of actionable recommendations aimed at accelerating the AMR response across the WHO African Region. In light of persistent resource constraints and limited workforce capacity, it emphasizes the need for AMR stakeholders, WHO and partners supporting AMR NAPs implementation to strategically reorient their technical support and focus on cost-effective, scalable and primarily remote approaches to maximize impact and support countries in achieving measurable progress by the end of 2027.

Fig. 1. Eight-year TrACSS participation trend



Country progress with the development of national action plans

Background

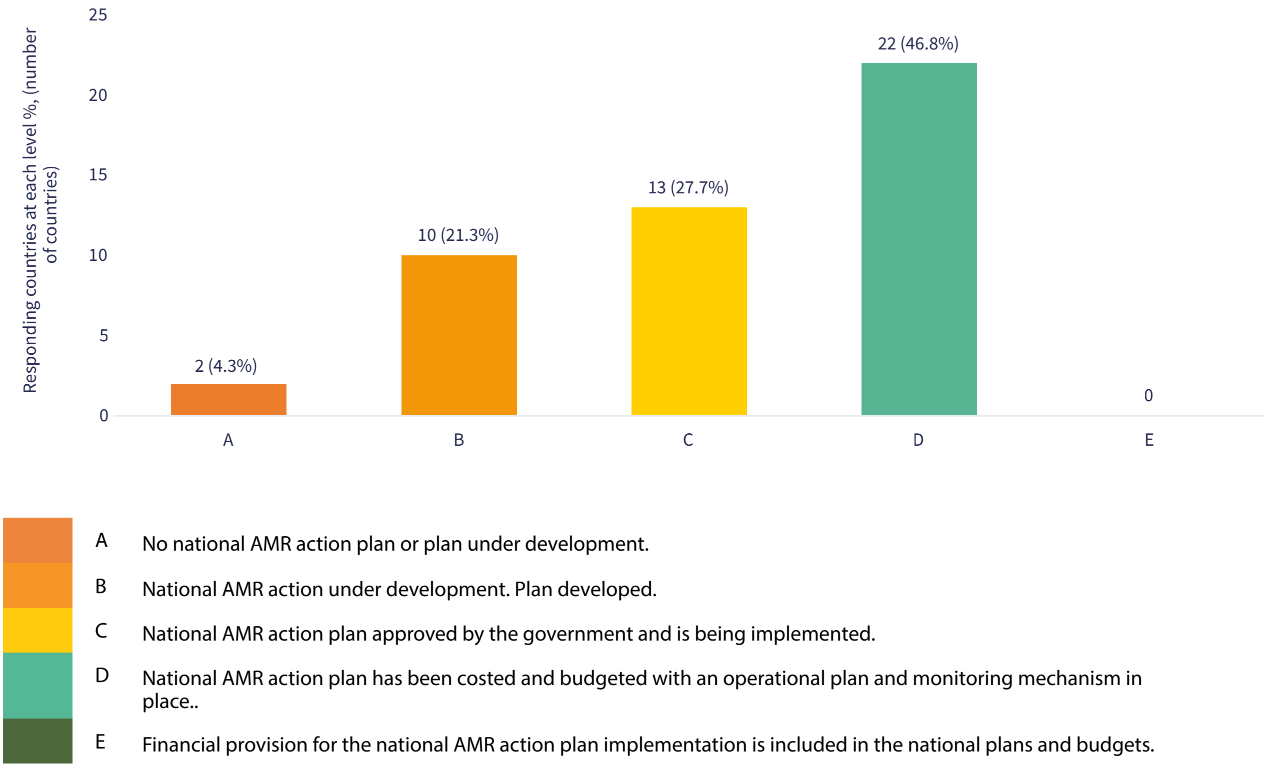
AMR poses a significant threat to global health, food security, economic development and the achievement of universal health coverage (UHC) and the SDGs. Without urgent and coordinated action, the world risks returning to a pre-antibiotic era where common infections become untreatable. To address this growing threat, Member States are encouraged to develop and implement NAPs on AMR, aligned with the Global Action Plan. These NAPs provide a strategic framework to guide national efforts and investments to contain AMR.

The capacity of a country to advance the development of NAPs on AMR involves several key stages. First, a national AMR action plan should be developed in alignment with the Global Action Plan. The plan should then be costed and budgeted to support effective resource mobilization. Once finalized, the plan needs to be formally approved by the government, with the involvement of all critical sectors, and progressively implemented. To ensure accountability and guided action, monitoring mechanisms should be established to track implementation progress. Additionally, securing financial provisions for implementation or aligning the plan with other cognate strategies is essential. This involves integrating key AMR interventions into other existing national plans and budgets, particularly within the health sector, such as health systems strengthening and health security plans.

Progress achieved

According to the 2024 TrACSS data, two countries are currently in the process of updating their NAPs on AMR (Level A). Of the 47 African Region Member States, 45 (95.7%) have developed NAPs using a One Health approach (Levels B to E) and 35 Member States (74.5%) have government-approved NAPs that are currently being implemented (Levels C to E). Furthermore, 22 Member States (46.8%) have developed costed and budgeted operational plans with monitoring mechanisms in place (Level D). However, no country has yet included financial provisions for AMR NAP implementation within their national budgets or financial plans (Level E) (Fig. 2).

Fig 2. Development of national action plans, 2024 (N=47)



A No national AMR action plan or plan under development.

B National AMR action under development. Plan developed.

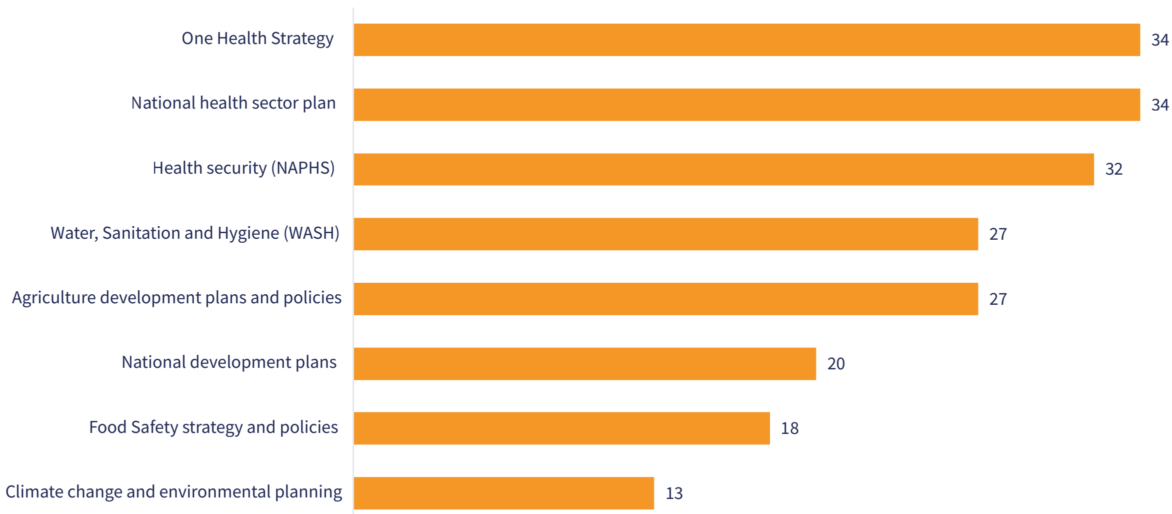
C National AMR action plan approved by the government and is being implemented.

D National AMR action plan has been costed and budgeted with an operational plan and monitoring mechanism in place..

E Financial provision for the national AMR action plan implementation is included in the national plans and budgets.

Integrating the AMR NAP with existing strategies and plans is essential for a coordinated and sustainable response to AMR. This integration fosters cross-sectoral collaboration, aligns national priorities, and optimizes the use of resources. Forty-three Member States (91.5%) have linked their AMR NAP to at least one of the following national plans or strategies: national action plan for health security (NAPHS); national health sector plan; One Health strategy; water, sanitation and hygiene (WASH); agricultural development plans and policies; food safety strategy and policies; national development plans; and climate change and environmental planning. Fig. 3 below illustrates the integration of AMR NAPs with other existing national plans.

Fig.3. Number of countries integrating the AMR NAP with other national strategies and plans (N=43)



Next steps

Strategic priorities on AMR national action plans in the WHO African Region.

The proposed strategic actions are listed below.

1. **Secure government endorsement of NAPs:** support 10 countries to move from draft to approved NAPs through targeted technical support and tailored advocacy with decision-makers.
2. **Ensure that NAPs are fully costed and monitored:** assist countries in prioritizing actions using the Smart Choices approach and WHO costing tools, while developing robust monitoring plans.
3. **Mobilize resources for implementation:** help at least 10 countries integrate AMR into national budgets and plans, and align with existing frameworks such as primary health care (PHC), UHC, NAPHS and disease-specific programmes.
4. **Engage donors and development partners:** advocate for AMR inclusion in major funding proposals (Global Fund, World Bank and The Pandemic Fund, among others) and national development strategies to secure sustainable financing.

Country progress on multisectoral and One Health collaboration/coordination

Background

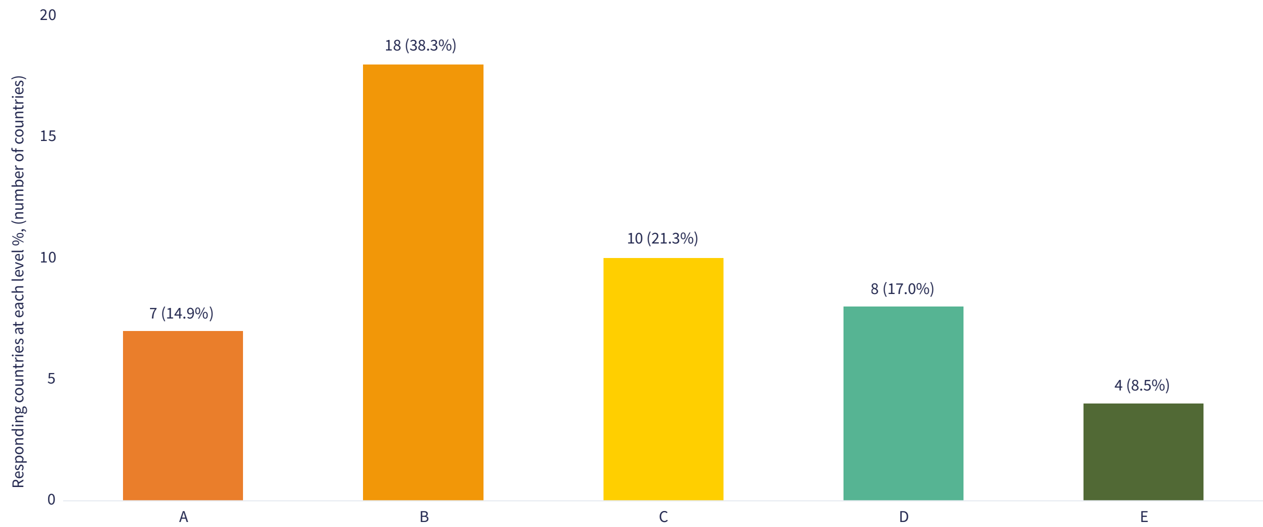
AMR is a complex issue that spans human health, animal health, agriculture and the environment. Addressing AMR requires a One Health approach that brings together stakeholders from all relevant sectors to ensure effective governance, policy coherence and resource mobilization. Establishing a functional multisectoral coordination mechanism enables countries to jointly plan, implement and monitor AMR-related actions, thus strengthening shared ownership, accountability and more efficient use of resources.

