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Pressure points

Africa's health systems amid global aid contraction

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Afrobarometer Policy Paper No. 101 | April 2026

Introduction

Since the COVID-19 pandemic, African governments have been compelled to reassess how best to protect hard-won public health gains while ensuring equitable and reliable care. These reassessments are taking place against a background of shifting geopolitical alignments, tightening fiscal space, and growing public expectations of quality public services. This reckoning intensified in 2025 with the disbanding of the United States Agency for International Development (USAID) and the cancellation of major foreign-funded health programmes, effectively dismantling one of the pillars of Africa's health-support architecture.

For more than two decades, USAID served as the operational backbone of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), translating the initiative's strategic vision into the clinics, supply chains, community programmes, and health-systems infrastructure that sustained much of Africa's HIV response (KFF, 2025). The loss of USAID introduced profound uncertainty regarding PEPFAR's future and signalled the erosion of the institutional machinery that had underpinned progress in HIV prevention and treatment across the continent (UNAIDS, 2025). Although a temporary waiver by the U.S. government permitted the continued supply of essential antiretroviral medicines, available estimates indicate that roughly 65% of USAID-managed PEPFAR awards were terminated or left in limbo, leaving millions of beneficiaries across sub-Saharan Africa exposed (Godbole, 2025, KFF, 2025).

Crucially, the shock to HIV/AIDS programming has reverberated beyond the HIV sector, exposing systemic vulnerabilities across health systems. Facilities, supply chains, and human-resource systems originally built around PEPFAR had evolved into core components of primary health care in several countries. As these platforms falter, the ripple effects have been immediate and far-reaching: drug shortages, supply-chain breakdowns, staffing disruptions, and widening health-care-delivery gaps (Cullinan, 2025). These consequences, documented by Médecins Sans Frontières (2025) and echoed in national health ministry reports, point to a broader destabilisation of the health-system foundations upon which many African countries have come to rely since 2000.

At the same time, persistent fiscal constraints have weakened African governments' ability to cushion the shock. The last three years have seen recurrent health-worker strikes and service disruptions in South Africa (Al Jazeera, 2023), Uganda (Abet, 2024), Kenya (Reuters, 2024), and Ethiopia (Human Rights Watch, 2025) as frontline staff protest unpaid allowances and deteriorating working conditions. In August 2025, Botswana declared a public-health emergency after its national medical supply chain failed, forcing the army to distribute scarce medicines across major hospitals (Al Jazeera, 2025). The Malawian government also warned of imminent tuberculosis-drug stockouts amid global aid cuts and domestic logistics bottlenecks (Masauli, 2025). In Zambia, revelations of widespread theft of donated medicines led the U.S. government to suspend $50 million in health aid and prompted forensic audits (U.S. Embassy in Zambia, 2025).

Together, external uncertainty and internal fiscal strain have deepened the cracks in health-system resilience, reinforcing the urgency to rethink Africa's health-financing architecture. Across the continent, reform and experimentation toward universal health coverage (UHC) are underway. In Ghana, the government increased National Health Insurance Scheme funding from GH¢ 5.9 billion in 2024 to GH¢ 9.8 billion in 2025 (Ghana Ministry of Finance & Economic Planning, 2025a, b), and enrolment was reported at around 18 million members in mid-2025, though official figures vary across government sources (Ghana National Health Insurance Authority, 2025). In Kenya, the National Hospital Insurance Fund has similarly undergone major reforms, including benefit expansion, civil-servant schemes, and subsidy mechanisms. That said, formal social health-insurance uptake remains limited: Only 17% of the population was covered in 2023, comprising just 27% of informal-sector workers (Nungo, Filippon, & Russo, 2024). In Nigeria, the passage of the National Health Insurance Authority Act of 2022 and the rollout of its implementation plan between 2023 and 2025 marked an important policy shift toward mandatory health coverage for all residents (Ilesanmi, Afolabi,

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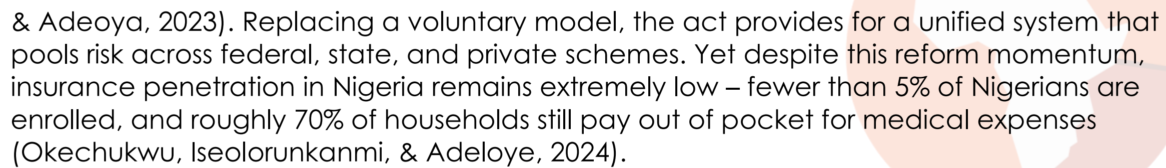


& Adeoya, 2023). Replacing a voluntary model, the act provides for a unified system that pools risk across federal, state, and private schemes. Yet despite this reform momentum, insurance penetration in Nigeria remains extremely low – fewer than 5% of Nigerians are enrolled, and roughly 70% of households still pay out of pocket for medical expenses (Okechukwu, Iseolorunkanmi, & Adeloye, 2024).

Vaccine-production hubs in Senegal, South Africa, and Egypt illustrate Africa's growing ambition to localise supply chains and strengthen health sovereignty (World Health Organization, 2021; Abdullahi et al., 2025). Meanwhile, digital health innovations – from mobile health to data-driven monitoring platforms – are beginning to fill gaps left by retreating donor programmes, though their impact remains uneven (Ahmed et al., 2025; Qoseem et al., 2024).

Amid these dynamics in the health sector, we draw on Afrobarometer survey data to explore how ordinary Africans are experiencing their health systems in transition.

Across 38 countries surveyed between January 2024 and September 2025, Africans rank health as the top policy issue that they want their governments to address, dislodging unemployment. In fact, fully seven in 10 Africans say their governments should ensure that all citizens have access to adequate health care even if that means they pay higher taxes.

In practice, persistent financing and delivery challenges in the health sector continue to impact citizens negatively. Most Africans say they worry about their ability to obtain and afford needed medical care. Among respondents who had contact with a public hospital or clinic in the past 12 months, many report difficulties accessing medical care and cite shortages of medical supplies, long wait times, and high costs.

Taken together, these findings reveal a continent undergoing a profound recalibration. With traditional pillars of health-care financing from external sources eroding and fiscal space tightening, African governments face the urgent task of aligning policy ambition with institutional capability. Yet the most enduring lesson from the ongoing transition is that health-system resilience must take into account the lived realities of citizens.