The capacity of a country to establish and strengthen multisectoral and One Health collaboration for addressing AMR progresses through several stages. First, the establishment of a multisectoral coordination mechanism, including sectors such as human health, animal health, agriculture and the environment, is a foundational step. This mechanism should be government-led and include representatives from all relevant sectors. Once established, the mechanism must be formalized through clear terms of reference, defined roles and responsibilities and regular meetings, with secure resources and reporting arrangements. As the collaboration matures, sectors begin to engage in joint work on AMR-related priorities. This includes developing common objectives, shared indicators and coordinated implementation of AMR NAPs and NAPHS. The collaboration should then evolve towards a fully integrated One Health approach, where planning, implementation, data sharing and evaluation are carried out collectively across sectors.

Progress achieved

As of 2024, 40 Member States (85.1%) in the WHO African Region had established multisectoral coordination committees or working groups on AMR under government leadership (Levels B to E). Among these, 22 Member States (46.8%) had functional mechanisms in place, with clear terms of reference, regular meetings, dedicated funding and defined reporting and accountability arrangements (Levels C to E). Additionally, four Member States (8.5%) had adopted integrated One Health approaches for AMR NAP implementation, utilizing relevant data and lessons learnt from all sectors to inform their actions (Level E). **However, seven Member States (14.9%) had not yet established a formal multisectoral governance or coordination mechanism on AMR (Level A)** (Fig. 4).

Fig 4. AMR multisectoral coordination mechanism, 2024 (N=47)



A No formal multisectoral governance or coordination mechanism on AMR exists.

B Multisectoral working group(s) or coordination mechanism committee on AMR established with government leadership.

C Formalized multisectoral coordination mechanism with technical working groups and established multisectoral working group(s) functional, with clear terms of reference, regular meetings, and funding for working group(s); activities and reporting/accountability arrangements are well defined.

D Joint work on issues including agreement on common objectives.

E Financial provision for the national AMR action plan implementation is included in the national plans and budgets.

The involvement of various sectors in multisectoral coordination is essential for the effective implementation of AMR NAPs. Addressing AMR requires a One Health approach that brings together all relevant sectors to ensure a coordinated and comprehensive response. In 44 Member States (93.6%), human health, terrestrial animal health and the environment are the sectors most actively involved in the multisector coordination mechanism.

Next steps

Strategic priorities for strengthening multisectoral and One Health collaboration/coordination in the WHO African Region

The proposed strategic actions are outlined below.

1. **Promote country-led, low-cost coordination:** encourage governments to use existing public health platforms (such as national public health institutes, One Health secretariats) and virtual tools (such as Zoom, Teams and WhatsApp) to sustain multisectoral coordination.
2. **Support priority countries lacking coordination structures:** provide simple, ready-to-use templates and virtual mentoring from peer countries with functional mechanisms to help the seven countries currently without multisectoral governance or coordination mechanisms (Level A) to help them establish government-led coordination structures (Level B).
3. **Strengthen and sustain existing mechanisms:** promote the integration of AMR into existing intersectoral mechanisms such as national planning platforms (for example, UHC and NAPHS), virtual reviews, and coordination meetings to strengthen multisectoral alignment. In parallel, conduct high-level advocacy to ensure the inclusion of key sector-specific representatives, including those from food production, food safety and plant health, in national multisectoral coordination platforms.
4. **Advance One Health integration through shared activities:** encourage countries for joint data sharing and collaboration during national events (for example, AMR Awareness Week) to operationalize One Health with minimal resource input**.**
5. **Mobilize resources through alignment and advocacy:** support countries to identify financing entry points within national sector budgets and align AMR coordination with donor-funded platforms (for example, Global Fund, Fleming Fund, Pandemic Fund, health security budget and One Health Trust Fund).

Country progress on awareness raising and understanding of AMR risks and response

Background

Public and professional awareness of AMR remains limited in many countries. Education campaigns targeting the general public, health-care providers, farmers and policy-makers are vital to promoting responsible use of antimicrobials, reducing misuse and fostering behaviour change. Increased awareness contributes to greater political commitment and public demand for AMR containment measures.

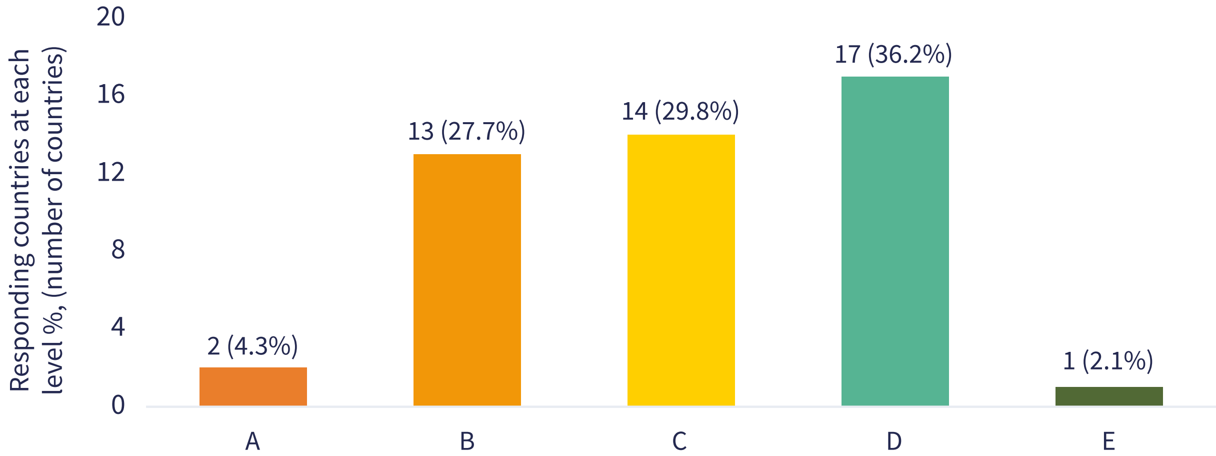
The capacity of a country to raise awareness and understanding of AMR risks and response develops progressively. In the early stages, some awareness-raising activities are carried out in parts of the country to inform the public and relevant groups about AMR risks and the actions needed to address them. As efforts advance, countries begin implementing small-scale AMR awareness campaigns that target specific stakeholder groups, though not yet comprehensively. With stronger commitment, countries implement government-supported national awareness campaigns, based on stakeholder analysis to target the majority of relevant audiences with tailored messaging appropriate to each sector. At a more advanced stage, countries routinely implement targeted, nationwide awareness and education activities aimed at influencing behaviour change among key stakeholders, including regular monitoring.

Progress achieved

According to the 2024 TrACSS data, 45 Member States (95.7%) in the WHO African Region have carried out at least some AMR awareness-raising activities in parts of the country to address risks and promote appropriate responses

(Level B to E). Among those, 14 Member States (29.8%) are implementing limited or small-scale AMR awareness campaigns targeting some – but not all – relevant stakeholder groups (Level C). Eighteen Member States (38.3%) have conducted nationwide campaigns targeting all or many priority stakeholder groups, based on stakeholder analysis and sector-specific messaging (Level D to E). Among these countries, only Algeria has reached the most advanced stage (Level E) of routinely implementing targeted, nationwide activities aimed at changing stakeholder behaviour with regular monitoring. However, two Member States (4.3%) have not yet implemented any significant AMR awareness-raising activities (Level A) (Fig. 5).

Fig 5. AMR awareness and understanding of AMR risk, 2024 (N=47)



A No significant awareness-raising activities on relevant aspects of AMR risks.

B Some activities carried out in parts of the country to raise awareness about AMR risks and actions that can be taken to address it.

C Limited or small-scale AMR awareness campaign targeting some but not all relevant stakeholders.

D Nationwide, government-supported AMR awareness campaign targeting all or the majority of priority stakeholder groups, based on stakeholder analysis, utilizing targeted messaging accordingly within sectors.

E Routine targeted, nationwide government-supported activities regularly implemented to change the behaviour of key stakeholders within sectors, with monitoring undertaken over the last 2–5 years.

Next steps

Strategic priorities for strengthening AMR awareness

The strategic actions outlined below are proposed.

1. **Initiate/enhance awareness in Levels A and B countries (15 countries)–*countries with limited or no existing awareness activities***
   - Support countries to launch low-cost, entry-level campaigns using WHO starter toolkits and pre-packaged messages, delivered through existing platforms such as social media and primary health clinics. Where feasible, integrate AMR messaging into ongoing national public health initiatives (for example, immunization and WASH activities) to increase visibility.
2. **Expand and standardize awareness efforts in Level C countries (14 countries)–*countries with small-scale AMR awareness campaign***
   - Provide targeted remote support (virtual training, templates and communication tools) to help countries expand from small-scale to nationwide government-led awareness campaigns. Encourage formal inclusion of AMR in national health communication strategies and budget frameworks to promote sustainability.

3. Sustain impact in Levels D and E countries (18 countries)

- Support efforts to improve monitoring and evaluation (M&E) systems that measure changes in stakeholder knowledge and behaviours. Expand outreach to underserved groups, such as the private sector and rural populations, and embed AMR content in sector-specific education and training (for example, schools, agriculture and veterinary services).