Afrobarometer surveys

Afrobarometer is a pan-African, nonpartisan survey research network that provides reliable data on African experiences and evaluations of democracy, governance, and quality of life. Ten survey rounds in up to 42 countries have been completed since 1999. Round 10 surveys (2024/2025) cover 38 countries. (See Appendix Table A.1 for a list of countries and fieldwork dates.)

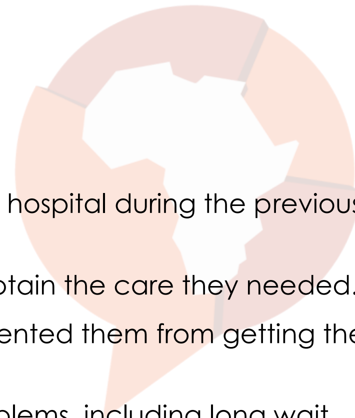
Afrobarometer's National Partners conduct face-to-face interviews in the language of the respondent's choice that yield country-level results with margins of error of +/-2 to +/-3 percentage points at a 95% confidence level. The Round 10 data set used in this analysis consists of 45,600 interviews, weighted to ensure nationally representative samples. Multi-country averages are presented using equal weighting across countries rather than population-proportional weights.

Key findings

On prioritisation of health care:

- On average across 38 surveyed countries, health ranks as the most important problem that Africans want their governments to address, overtaking unemployment at the top of citizens' policy agenda.

- Seven in 10 Africans (70%) say their governments should ensure that all citizens have access to adequate health care, even if that means raising taxes.



On experiences with the health system:

- Among Africans who had contact with a public clinic or hospital during the previous year:
  - Half (51%) say it was "difficult" or "very difficult" to obtain the care they needed.
  - Almost two-thirds (63%) indicate that high costs prevented them from getting the care or medicines they needed.
  - Majorities report encountering a variety of other problems, including long wait times (79%), a lack of medicines or other supplies (71%), facilities in poor condition (58%), and/or absent doctors or other medical staff (56%).
- Almost two-thirds (65%) of Africans say that they or a family member went without needed health care during the previous year, including 26% who say this happened "many times" or "always."

On health insurance and health-care vulnerability:

- On average across 36 countries, most citizens (79%) say they do not have any form of medical-aid coverage.
  - The most common reasons for not having medical aid are that people can't afford it (35%), don't know of any available health-insurance schemes (33%), and find enrolment procedures complicated (11%).
- More than half (53%) of Africans say they worry "a lot" that if they or someone in their family gets sick, they will not be able to obtain or afford needed medical care. Another 35% say they worry "somewhat" or "a little."

On government performance on improving basic health services:

- Fewer than half (45%) of Africans say their government is performing "fairly well" or "very well" on improving basic health services, though assessments vary widely by country.

Health-care delivery: The context

Health-care infrastructure

As part of the data-collection process, Afrobarometer fieldwork teams observe and document local infrastructure, including hospitals and clinics within walking distance of the sampled enumeration area (EA). Since the sampled EAs are nationally representative, the data provide reliable indicators of infrastructure and service availability for the country.[1]

On average across 38 countries, Afrobarometer teams found health clinics or hospitals within easy walking distance of nearly half (47%) of EAs. However, as Figure 1 shows, the presence of health facilities varies widely across countries and by urban-rural location.

As might be expected, clinics are considerably more accessible in urban (63%) than in rural areas (44%), with the rural-urban gap exceeding 30 percentage points in Morocco (35 points), Zambia (35 points), Eswatini (37 points), Malawi (41 points), and Liberia (46 points).

[1] Afrobarometer samples are based on a selection of EAs drawn randomly from the national census frame. In most countries, eight interviews are conducted in each selected EA, so interview teams usually visit between 150 (for surveys with n=1,200) and 300 (for surveys with n=2,400) EAs. Because of the smaller sample sizes, the margin of error on the results reported for the presence of health clinics is higher than for findings captured in individual interviews.

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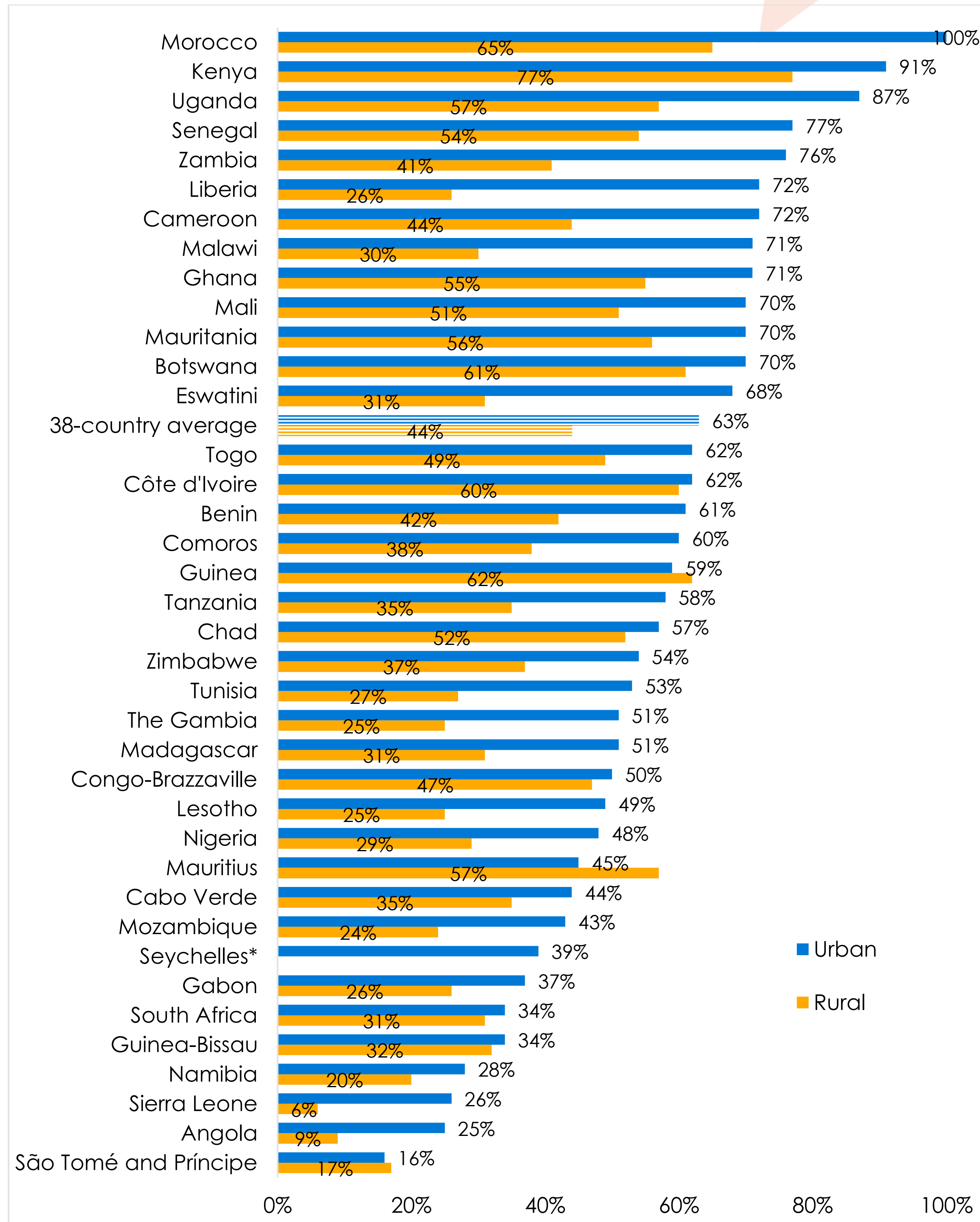
Almost all sampled urban residents in Morocco (100%), Kenya (91%), and Uganda (87%) live within walking distance of a clinic, while the same is true for just 16% of urban residents in São Tomé and Príncipe and 25% in Angola. In rural areas, Kenyans (77%) have the best chance of having a nearby health clinic, while only 6% of Sierra Leoneans can say the same.

Figure 1: Clinic in enumeration area or within easy walking distance | by urban-rural location | 38 countries | 2024/2025



Afrobarometer data collectors were asked: *Are the following facilities present in the primary sampling unit/enumeration area or within easy walking distance: Health clinic (private or public or both)?*
** In Seychelles, all surveyed EAs are considered urban.*

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Mauritius presents a distinctive pattern: Rural EAs are more likely than urban EAs to have a clinic within walking distance (57% vs. 45%). However, this finding should be interpreted with caution. During early rounds of fieldwork in Mauritius, there was considerable discussion among field teams about what constitutes "easy walking distance." In some instances, facilities that were visible from an EA were nonetheless judged too distant to qualify under Afrobarometer's definition. Moreover, as a geographically small and highly connected island state, Mauritius differs from larger countries in that major hospital facilities in the capital and other urban centres are accessible to much of the population within a short drive. Thus, while not always within walking distance of sampled EAs, health-care infrastructure may still be relatively accessible in practical terms.

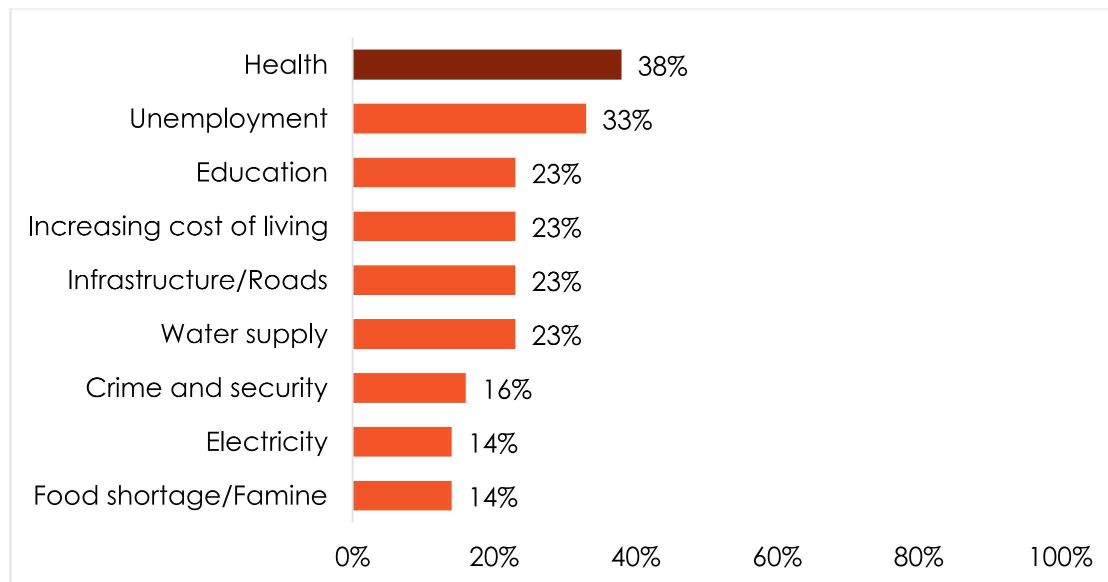
Demand for health care

Given the persistent challenges facing health-care financing in African, now further complicated by the withdrawal of USAID support, what do Africans expect from their own governments?

Across the 38 surveyed countries, health emerges, for the first time in Afrobarometer surveys, as the most important problem that Africans want their governments to address (Figure 2). On average, 38% of respondents cite health among their top three policy concerns, placing it ahead of unemployment (33%) as well as education, the increasing cost of living, infrastructure/roads, and water supply (all 23%).

This represents a notable shift from Afrobarometer's Round 9 (2021/2023) findings, when health trailed unemployment as the continent's leading concern. The fact that health has now overtaken unemployment probably suggests the extent to which rising costs of care, disruptions in service provision, donor retreat, and wider system fragilities are being felt across the continent.