4. Leverage cross-cutting platforms (all levels)

- Maximize visibility and efficiency by aligning AMR messages with World AMR Awareness Week (WAAW) and key national or international health days (for example, World Tuberculosis (TB) Day, World Patient Safety Day, Food Safety Day and WASH campaigns). Promote knowledge exchanges through regional webinars and the establishment of an AMR awareness community of practice.
- Advocate for the active participation of policy-makers, including members of parliament, and AMR survivors in nationwide awareness campaigns to enhance understanding of AMR across communities and sectors.

Country progress on training and professional education on AMR

Background

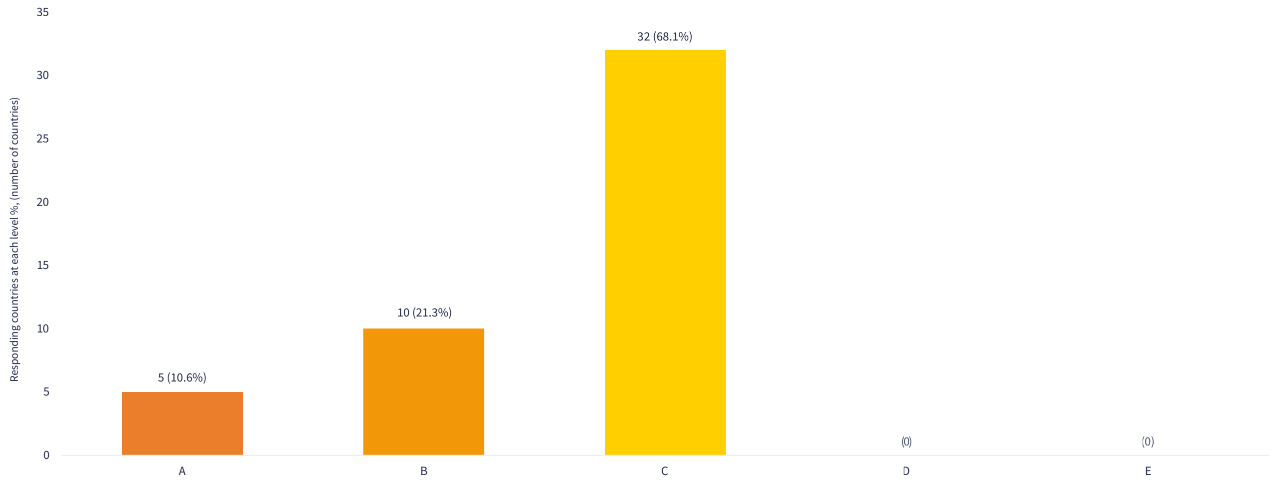
Training and professional education on AMR are essential to equip health-care providers with the knowledge and skills needed to prevent, detect and manage AMR. The capacity of a country to establish and strengthen training and professional education on AMR in the human health sector progresses through several key stages. In the early stages, countries begin by offering ad hoc AMR training courses, typically limited to certain disciplines within the human health sector. As systems evolve, AMR content is introduced into some pre-service training programmes and some in-service training or continuing professional development (CPD) activities for selected human health workers. With increased commitment, countries expand AMR education to cover all relevant health-related cadres at the pre-service level, while ensuring that in-service training or CPD on AMR is made available nationwide to a broad range of human health professionals. At a more advanced stage, AMR education is systematically and formally incorporated across all pre-service curricula for relevant human health cadres. In-service training and CPD activities are widely institutionalized and accessible to professionals across the public and private sectors.

Progress achieved

According to the 2024 TrACSS data, 42 Member States (89.4%) in the WHO African Region are delivering at least ad hoc AMR training in certain human health disciplines (Levels B to E). The most common approach, observed in

32 countries (68.1%) is the inclusion of AMR in some pre-service and in-service training or CPD activities (Level C). However, no country has yet reached Level D, where AMR training is delivered nationwide across all relevant cadres, nor Level E, where AMR content is systematically incorporated into curricula for all human health professionals. Meanwhile, five countries (10.6%) remain at Level A, having yet to initiate any AMR-related training for health workers (Fig.6).

Fig. 6. Training and education on AMR for human health workers, 2024 (N=47)



A	No training on AMR for human health workers.
B	Ad hoc AMR training courses in some human health-related disciplines.
C	AMR is covered in (1) some pre-service training and (2) some in-service training or other CPD for human health workers.
D	AMR is covered in pre-service training for all relevant cadres. In-service training or other CPD covering AMR is available for all types of human health workers nationwide.
E	AMR is systematically and formally incorporated in pre-service training curricula for all relevant human health cadres. In-service training or other CPD on AMR is taken up by relevant groups for human health nationwide in the public and private sectors.

Next steps

Strategic priorities for strengthening training and professional education on AMR

The proposed strategic actions are outlined below.

1. **Support foundational training in Level A countries (five countries)–*countries with no training on AMR***
   - Develop context-specific AMR awareness packages for health workers and conduct remote training needs assessments to identify priority groups and content gaps. Facilitate experience-sharing webinars to showcase successful national models for training integration and delivery.

2. **Consolidate and expand training in Levels B and C countries (42 countries)**
   - Support the establishment of structured AMR training programmes and help countries in formalizing national AMR training strategies, which shift from ad hoc efforts to structured approaches. Promote blended learning models (e-learning plus virtual sessions) to improve accessibility, especially in remote or understaffed areas, with a focus on health workers involved in antibiotic prescribing, IPC and diagnostics.

3. **Institutionalize AMR in pre-service education (towards Level D and E)**
   - Collaborate with national academic and educational institutions, regulatory bodies and ministries to update or integrate health education curricula with AMR-specific competencies; integrate AMR modules into training programmes for doctors, nurses, pharmacists and laboratory (lab) professionals; and use virtual technical review panels and model syllabi to fast-track curriculum updates.
4. **Develop and disseminate standardized training resources**
   - Ensure the availability and wide dissemination of AMR training resources through platforms such as Open-WHO, WHO Academy and regional knowledge hubs.
5. **Establish systems to monitor AMR training implementation and outcomes**
   - Integrate AMR training and professional education indicators into regional M&E systems, and use simple digital tools (for example, online surveys and reporting forms) to monitor implementation across countries.
6. **Expand AMR training through strategic integration**
   - Advocate for the inclusion of AMR in health workforce strategies, UHC packages and NAP implementation. Support countries to leverage existing resources (for example, IPC, lab systems and Global Fund programmes) and integrate AMR content into ongoing training platforms like CPD programmes and regional health schools.

Country progress on national surveillance systems for antimicrobial resistance

Background

Data on the prevalence of AMR and patterns of AMC are crucial to inform clinical decision-making, guide policy, and track progress. Establishing surveillance systems that include participation in the WHO Global Antimicrobial Resistance and Use Surveillance System (GLASS) enables countries to generate reliable evidence for action at national and global levels.

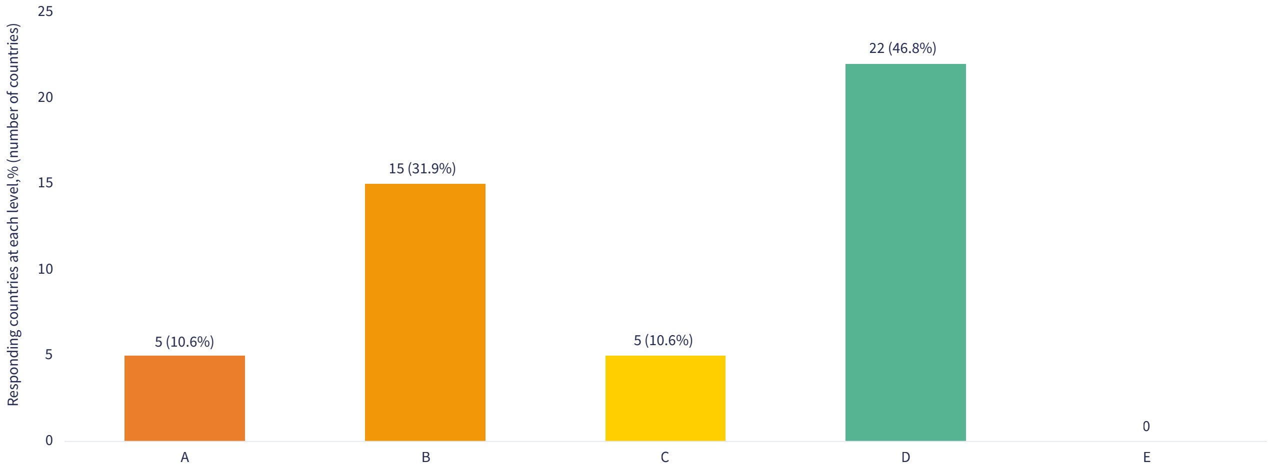
The development of AMR surveillance capacity in the human health sector begins with local data collection on common bacterial infections in hospitalized patients. At this early stage, efforts are often fragmented and lack standardized methods, national coordination and quality management. As systems mature, countries begin aggregating AMR data at the national level, although challenges with harmonization and oversight may persist. With further progress, a structured and standardized national surveillance system is established, supported by a network of sentinel sites, a designated national reference laboratory, and a national coordinating centre that compiles and disseminates regular reports. In more advanced systems, AMR surveillance is fully institutionalized and integrated with data on AMC and use.

Progress achieved:

Forty-two Member States (89.4%) in the WHO African Region collect AMR data locally for common bacterial infections in hospital and community settings (Levels B to E). However, in 15 of these countries (31.9%), data collection does not follow a standardized approach and lacks national coordination and/or quality management mechanisms (Level B).

In contrast, 22 Member States (46.8%) have established standardized national AMR surveillance systems, including a national coordinating centre that produces regular AMR surveillance reports (Level D). However, no country has yet reached the stage of linking AMR surveillance data with AMC and/or use data in the human health sector (Level E). In addition, five Member States (10.6%) currently lack the capacity to generate and report AMR data (Level A) (Fig. 7).

Fig. 7. National AMR surveillance activities in human health, 2024 (N=47)



A No capacity for generating data (antibiotic susceptibility testing and accompanying clinical and epidemiological data) and reporting on antibiotic resistance.

B AMR data is collated locally for common bacterial infections in hospitalized and community patients, but data collection may not use a standardized approach and lacks national coordination and/or quality management.