Figure 2: Policy priorities | 38 countries | 2024/2025



Respondents were asked: *In your opinion, what are the most important problems facing this country that government should address? (Figure shows % of respondents who cite each problem as one of up to three priorities. The health category also includes responses coded as "illness/sickness," "HIV/AIDS," and "COVID-19.")*

The ranking of health as the top policy priority is reflected in strong public sentiment that access to health care should be a guaranteed right. Across the 38 surveyed countries, Africans overwhelmingly (70%) support the idea that governments must ensure health care for all, even if doing so requires higher taxes (Figure 3).

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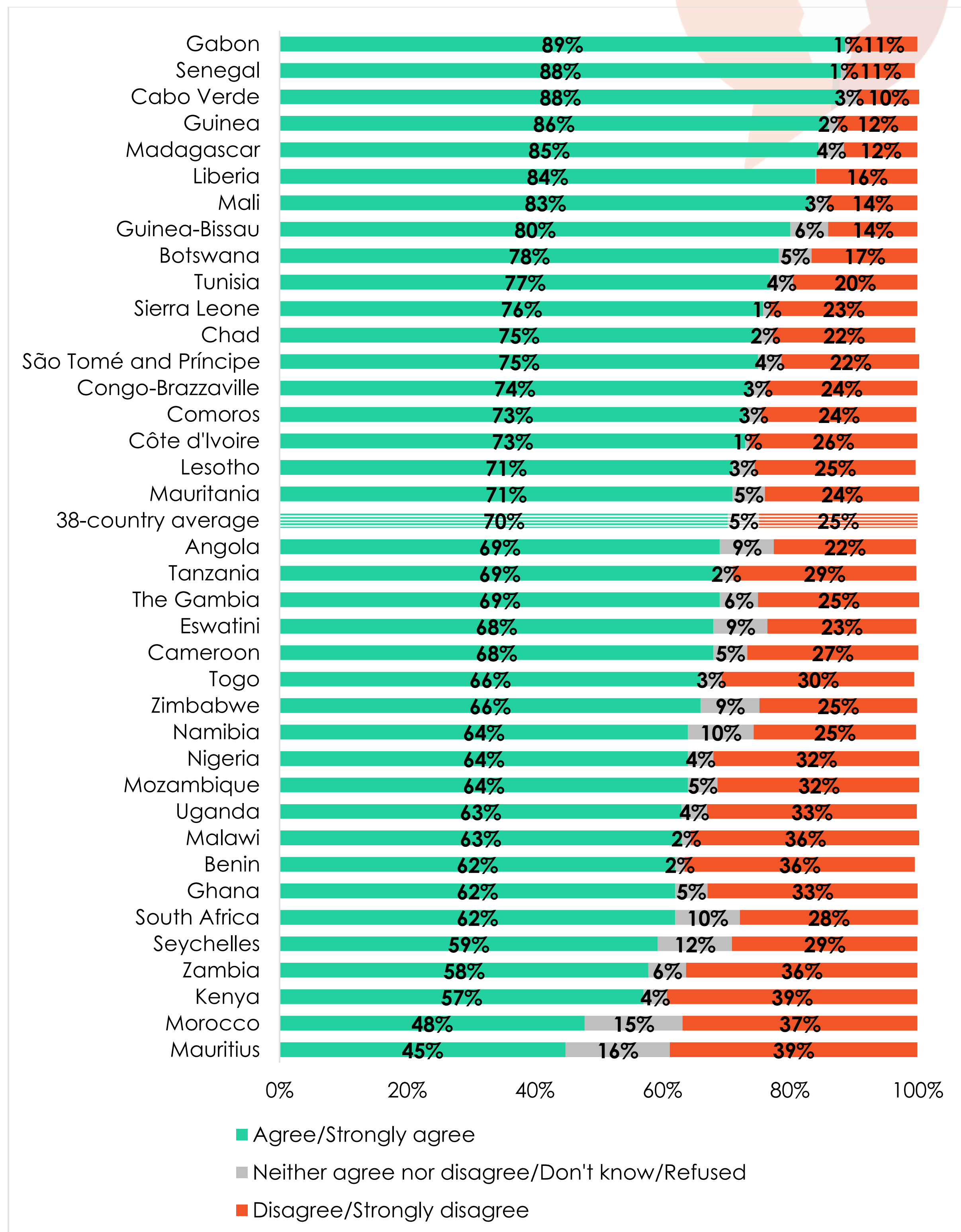
Figure 3: Government should ensure health care for all, even if taxes must go up | 38 countries | 2024/2025



Respondents were asked: *Please tell me whether you agree or disagree with the following statement: Government should ensure that all citizens have access to adequate health care, even if that means raising taxes.*

This sentiment is very strong in several countries, notably Gabon, Senegal, and Cabo Verde, where nearly nine in 10 respondents support health care for all citizens. Such strong support

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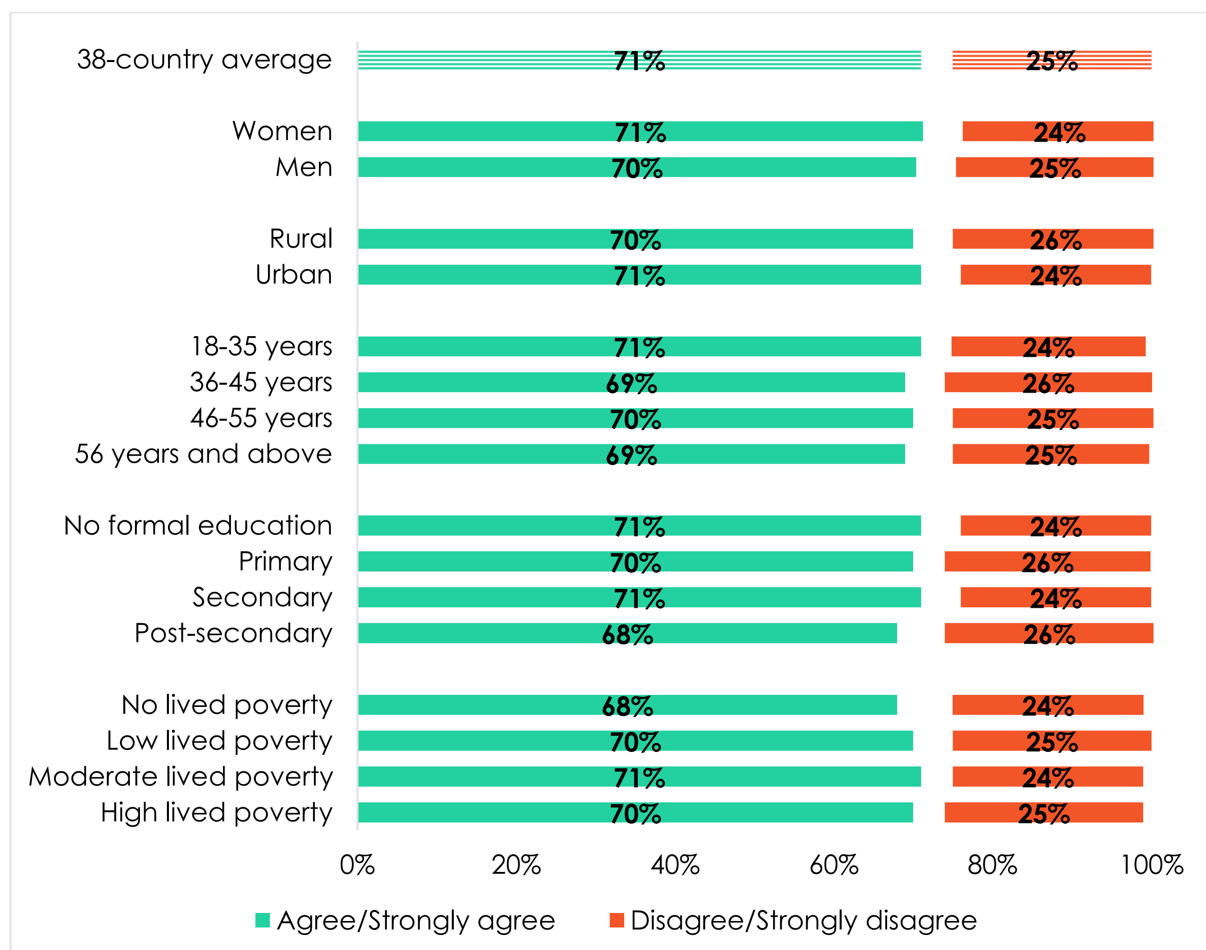
may reflect both high expectations of the state and the continued centrality of public health systems in people's everyday lives.

Opposition to health care for all if it might require higher taxes is a minority view in all surveyed countries. Even in countries with relatively high disapproval – Mauritius (39%), Kenya (39%), Morocco (37%), Zambia (36%), Benin (36%), and Malawi (36%) – support still outweighs opposition.

Individual demographics do not appear to matter: Support for universal health care is consistently high (exceeding two-thirds of respondents) across all major demographic groups (Figure 4).

These findings suggest that Africans from all walks of life, regardless of their social or economic standing, overwhelmingly believe that government should take responsibility for ensuring adequate health care for all, even if achieving that goal requires raising taxes. Public expectations for UHC are thus politically robust, offering governments a strong social mandate to pursue reforms and expand investment in the health sector.

Figure 4: Government should ensure health care for all, even if taxes must go up | by demographic group | 38 countries | 2024/2025



Respondents were asked: *Please tell me whether you agree or disagree with the following statement: Government should ensure that all citizens have access to adequate health care, even if that means raising taxes.*

Experience with the health-care system

If Africans rank health at the top of their policy agenda and call for tax-funded health care for all, how do these stances align with their experience of health-care delivery?

Contact with health-care facilities

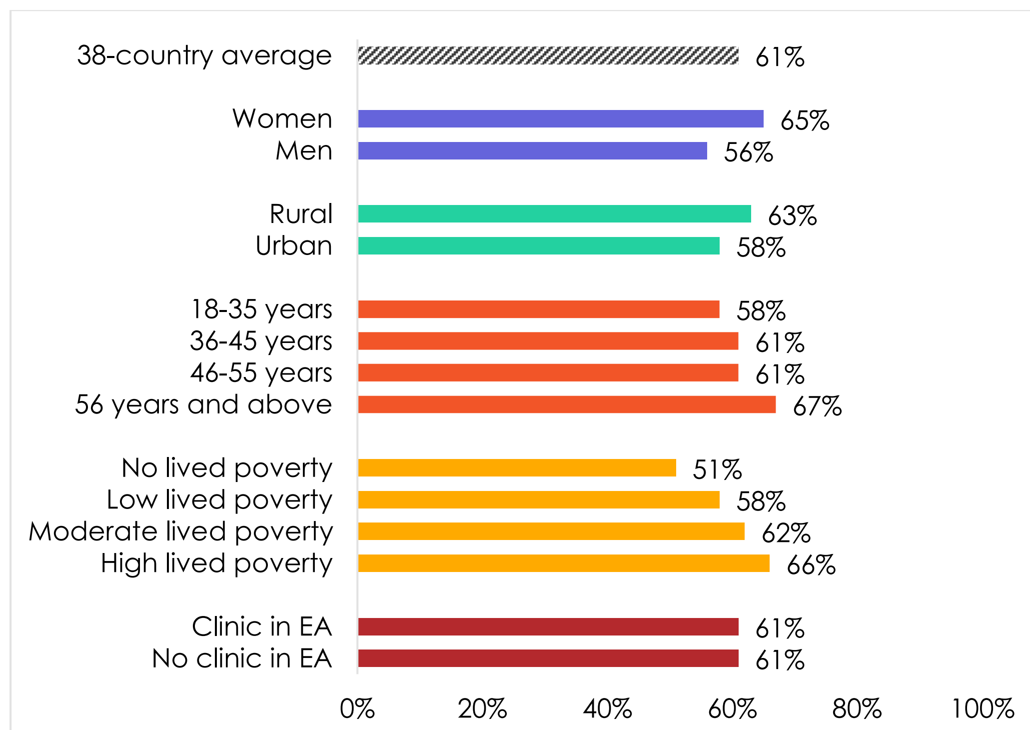
On average, 61% of Africans had contact with a public clinic or hospital during the year preceding the survey (Figure 5). This average masks substantial differences across demographic categories. Significantly more women than men report visiting a public health facility (65% vs. 56%). This gender gap reflects well-documented differences in health-seeking behaviour, including women's greater engagement with reproductive, maternal, and preventive health services (Galdas, Cheater, & Marshall, 2005).