C AMR data is collated nationally for common bacterial infections in hospitalized and community patients, but national coordination and standardization are lacking.

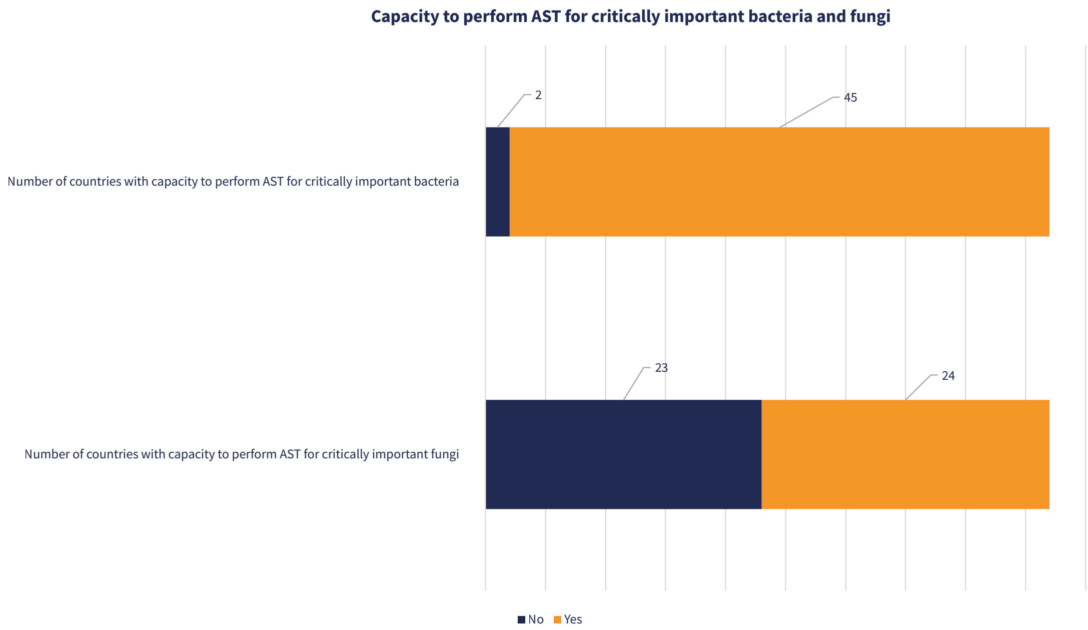
D There is a standardized national AMR surveillance system for collecting data on common bacterial infections in hospitalized and community patients, with an established network of surveillance sites, a designated national reference laboratory for AMR and a national coordinating centre that produces reports on AMR.

E The national AMR surveillance system links AMR surveillance with AMC and/or use data for human health.

Clinical laboratory services

Microbiology laboratories play a crucial role in detecting, identifying and monitoring infectious agents to support clinical diagnosis, disease surveillance and AMR control. These laboratories provide essential data for patient care, guide antimicrobial treatment decisions and contribute to public health responses by identifying outbreaks and tracking resistance patterns. As shown in Fig.8, 45 Member States (95.7%) have a capacity to perform antimicrobial susceptibility testing (AST) for critically important bacteria. However, only 51.0% have equivalent capacity for fungal pathogens in the Region.

Fig. 8. Capacity to perform AST for critically important bacteria and fungi, 2024 (N=47)



Next steps

Strategic priorities for strengthening AMR surveillance in the WHO African Region

The strategic actions listed below are proposed.

1. **Build foundational capacity in Level A countries (five countries)–*countries currently lacking the capacity to generate and report AMR data***
   - Support GLASS enrolment to guarantee the adoption of standardized protocols and assist in establishing basic bacteriology labs and initial sentinel sites.
   - Provide remote training and mentoring on pathogen isolation, AST and data management. Help develop phased national surveillance plans and mobilize seed funding and partner support to launch reporting systems.
2. **Standardize surveillance systems in Levels B and C countries (20 countries)**
   - Map current data collection practices to identify gaps, update national AMR guidelines in line with GLASS and establish or reinforce coordinating centres for data oversight and reporting.
   - Advocate for and provide technical support to countries at this level to facilitate the reporting of collected data through the GLASS-AMR system.
   - Support the implementation of quality assurance measures (standard operating systems (SOPs), external quality assessment (EQA) and supervision), provide targeted training for focal points and lab staff on standard methodologies and data flow, and progressively expand sentinel site networks using harmonized tools and timelines.

3. **Strengthen integrated surveillance in Level D countries (22 countries)**

   - Introduce surveillance in hospitals using existing platforms and establish interoperable systems linking AMR and pharmaceutical data. Train focal points in data triangulation using WHO tools (GLASS-AMU module and AMC Toolkit), and develop integrated dashboards to support stewardship, regulatory decisions, treatment guideline updates and procurement planning.

4. **Cross-cutting regional and supportive actions**

   - Organize regional knowledge-sharing webinars and thematic workshops, and promote twinning or mentorship between advanced (Level D) countries and those at earlier stages of AMR surveillance to promote regional learning and cross-country support.
   - Institutionalize multisectoral AMR data review meetings, develop user-friendly bulletins for decision-makers and use surveillance findings to inform updates to NAPs, stewardship activities and procurement strategies.
   - Embed AMR surveillance in national health, UHC and preparedness plans; engage partners such as the Global Fund and Fleming Fund; and advocate for dedicated domestic funding under national health budgets.

Monitoring system for antimicrobial consumption and use

Background

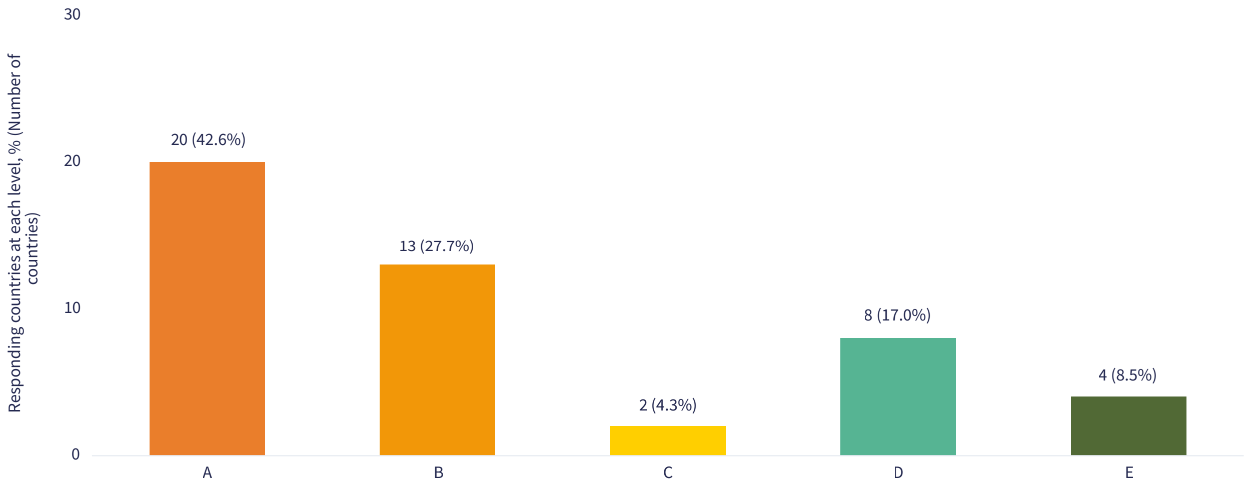
Monitoring AMC and use (AMU) is a critical component of national efforts to combat AMR. Reliable AMC/AMU data help countries understand prescribing and usage patterns across human, animal and agricultural sectors. This information is essential for identifying misuse and overuse of antimicrobials, guiding stewardship interventions and informing regulatory and policy decisions.

The development of systems for monitoring AMC and use begins with the establishment of a basic surveillance framework designed to track national-level antibiotic sales or consumption within the health system. As the system evolves, countries begin routinely monitoring total antimicrobial sales at the national level and may initiate subnational efforts to monitor antibiotic use. With further progress, surveillance expands to include the assessment of prescribing practices and the appropriateness of antibiotic use within a structured national sample of health care facilities. In advanced systems, comprehensive data on both antimicrobial sales/consumption and prescribing practices are collected and reported on a regular basis from a representative sample of public and private sector facilities.

Progress achieved

As shown in Fig. 9 below, 14 Member States (29.8%) in the WHO African Region monitor total antimicrobial sales at national level and/or some monitor antibiotics use at subnational level (Levels C to E). Among these, eight countries (17.0%) have progressed to Level D, where prescribing practices and appropriate antibiotic use are monitored in a national sample of health care settings. Four countries (8.5%) have reached the most advanced stage (Level E), where regular monitoring and reporting are conducted on antimicrobial sales and prescribing practices in representative public and private health facilities. However, 20 Member States (42.6%) currently lack a national plan or system to monitor AMU in the human health sector (Level A) while in 13 countries (27.7%) a system exists for surveillance of AMU (Level B).

Fig. 9. Monitoring systems for consumption and rational use of antimicrobials in human health, 2024 (N=47)



A	No national plan or system for monitoring use of antimicrobials.
B	System designed for surveillance of AMU; it includes monitoring national-level sales or consumption of antibiotics in health services.
C	Total sales of antimicrobials are monitored at national level and/or some monitoring of antibiotic use at subnational level.
D	Prescribing practices and appropriate antibiotic use are monitored in a national sample of health care settings.
E	On a regular basis (every year/2 years), data are collected and reported on: (a) antimicrobial sales or consumption at the national level for human use; and (b) antibiotic prescribing and appropriate/rational use, in a representative sample of public and private health facilities.

Next steps

Strategic priorities for strengthening AMC/AMU monitoring in the WHO African Region

The strategic actions outlined below are proposed.

1. **Initiate AMU monitoring in Level A countries (20 countries)–*countries currently lacking any national plan or system to monitor AMU***
   - Conduct rapid assessments to map existing data sources (for example, imports/exports and pharmacy records) and develop national AMU surveillance plans aligned with GLASS-AMU and the WHO AMC Toolkit. Launch pilot data collection in selected public facilities using simplified WHO tools, train a core group of focal points in data collection and anatomical therapeutic chemical (ATC)/defined daily dose (DDD) classification, and link AMU monitoring with existing IPC, stewardship or UHC platforms to maximize resources.
2. **Operationalize systems in Level B countries (13 countries)–*countries have a system under development or planning stage but lack full implementation***
   - Provide remote technical guidance on facility selection and tool customization and help develop SOPs and data flow systems for AMU monitoring. Facilitate coordination among AMR focal points, pharmacy

authorities and stewardship teams, while offering virtual coaching to strengthen data quality and local capacity. Promote the use of OpenWHO, WHO academy and regional e-learning platforms to extend training to broader networks.

3. **Expand and institutionalize monitoring in Level C and D countries (10 countries)**
   - Advocate for and provide technical support to countries at this level to facilitate the reporting of collected AMC/AMU data through the GLASS-AMC system.
   - Advocate for the expansion of AMR surveillance to additional regions and facility types, including primary care and private sector settings. Support the institutionalization of routine reporting using WHO-recommended templates, promote the integration of prescribing data into AMS programmes with feedback mechanisms, and encourage the use of surveillance data to inform policy decisions such as procurement planning, formulary reviews and updates to treatment guidelines.
4. **Consolidate and leverage progress in Level E countries (four countries)–*countries conducting regular, representative monitoring of sales and prescribing practices***
   - Document and share success stories across the Region and use AMU data to assess the effectiveness of stewardship programmes and regulatory efforts. Encourage the inclusion of AMU metrics in public dashboards or facility reporting systems and expand surveillance to the private sector to address data gaps.
5. **Cross-cutting regional and supportive actions**
   - Organize regional AMU workshops and facilitate country-to-country technical exchanges through webinars or mentoring. Develop toolkits and guidance for rapid AMU system setup and adapt WHO training modules by translating them into local languages for self-paced learning.
   - Advocate for countries to link AMU surveillance data to AMS interventions and deploy health information systems for improved efficiency.

Reducing the incidence of infection through effective sanitation, hygiene and infection prevention measures

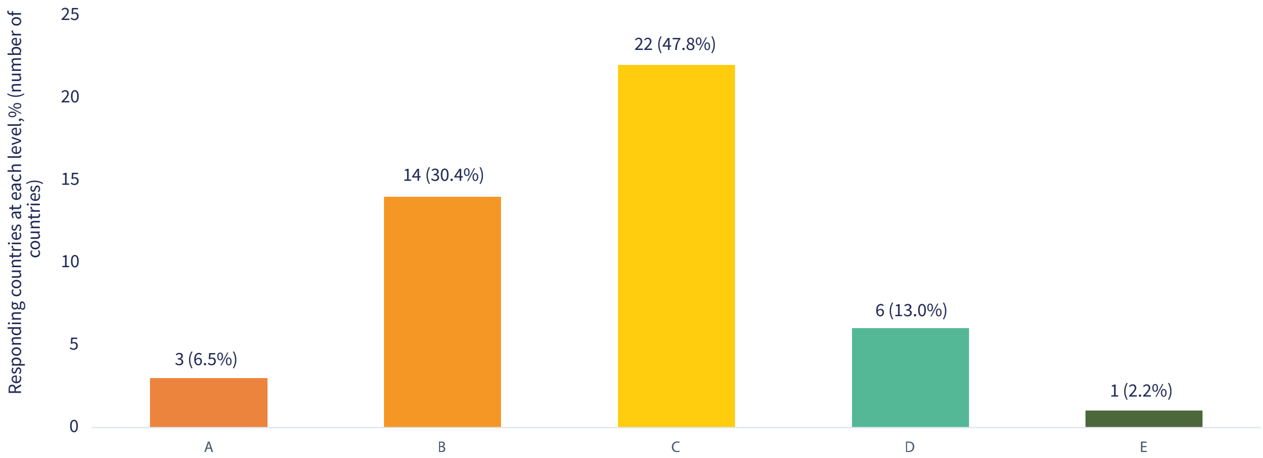
Background

Strengthening IPC in health care settings is a cost-effective strategy to reduce the spread of resistant pathogens. Implementing IPC programmes based on the WHO core components protects patients, health workers and the broader community. The foundation of national IPC capacity involves establishing a national IPC programme or operational plan, along with national IPC standards. As progress is made, selected health facilities begin actively implementing these guidelines, supported by monitoring and feedback mechanisms. Further advancement is characterized by IPC programmes fully aligned with WHO IPC core component guidelines, with plans and guidelines implemented nationwide, and all health care facilities equipped with the necessary materials and infrastructure to carry out IPC in accordance to national standards. At the highest level, compliance and effectiveness are regularly evaluated and published, with plans and guidance continuously updated, based on monitoring results, to maintain and improve IPC performance. The global action plan and monitoring framework on IPC can be found here.

Progress achieved

As shown in Fig. 10 below, 29 Member States (63.0%) have reported having selected health facilities to implement IPC guidelines, with monitoring and feedback mechanisms in place (Levels C to E). Among these, six Member States indicated that their health care facilities have the necessary materials and equipment to perform IPC in accordance with national standards (Level D). Notably, Mali has reached the most advanced stage (Level E), with regular evaluation and reporting on the compliance and effectiveness of the national IPC programme. **However, three Member States (6.5%) currently lack a national IPC programme or operational plan (Level A) while** 14 Member States (30.4%) in the WHO African Region have established national IPC programmes with operational plans and guidelines in place, but these are not yet fully implemented (Level B).

Fig. 10: IPC in human health care, 2024 (N=46)*



A No national IPC programme or operational plan is available.

B A national IPC programme or operational plan is available. National IPC and water, sanitation and hygiene (WASH) and environmental health standards exist, but are not fully implemented.

C A national IPC programme and operational plan are available and national guidelines for health care and IPC are available and disseminated. Selected health facilities are implementing the guidelines, with monitoring and feedback in place.

D National IPC programme available according to the WHO IPC core component guidelines and IPC plans and guidelines are implemented nationwide. All health care facilities have a functional built environment (including water and sanitation), and necessary materials and equipment to perform IPC, per national standards.

E IPC programmes are in place and functioning at national and health facility levels, per the WHO IPC core component guidelines. Compliance and effectiveness are regularly evaluated and published. Plans and guidance are updated in response to monitoring.

**Angola* *did not provide data on this indicator.*

Next steps

The following strategic priorities are proposed to strengthen IPC implementation in the WHO African Region.

1. **Establish Initiate an IPC programme in Level A countries (three countries)–*countries currently lacking a formal national IPC programme***
    - Conduct baseline assessments of IPC structures, facility practices and policy gaps. Support the development of national IPC programmes and operational plans aligned with WHO IPC core components.
    - Facilitate the formation of IPC technical working groups with cross-sectoral representation (WASH, AMR and quality of care), promote high-level political engagement to secure funding and leadership commitment, and provide technical support using WHO tools such as the infection prevention and control assessment framework (IPCAF) and core component checklists.
2. **Operationalize and scale IPC implementation in Level B countries (14 countries)–*IPC programmes exist but are not fully implemented at facility level***
    - Provide remote training and mentorship for IPC focal persons at all levels through digital platforms and e-learning modules to support IPC rollout in national and regional referral hospitals.
    - Supply essential planning tools for personal protective equipment (PPE), disinfectants and hand hygiene; Promote the use of monitoring tools to strengthen IPC programmes (for example, IPCAF dashboards and checklists); and integrate IPC indicators into national health management information systems (HMIS) and supervision tools.
    - Promote ownership and accountability through engagement with facility leadership and establish regular feedback loops to foster local commitment and sustainable IPC practices.
3. **Expand monitoring and feedback systems in Levels C and D countries (29 countries)**
    - Support the scale-up of IPC across all levels of care, ensuring that minimum standards for WASH, waste management and hand hygiene are consistently met.
    - Advocate for the implementation of routine feedback systems and quarterly performance reviews and promote the integration of IPC data with patient safety, AMR and quality improvement initiatives to enhance multisectoral impact.
4. **Consolidate and share best practices in Level E countries (one country)–*IPC is fully implemented and performance is evaluated regularly***
    - Document and share practical approaches that countries use to evaluate and report on their national IPC programmes.
    - Host webinars for exchange and dissemination of IPC best practices.
5. **Cross-cutting regional and supportive actions**
    - Build a regional network of IPC focal points for knowledge exchanges and support regional IPC champions to elevate political visibility and resource prioritization.
    - Promote joint planning between IPC and WASH programmes, implement the Water and Sanitation for Health Facility Improvement Tool (WASH FIT) in priority facilities, and ensure IPC reviews include WASH conditions, especially in underserved areas.
    - Advocate for dedicated IPC funding within health budgets and UHC packages, align IPC with emergency preparedness and AMR plans, and leverage donor mechanisms (for example, Global Fund and World Bank) to expand national implementation.

Optimizing antimicrobial use

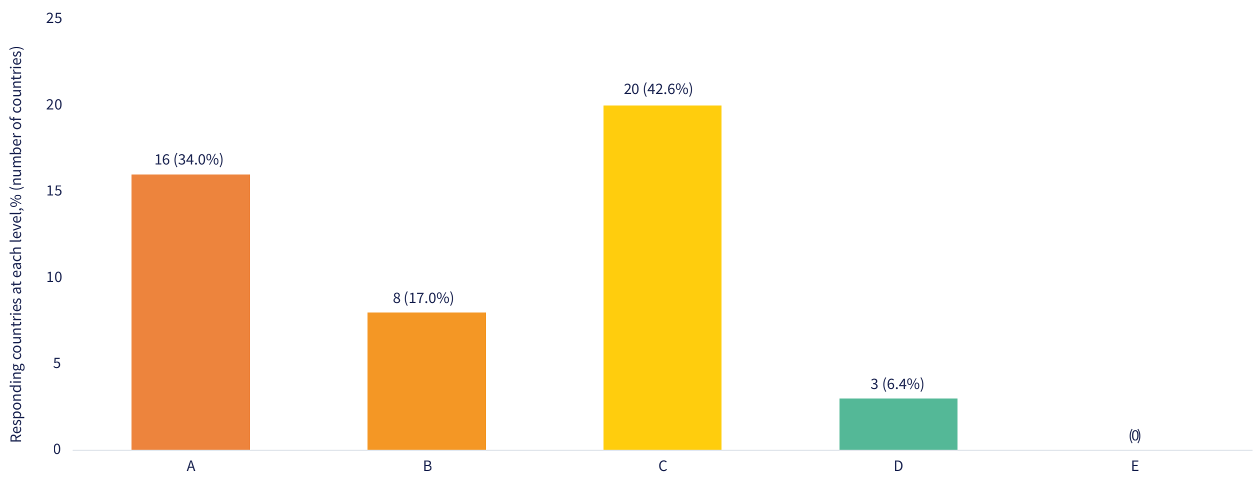
Background

Promoting the appropriate use of antimicrobials is essential to preserving their effectiveness and preventing the development of AMR. Efforts to optimize AMU begin with the development of national policies to promote appropriate AMU and stewardship activities for community and health care settings. As progress continues, national guidelines for AMU become available, with stewardship programmes being implemented in selected health care facilities. Further advancement is characterized by nationwide implementation of AMS programmes in most health care facilities, where monitoring and surveillance data are actively used to inform actions and update treatment guidelines and EMLs. At the most advanced stage, national guidelines on optimizing antibiotic use are fully implemented for all major syndromes, with systematic feedback of data usage to prescribers to promote rational use.