Geographic location also shapes patterns of contact. Despite having fewer health facilities within easy reach (Figure 1 above), rural residents (63%) are more likely than urbanites (58%) to report contact with public clinics. This can be attributed to the fact that in many settings, public clinics constitute the backbone of rural health systems, while urban residents have comparatively greater access to private providers.

Use of public health services increases with age, from 58% among 18- to 35-year-olds to 67% among those over age 55.

Socioeconomic conditions emerge as a particularly strong differentiator for visiting a public health facility. Citizens experiencing high lived poverty[2] (66%) are far more likely to depend on public health facilities than those who are economically well off (51%). For low-income households, public facilities tend to be the only affordable or accessible option, highlighting their role as a critical safety net.

Figure 5: Contact with a public clinic or hospital | by demographic group | 38 countries | 2024/2025



***Respondents were asked:** In the past 12 months, have you had contact with a public clinic or hospital?*

[2] Afrobarometer's Lived Poverty Index (LPI) measures respondents' levels of material deprivation by asking how often they or their families went without basic necessities (enough food, enough water, medical care, enough cooking fuel, and a cash income) during the preceding year. For more on lived poverty, see Mattes and Lekalake (2025).

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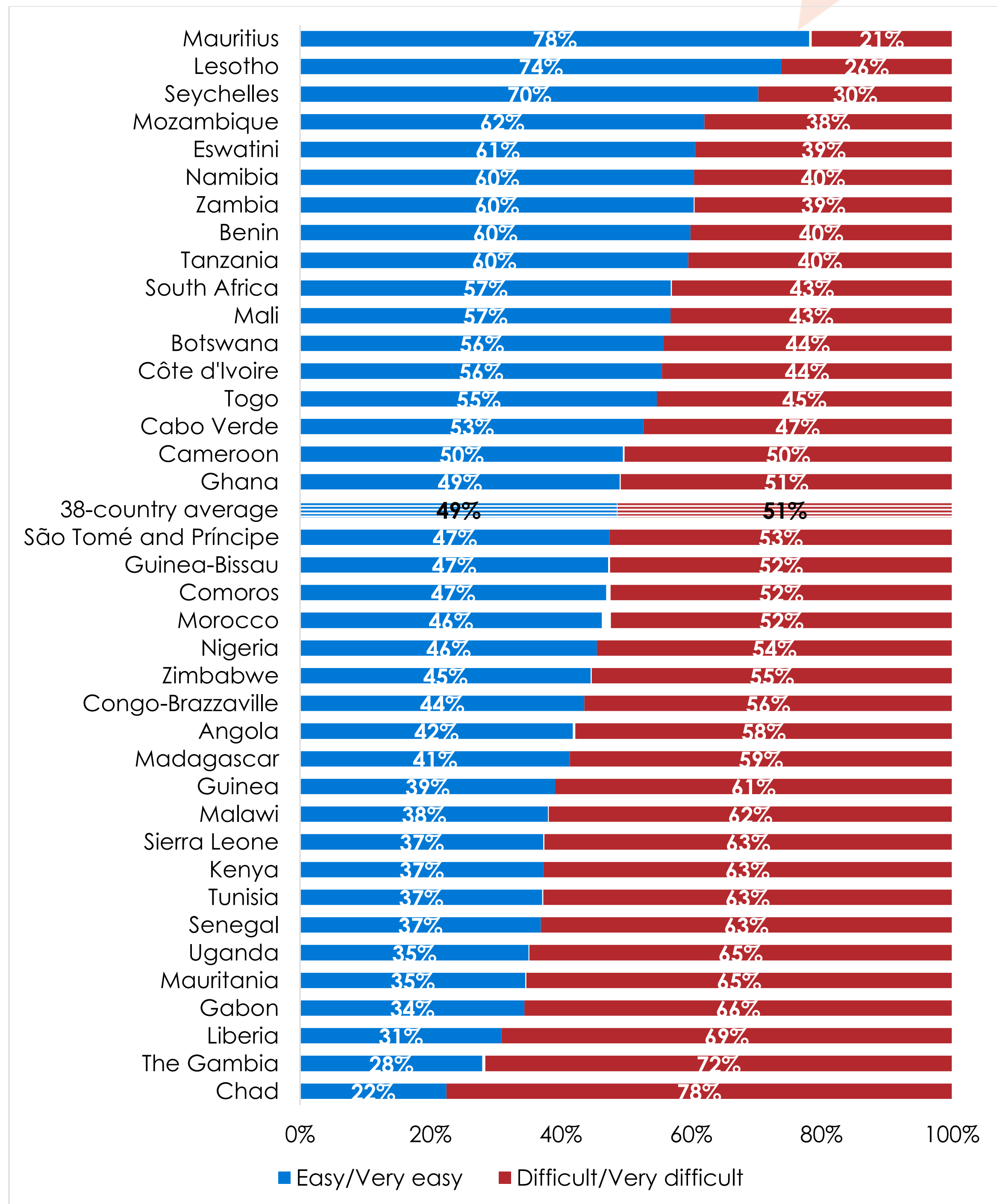
Ease of obtaining health care

About half (49%) of respondents who made contact with the public health-care system during the previous year say it was "easy" or "very easy" to obtain the services they needed, while a slim majority (51%) found it "difficult" or "very difficult" (Figure 6).

Figure 6: Ease of obtaining medical care at public health facilities | 38 countries | 2024/2025



Respondents who had contact with a public clinic or hospital during the previous year were asked: *How easy or difficult was it to obtain the medical care or services you needed? (Respondents who did not have contact with a public clinic or hospital are excluded.)*

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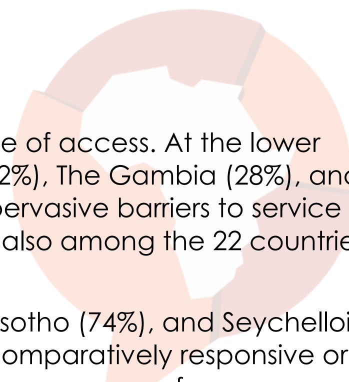


Country-level patterns reveal striking disparities in perceived ease of access. At the lower end of the spectrum, fewer than one-third of citizens in Chad (22%), The Gambia (28%), and Liberia (31%) say it was easy to obtain medical care, signalling pervasive barriers to service access. Gabon (34%), Mauritania (35%), and Uganda (35%) are also among the 22 countries where fewer than half of citizens report easy access.