Progress achieved

As shown in Fig. 11, nearly half of the Member States, 23 (48.9%), have national guidelines in place and AMS programmes implemented in at least some health care facilities (Levels C to E). Among these, only three Member States have reached the stage where stewardship programmes are operational in most health care facilities nationwide, and monitoring and surveillance data are used to inform actions and update treatment guidelines and EMLs (Level D). However, no country has yet reached Level E, where national guidelines are implemented for all major syndromes. Eight Member States (17.0%) have developed national policies to promote appropriate AMU and AMS activities in community and health care settings (Level B). In contrast, 16 Member States (34.0%) remain at Level A, with either no policies or only weak national frameworks in place to ensure the appropriate availability, quality and disposal of antimicrobials.

Fig. 11. Optimizing antimicrobial use in human health, 2024 (N=47)



A No/weak national policies for appropriate AMU, including availability, quality and disposal of antimicrobials.

B National policies to promote appropriate AMU/AMS activities developed for the community and health care settings.

C National guidelines for appropriate use of antimicrobials are available and AMS programmes are being implemented in some health care facilities.

D National guidelines for appropriate use of antimicrobials are available and AMS programmes are being implemented in most health care facilities nationwide. Monitoring and surveillance results are used to inform action and to update treatment guidelines and EMLs.

E National guidelines on optimizing antibiotic use are implemented for all major syndromes and data on use are systematically fed back to prescribers.

Legislation on antimicrobial use

Ensuring the continued effectiveness of antimicrobials is a key pillar of the Global Action Plan on AMR. AMS programmes, supported by clinical guidelines, policies and regulations, together with their effective enforcement, are essential to preserving the efficacy of these vital medicines. In this regard, 40 Member States (85.1%) reported having regulations in place governing the prescription and sale of antimicrobials for human use.

Next steps

Strategic priorities for strengthening antimicrobial stewardship in the WHO African Region

The strategic actions listed below are proposed.

1. **Establish basic AMS policies in Level A countries (16 countries)–*countries lacking national policies for appropriate AMU***
   - Support countries to conduct rapid policy reviews to identify gaps in regulation and implementation. Support the development or update of national AMS frameworks aligned with AMR NAPs and regulatory strategies and convene virtual consultations with key stakeholders.
   - Raise awareness among health authorities about AMS as a cost-effective, safety-enhancing intervention, and pilot stewardship initiatives in selected tertiary hospitals to serve as models for broader implementation.

2. **Operationalize AMS policies in Level B countries (eight countries)–*policies exist but are not fully implemented***
   - Support the development of operational guidelines and facility-level protocols, revise national treatment guidelines for common infections, and strengthen AMS committees at facility and district levels.
   - Build capacity through remote and on-site training for prescribers, pharmacists and managers on antibiotic audits and stewardship practices. Launch targeted awareness campaigns to promote rational use and address informal antibiotic markets.
3. **Expand AMS implementation in Levels C and D countries (23 countries)**
   - Advocate for and support the expansion of AMS programmes from tertiary to district and primary care facilities to enable nationwide implementation. Facilitate the introduction and use of standardized monitoring tools (for example, point prevalence surveys and prescribing audits) to monitor AMU practices, identify gaps and inform targeted interventions.
   - Advocate for the use of AMR/AMU data to update treatment guidelines and EMLs, and provide targeted remote support (e-learning, virtual supervision and mentorship) to help countries progress from Level C to D.
4. **Support high-performing countries to reach Level E–*no country has yet fully integrated AMS guidelines across all major syndromes with established feedback loops***
   - Support countries to develop syndrome-specific guidelines based on resistance data, institutionalize feedback mechanisms linking AMU data with prescribing behaviour, and promote digital systems for prescribing and data visualization. Promote the integration of AMS into hospital accreditation and governance systems, and evaluate its impact using clinical, microbiological and economic indicators.
5. **Regional and cross-cutting actions**
   - Promote knowledge exchanges and cross-country learning through regional webinars and virtual case-sharing forums; document and share implementation guides, case studies and tools from advanced (Level D) countries.
   - Advocate for the incorporation of AMS into pre-service and in-service curricula for key health professions. Develop modular training accessible via OpenWHO, WHO Academy and regional platforms. Foster collaboration across AMR, IPC, WASH and pharmaceutical sectors for integrated implementation.
   - Advocate for dedicated domestic funding for AMS in hospitals and regulatory bodies. Embed AMS into donor-funded programmes (such as, Global Fund, World Bank, UHC, TB, HIV and malaria), and include AMS indicators in national health monitoring and quality improvement frameworks.

Adoption of AWaRe classification of antibiotics in the national essential medicines lists

Background

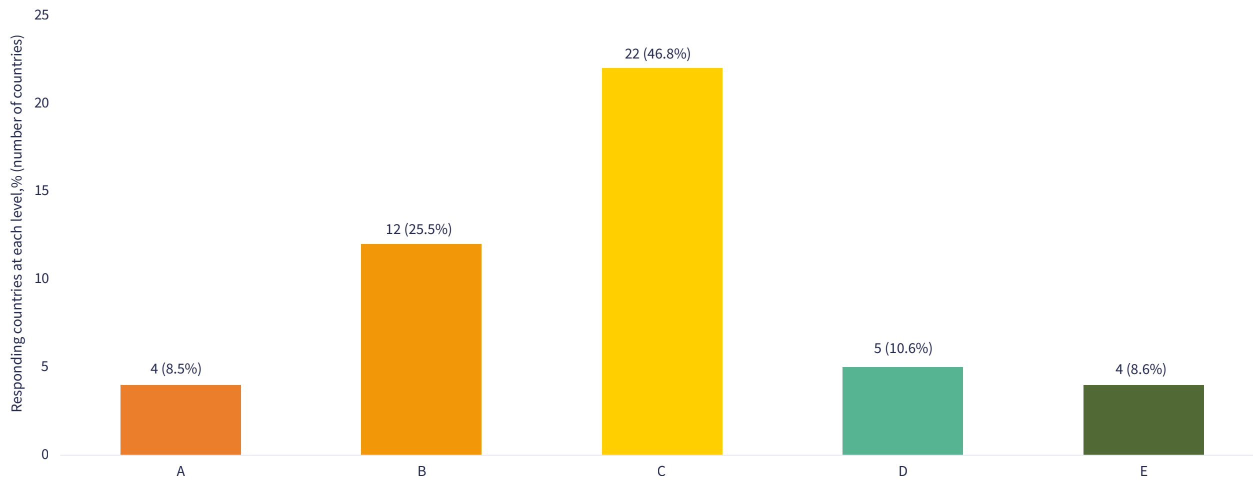
The WHO AWaRe classification serves as a practical tool to guide antibiotic stewardship and inform essential medicine lists, procurement and surveillance. Its adoption supports the prioritization of Access group antibiotics for common infections, while restricting the use of Watch and Reserve antibiotics to specific cases to limit the development of resistance.

Efforts to adopt the WHO AWaRe classification of antibiotics begin with raising awareness and building national knowledge around its use and purpose. As countries progress, the AWaRe classification is formally adopted into NEMLs, which align medicine selection with WHO recommendations. Further progress is evident when countries begin monitoring antibiotic consumption and reporting data in accordance with the AWaRe classification. At the most advanced stage, the AWaRe classification is fully integrated into national AMS strategies, including its application in treatment guidelines and protocols to optimize antibiotic prescribing practices.

Progress achieved

Thirty-one Member States (65.9%) in the WHO African Region have integrated the AWaRe classification of antibiotics into their NEMILs (Levels C to E). Among these, five Member States (10.6.1%) are monitoring antibiotic consumption and reporting data according to the AWaRe classification (Level D), and four (8.5%) have incorporated the classification into their AMS strategies, including its use in national treatment guidelines (Level E). In addition, 12 Member States (25.5%) have knowledge of the AWaRe classification but have not yet adopted it in NEMLs (Level B). However, four Member States (8.5%) currently have no knowledge or information about the AWaRe classification of antibiotics (Level A) (Fig. 12).

Fig 12. Adoption of the AWaRe classification in national EMLs, 2024 (N=47)



A Country has no knowledge or information about the AWaRe classification of antibiotics.

B Country has knowledge about the AWaRe classification of antibiotics but has not yet adopted it.

C Country has adopted the AWaRe classification of antibiotics in their national essential medicine list (EML).

D Country has adopted the AWaRe classification of antibiotics in their national EML and is monitoring its antibiotic consumption and reporting it according to the AWaRe classification.

E Country has adopted the AWaRe classification of antibiotics in their national EML, is monitoring its antibiotic consumption and reporting it according to the AWaRe classification and has incorporated AWaRe into its AMS strategies (for example, treatment guidelines).

Next steps

Strategic priorities for strengthening adoption and use of the AWaRe classification in the WHO African Region

The strategic actions outlined below are proposed.