At the opposite extreme, large majorities of Mauritians (78%), Basotho (74%), and Seychellois (70%) report that they obtained services with ease, suggesting comparatively responsive or more accessible health-care systems. A second group of above-average performers – including Mozambique (62%), Eswatini (61%), Namibia (60%), Zambia (60%), Benin (60%), and Tanzania (60%) – also stand out for their relatively favourable access conditions.

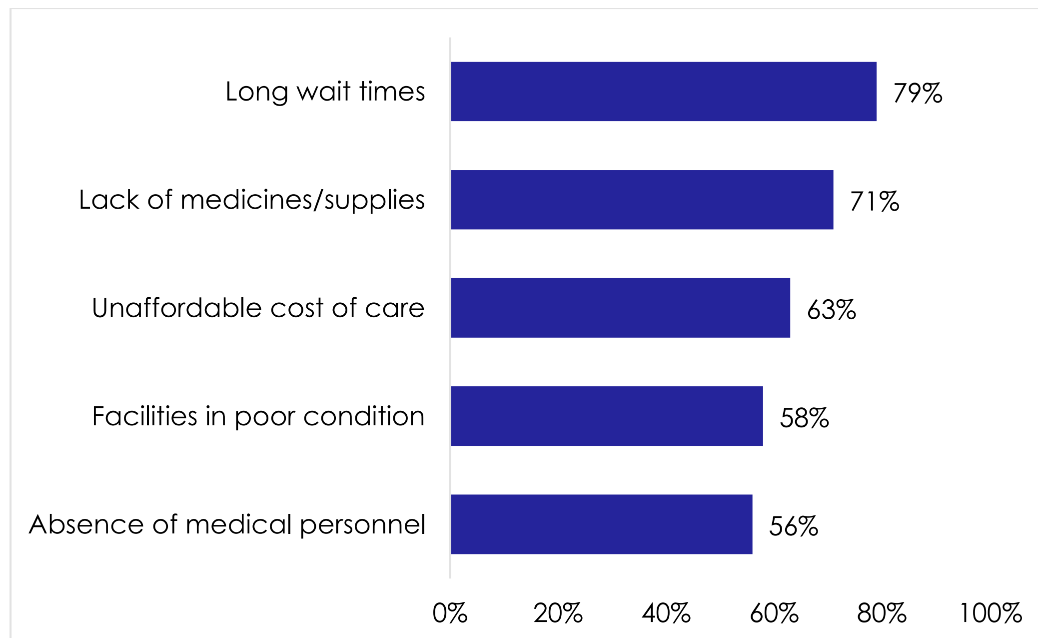
The gap of more than 50 percentage points between the lowest- and highest-scoring countries highlights large differences in health-system capacity, service organisation, and the geographic reach of care across the continent.

Problems encountered at health facilities

Among Africans who had contact with a public health facility, experiences of poor service quality are widespread (Figure 7). The most frequently reported problem is long wait times; eight in 10 respondents (79%) say they experienced excessive waits "once or twice," "a few times," or often" during the previous year.

Majorities also report encountering a lack of medicines or supplies (71%), high costs that prevented them from getting the care or medicines they needed (63%), facilities in poor condition (58%), and/or the absence of medical personnel (56%). Taken together, these findings suggest that service-quality challenges are systemic.

Figure 7: Poor service quality encountered at public health facilities | 38 countries* | 2024/2025



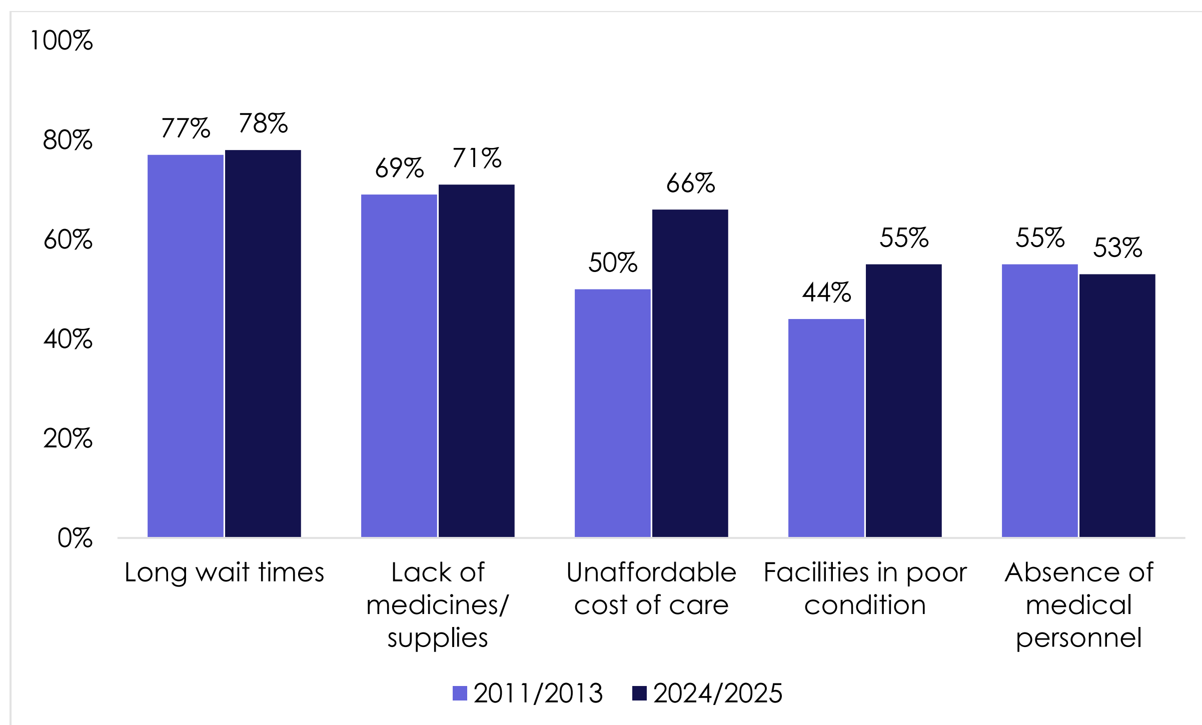
Respondents who had contact with a public clinic or hospital during the previous year were asked: *And have you encountered any of these problems with a public clinic or hospital during the past 12 months: Lack of medicines or other supplies? Absence of doctors or other medical personnel? Long waiting times? Poor condition of facilities? High cost that prevented you from getting the care or medicines you needed? (% who say "once or twice," "a few times," or "often") (Respondents who did not have contact with a public clinic or hospital are excluded.)*