1. **Build awareness and engagement in Level A countries (four countries)–*no knowledge or information about AWaRe***
   - Raise awareness by organizing virtual sensitization sessions for policy-makers, prescribers and essential medicine committees. Distribute WHO AWaRe guidance (including the 2023 model list and policy briefs) and integrate AWaRe messaging into broader AMR campaigns (for example, WAAW) and training curricula for AMR and regulatory focal points.
2. **Facilitate integration into NEMLs in Level B countries (12 countries)–*AWaRe is known but not adopted in EML***
   - Provide remote technical support to revise NEMLs using the AWaRe classification. Advocate for regulatory policies to reflect AWaRe categories in prescribing and dispensing practices.
3. **Strengthen monitoring and reporting in Levels C and D countries (27 countries)**
   - Provide technical support and tools to scale up antibiotic consumption monitoring (ATC/DDD and AMC Toolkit) disaggregated by AWaRe group.
4. **Strengthen integration into stewardship programmes in Level E countries (four countries)**
   - Support countries in assessing and evaluating the impact of the AWaRe classification on prescribing patterns, antimicrobial costs and resistance trends
5. **Regional and cross-cutting actions**
   - Establish an AWaRe community of practice under the AMR regional platform. Conduct virtual trainings on AWaRe classification, AMC reporting and stewardship integration. Include AWaRe assessments in regional AMR/regulatory reviews and NAP evaluations.
   - Advocate for AWaRe inclusion in donor-funded initiatives (Global Fund, World Bank and Fleming Fund) to support AMS and UHC efforts.

Progress on global and regional AMR commitments in the WHO African Region

Regional strategy for expediting the implementation and monitoring of NAPs on AMR, 2023–2030, in the WHO African region

This section presents progress towards the key performance indicators (KPIs) outlined in the Regional strategy for expediting the implementation and monitoring of national action plans on AMR (2023–2030) in the WHO African Region. The KPIs are based on the criteria defined in the WHO AFRO KPI Compendium, as detailed in the Performance Indicator Reference Sheet (PIRS)1. The analysis is informed by data reported through the 2024 TrACSS.

As shown in Table 1, between 2022 and 2024 significant progress was made in the WHO African Region towards implementing AMR NAPs, as outlined in the regional strategy. The most notable achievement was observed in One Health governance, where the number of countries with functional, multisectoral coordination mechanisms increased from 15 (32%) to 22 (46.8%). Substantial gains were also made in public awareness, with 18 countries (38.2%) conducting nationwide AMR awareness campaigns across sectors in 2024, more than double the eight countries (17%) reported in 2022. In the area of AMR surveillance, 25 countries (53.1%) were enrolled in and actively reporting to GLASS in 2024, compared to 16 (34%) in 2022, indicating a growing use of data for guiding national AMR policies and strategies.

Table 1. Progress on the regional AMR commitments in the WHO African Region

Regional strategy for expediting the implementation and monitoring of NAPs on AMR, 2023–2030, in the WHO African Region (targets)				
Indicator	**Definition**	**2022 baseline # (%)**	**2024 status # (%)**	**2030 target # (%)**
Percentage of Member States that have functional One Health AMR governance mechanisms which include defined roles and responsibilities across sectors and established accountability arrangements, thus achieving priority AMR interventions.	The indicator measures the proportion of countries in the WHO African Region that have established functional One Health AMR governance mechanisms to oversee the implementation of their national NAPs on AMR. A functional governance mechanism is one that meets all of the following criteria: the presence of dedicated human and financial resources to support the coordinating body, regular quarterly meetings of a multisectoral coordinating group, defined roles and responsibilities across sectors with clear terms of reference, and legal and institutional mandates that establish accountability for implementing and monitoring priority AMR activities.	15 (32%)	22 (46.8%)	47 (100%)

1 World Health Organization Regional office for Africa, KPI Compendium, 2023

Continued...

Regional strategy for expediting the implementation and monitoring of NAPs on AMR, 2023–2030, in the WHO African Region (targets)				
Indicator	**Definition**	**2022 baseline # (%)**	**2024 status # (%)**	**2030 target # (%)**
Percentage of Member States that have in-country M&E systems to track and report on the progress of NAPs.	This indicator measures how many countries in the WHO African Region have established national systems to monitor the implementation of their AMR NAPs. An in-country M&E system is considered established when it is well-coordinated and able to track progress towards planned AMR interventions. At the country level, a functional M&E system must meet at least two of the following four criteria: the existence of an M&E plan for the AMR NAP; the presence of a designated focal point or working group responsible for M&E; regular data collection across all relevant sectors; and timely submission of the annual TrACSS.	27 (57%)	32 (68%)	47 (100%)
Percentage of Member States that are conducting nationwide AMR awareness campaigns involving different sectors.	This indicator measures the extent to which countries in the WHO African Region are implementing broad, multi-sectoral public awareness efforts on AMR. AMR awareness campaigns are designed to improve knowledge and understanding of AMR through effective communication, education and training, while promoting responsible practices among the public and relevant sectors. At the national level, a country is considered to be conducting nationwide awareness campaigns if it meets at least two of the following three criteria: involvement of all priority sectors following the One Health approach; development and delivery of targeted messaging tailored to specific sectors and communities across the nation; and annual government support for nationwide or community-based campaigns, such as WAAW.	8 (17%)	18 (38.2%)	47 (100%)
Percentage of Member States that have enrolled in GLASS, and report and use data for decision-making.	This indicator measures the extent to which countries in the WHO African Region are engaged in GLASS by actively reporting data on a regular basis and using the data to inform decision-making, and ensuring the development of evidence-based strategies and interventions to combat AMR at the national level.	16 (34%)	25 (53.1%)	47 (100%)

Continued...

Regional strategy for expediting the implementation and monitoring of NAPs on AMR, 2023–2030, in the WHO African Region (targets)

Indicator	Definition	2022 baseline # (%)	2024 status # (%)	2030 target # (%)
Percentage of Member States that are implementing interventions to optimize responsible use of antimicrobials in health care facilities for improved patient outcomes.	This indicator measures the extent to which countries in the WHO African Region are implementing interventions that promote the responsible and appropriate use of antimicrobials in health care settings. These interventions typically include the reinforcement of national regulations and laws, the development and implementation of AMS policies, the establishment of guidelines for AMU, and regular M&E of antimicrobial prescribing practices in health care facilities.	20 (43%)	23 (48.9%)	47 (100%)

Next step

- Maintain active engagement with Member States to ensure the completion of the TrACSS survey, thereby enabling the preparation of a regional progress report on the implementation of the regional strategy. This report will be submitted biennially to the WHO Regional Committee for Africa, starting in 2025.

UNGA Political Declaration of the High-level Meeting on Antimicrobial Resistance

At the 79th United Nations General Assembly (UNGA) High-Level Meeting on AMR, global leaders endorsed a political declaration outlining clear targets and actions to address AMR. This section presents the progress made by the WHO African Region towards achieving the targets set in the political declaration. The analysis is informed by data gathered from the TrACSS Global Database and WHO GLASS AMR and AMU Dashboard as indicated in the Monitoring Framework for the WHO Strategic and Operational priorities to address drug-resistant bacterial infections (2025–2035).

Table 2. Progress on the Global AMR commitments in the WHO African Region

UNGA Political Declaration on Antimicrobial Resistance	
Targets	**2024 progress**
By 2030, all countries should have developed or updated and be implementing multisectoral national AMR action plans with clear targets, aligned with national capacities and priorities, and supported by effective coordination mechanisms and sustainable resources.	All 47 Member States have developed national AMR action plans, thus meeting a foundational milestone towards the 2030 target of all countries having multisectoral AMR NAPs. However, none of the countries have allocated dedicated financial resources for implementation within their national budgets, thereby highlighting a significant gap in meeting the global commitment to sustainable and well-funded AMR responses. Furthermore, 22 countries (46.8%) have established functional One Health AMR governance mechanisms, which are essential for effective multisectoral coordination and implementation of priority interventions.
Improve M&E of the implementation of multisectoral NAPs on antimicrobial resistance by building country-level technical capacity and ensure that 95% of countries participate in the annual TrACSS by 2030.	The WHO African Region has demonstrated strong progress, with all Member States (100%) participating in the 2024 TrACSS survey, thus exceeding the global participation target of 95%.
About 90% of countries meeting all WHO minimum requirements for IPC programmes at the national level by 2030.	Currently, 14.8% of Member States in the WHO African Region have implemented national IPC programmes aligned with WHO guidelines on the core components of IPC.
Improve access to diagnosis and care, so that at least 80% of countries can test resistance in all bacterial and fungal pathogens included in GLASS by 2030.	Substantial progress has been made in laboratory diagnostic capacity for bacterial AMR, with 95.7% of countries in the WHO African Region able to perform AST for critically important bacteria. However, a significant gap remains in fungal AMR surveillance, given that only 51% of countries have established the capacity to conduct AST for critically important fungi.
At least 70% of overall human antibiotic use globally within the WHO Access group by 2030 through investing in and strengthening stewardship programmes.	Five countries in the Region have attained this target, with overall regional antibiotic use comprising 62.5% from the WHO Access group. ** Moreover, 31 countries (65.9%) in the WHO African Region have adopted the AWaRe classification in their national EMLs. Among these, 19.1% (nine countries) are actively monitoring and reporting antibiotic consumption based on the AWaRe classification. While this indicator does not directly measure progress towards the above target, it reflects countries' capacity to track antibiotic use by AWaRe groups, providing essential data for assessing progress towards the 2030 target.
All countries to report quality surveillance data on AMR and AMU by 2030, through existing global surveillance systems, including GLASS.	Currently, 45 Member States (95.7%) in the WHO African Region are enrolled in GLASS and 27 (57.4%) countries have submitted national AMR data, while 12 (25.5%) countries have submitted AMU data at least once since 2021.

****Data are from eight countries that submitted GLASS AMC/AMU data and may not be representative of the entire Region.*

Next step

- Strengthen collaboration with the Food and Agriculture Organization, World Organisation for Animal Health, United Nations Environment Programme and other relevant stakeholders to contribute to the preparation of the progress report on the implementation of the current political declaration on AMR, to be presented at the eighty-first session of the UN General Assembly.

Key strategic actions for Member States of the WHO African Region

NAP development and implementation

- Prioritize the integration of financial provisions for AMR NAP implementation into national budgets, given that no country has incorporated such provisions since 2022.
- Update AMR NAPs into realistic, costed and budgeted operational plans that align with national priorities to facilitate more effective implementation and resource mobilization.

Multisectoral and One Health collaboration/coordination

- Prioritize the establishment of functional AMR multisectoral working groups and ensure they are supported by formalized coordination mechanisms with clearly defined terms of reference, regular meetings and defined funding and accountability structures.
- Engage the Quadripartite and other partners to provide technical assistance and resources aimed at strengthening the operational capacity of these working groups.

Raising awareness and education on AMR

- Integrate AMR awareness campaigns with other key programmes, such as World Hand Hygiene Day, IPC Week, World Health Day, World Tuberculosis Day, World Immunization Week and World Malaria Day, among others, to enhance sustainability and improve visibility.
- Regularly assess the effectiveness of AMR campaigns to ensure their continued impact in addressing AMR.

Training and professional education on AMR

- Expand AMR training and professional education programmes to ensure that they reach a broader range of health care workers and stakeholders.
- Systematically incorporate AMR into training curricula for human health professionals.

Strengthen the knowledge and evidence base through surveillance and research

- Enroll in GLASS to benefit from capacity-building and technical guidance provided by WHO for data generation and reporting on AMR.
- Collaborate with international partners to mobilize resources aimed at strengthening national AMR surveillance systems.

Monitoring system for antimicrobial consumption and use

- Collaborate with the Quadripartite for technical assistance and guidance in developing and implementing national systems for monitoring AMU and ensuring alignment with the GLASS-AMC.

Reducing the incidence of infection through effective sanitation, hygiene and infection prevention measures

- Prioritize the full implementation of national IPC and WASH programmes in alignment with WHO guidelines, and ensure that all core components are integrated into national health care systems.

Optimize the use of antimicrobial medicines

- Develop and strengthen national policies and guidelines to promote the appropriate use of antimicrobials, including the implementation of stewardship programmes across health facilities.
- Adopt and regularly update EMLs based on the WHO AWaRe classification to optimize antimicrobial selection and use.

Key interventions WHO and partners should prioritize to support Member States

1. **Deliver targeted technical assistance remotely:** provide one-on-one virtual clinics and host regional webinars on core topics (such as NAP costing, GLASS, One Health integrated surveillance, AMC/AMU, IPC and AMS). Maintain an on-demand technical helpdesk with templates, SOPs and guides aligned with TrACSS indicators.
2. **Accelerate AMR integration into health and development platforms:** promote alignment of AMR with NAPHS, UHC, disease programmes, national laboratories and other health strategies. Support embedding AMR costs in national budgets and development plans through tailored policy briefs and advocacy kits.
3. **Strengthen capacity for surveillance and stewardship:** offer remote training and eLearning modules on GLASS-AMR/AMU, AMS, IPC and lab surveillance via OpenWHO and regional hubs. Foster online mentorship and south-south exchanges to link early-stage countries with more advanced performers.
4. **Expand awareness and stewardship through campaigns:** promote WAAW as a flagship platform supported with adaptable regional toolkits. Encourage integration of AMR messaging into broader public health campaigns (for instance, WASH, immunization and patient safety). Support the implementation of nationwide AMR knowledge, attitudes and practices (KAP) surveys using regional tools and guidelines.
5. **Strengthen M&E with focused indicators:** help countries adopt simplified M&E frameworks based on TrACSS, and regional and global targets and create a regional dashboard to track progress. Build national capacity through remote coaching and hands-on guidance for tracking key AMR indicators.
6. **Mobilize resources and forge strategic partnerships:** support development of national resource mobilization strategies and facilitate dialogue with donors and partners. Advocate for pooled regional support mechanisms to boost action in resource-constrained settings.

By adopting these practical and scalable actions, WHO can help Member States advance towards TrACSS Levels C/D/E targets by 2027, despite financial and staffing constraints, while sustaining momentum towards the 2030 regional and global targets on AMR.

Conclusion

The 2024 TrACSS survey reveals that countries in the WHO African Region have made commendable strides in advancing the implementation of their national AMR action plans, with nearly all Member States engaging in core areas such as awareness, surveillance, stewardship, IPC and policy development. Significant milestones have been achieved, most notably 100% of countries now have NAPs, a majority of countries have initiated AMR awareness and IPC activities, and the integration of tools like the AWaRe classification and GLASS continue to expand.

However, the survey also highlights persistent and widespread gaps that must be urgently addressed to meet the targets outlined in the WHO Regional Strategy (2023–2030) and the 2024 UNGA Political Declaration. Critical challenges include the lack of dedicated domestic financing for AMR implementation, limited multisectoral coordination, weak training and stewardship programmes, and fragmented surveillance of AMU and fungal AMR. Furthermore, only very few countries have achieved the most advanced level (Level E) across any of the TrACSS indicators.

To bridge these gaps in the context of constrained resources and workforce limitations, stakeholders, WHO and partners must strategically refocus their technical support to maximize impact using cost-effective, scalable and mostly remote modalities.

Annexes

Annex 1. Summary of country response, TrACSS, 2024

(Red–no capacity; orange–limited capacity; yellow–developed capacity; green–demonstrated capacity; dark green–sustained capacity).

Country	Multi-sector and One Health collaboration/ coordination	Country progress with development of a NAP on AMR	Raising awareness and understanding of AMR risks and response	Training and professional education on AMR	National monitoring system for consumption and rational use of anti-microbials	National surveil-lance system for AMR	IPC	Optimizing AMU	Adoption of "AWaRe" classification of antibiotics in the NEML
Algeria	D	C	E	C	D	D	D	C	B
Angola	A	A	A	C	A	B	No Data	B	A
Benin	B	D	B	B	D	B	B	A	D
Botswana	B	B	D	C	A	B	C	A	B
Burkina Faso	E	D	C	C	D	D	B	C	D
Burundi	B	D	D	B	A	D	B	A	C
Cabo Verde	B	B	C	C	A	B	B	A	B
Cameroon	A	C	D	B	A	D	B	A	B
Central African Republic	E	D	B	C	A	B	B	C	B
Chad	B	B	B	A	A	D	B	A	C
Comoros	B	C	C	A	A	A	B	A	A
Congo	D	D	B	C	A	B	C	A	C
Côte d'Ivoire	E	D	D	C	D	D	D	C	D
Democratic Republic of the Congo	B	B	C	C	A	D	C	C	C
Equatorial Guinea	D	B	A	A	A	A	A	A	A
Eritrea	C	D	D	C	A	B	C	B	B
Eswatini	C	C	C	C	E	D	C	C	B
Ethiopia	D	D	D	C	D	D	C	C	D
Gabon	A	D	B	A	E	B	B	A	C
Gambia	B	D	D	B	B	B	A	C	C
Ghana	D	D	C	C	D	D	C	C	C
Guinea	C	D	C	C	B	D	B	C	B
Guinea-Bissau	C	B	B	C	B	B	B	B	C
Kenya	D	D	D	C	D	D	D	C	E
Lesotho	B	C	D	B	B	A	C	B	C
Liberia	D	D	D	C	B	C	C	C	C
Madagascar	B	C	D	C	A	C	C	A	C
Malawi	B	A	B	C	E	D	D	D	E
Mali	E	D	B	C	B	D	E	C	D
Mauritania	B	B	B	A	A	A	A	A	A
Mauritius	B	C	C	C	A	D	C	C	C
Mozambique	A	C	D	C	B	B	C	B	C
Namibia	B	C	D	C	C	C	C	C	C
Niger	B	B	D	C	B	D	C	B	B
Nigeria	C	D	C	C	B	D	C	C	C
Rwanda	C	C	B	C	B	D	D	C	B
Sao Tome and Principe	A	C	C	B	B	B	C	A	C
Senegal	B	D	D	B	A	B	B	C	C
Seychelles	A	B	C	B	A	B	C	A	C
Sierra Leone	C	D	B	C	B	B	C	A	B
South Africa	C	C	B	C	B	D	C	C	C
South Sudan	B	B	B	B	A	A	B	A	C
Togo	A	D	C	B	A	C	B	B	B
Uganda	B	C	C	C	D	D	C	D	E
United Republic of Tanzania	D	D	D	C	E	D	D	C	E
Zambia	C	D	C	C	A	D	C	D	C
Zimbabwe	C	D	D	C	C	C	C	B	C

Annex 2. List of countries that participated in TrACSS 2024

S/No.	Country	World Bank income group
1.	Algeria	MIC (upper)
2.	Angola	LIC
3.	Benin	MIC (lower)
4.	Botswana	MIC (upper)
5.	Burkina Faso	LIC
6.	Burundi	LIC
7.	Cabo Verde	MIC (lower)
8.	Central African Republic	LIC
9.	Chad	LIC
10.	Comoros	MIC (lower)
11.	Congo	LIC
12.	Côte d'Ivoire	MIC (lower)
13.	Cameroon	MIC (lower)
14.	Democratic Republic of the Congo	LIC
15.	Equatorial Guinea	MIC (upper)
16.	The Gambia	LIC
17.	Eritrea	LIC
18.	Eswatini	MIC (lower)
19.	Ethiopia	LIC
20.	Gabon	MIC (upper)
21.	Ghana	MIC (lower)
22.	Guinea	LIC
23.	Guinea-Bissau	LIC
24.	Kenya	MIC (lower)
25.	Lesotho	MIC (lower)
26.	Liberia	LIC
27.	Madagascar	LIC
28.	Malawi	LIC
29.	Mali	LIC

Continued...

S/No.	Country	World Bank income group
30.	Mauritania	MIC (lower)
31.	Mauritius	MIC (upper)
32.	Mozambique	LIC
33.	Namibia	MIC (upper)
34.	Niger	LIC
35.	Nigeria	MIC (lower)
36.	Rwanda	LIC
37.	Sao Tome and Principe	MIC (lower)
38.	Senegal	LIC
39.	Seychelles	HIC
40.	Sierra Leone	LIC
41.	South Africa	MIC (upper)
42.	South Sudan	LIC
43.	Togo	LIC
44.	Uganda	LIC
45.	United Republic of Tanzania	MIC (lower)
46.	Zambia	MIC (lower)
47.	Zimbabwe	LIC

Annex 3. TrACSS questionnaire

The TrACSS questionnaire remains unchanged in 2024 from the 2023 version and can be accessed at: https://cdn.who.int/media/docs/default-source/antimicrobial-resistance/tracss-7.0-questionnaire-final.pdf?sfvrsn=c17bccd2_1&download=true.

The WHO Regional Office for Africa

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Benin
Botswana
Burkina Faso
Burundi
Cabo Verde
Cameroon
Central African Republic
Chad
Comoros
Congo
Côte d'Ivoire
Democratic Republic of the Congo
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Gabon
Gambia
Ghana
Guinea
Guinea-Bissau
Kenya
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