**Question about unaffordable cost of care was not asked in Mauritius.*

Comparing reported problems across 27 countries surveyed consistently between 2011/2013 and 2024/2025, long wait times have held steady as the most frequently reported problem, while lack of medicines or supplies remains almost unchanged in second place (Figure 8).

Two areas show sharp deterioration: The proportions reporting unaffordable costs and poorly maintained facilities increased by 16 and 11 percentage points, respectively. Absent medical personnel remains a majority experience, just as it was more than a decade ago.

Figure 8: Poor service quality encountered at public health facilities | 27 countries* | 2011-2025



Respondents who had contact with a public clinic or hospital during the previous year were asked: *And have you encountered any of these problems with a public clinic or hospital during the past 12 months: Lack of medicines or other supplies? Absence of doctors or other medical personnel? Long waiting times? Poor condition of facilities? High cost that prevented you from getting the care or medicines you needed? (% who say "once or twice," "a few times," or "often") (Respondents who did not have contact with a public clinic or hospital are excluded.)*

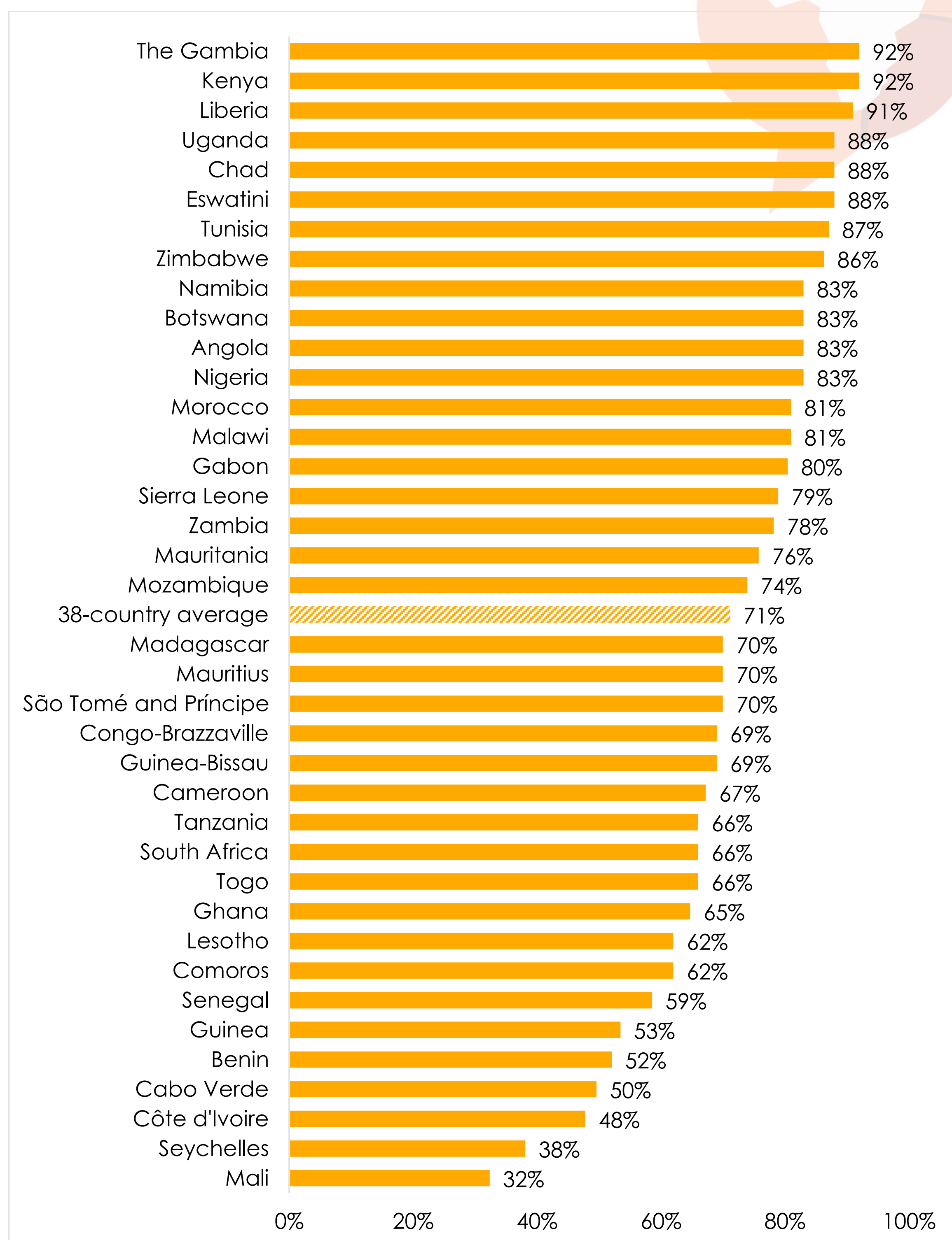
**Question about unaffordable cost of care was not asked in Mauritius.*

Note: Two questions were phrased slightly differently in 2011/2013: The question about facilities asked about "dirty" facilities, and the question about staff asked about "absent doctors."

Shortages of medicines and supplies at public health facilities are a common experience across the continent, though the severity varies considerably by country (Figure 9). Country-level prevalence ranges from a low of 32% in Mali to a high of 92% in Kenya and The Gambia – a 60-percentage-point spread that underscores the uneven distribution of this challenge across African public health systems.

Shortages of medicines and supplies are a majority experience in all surveyed countries except Mali, Seychelles (38%), Côte d'Ivoire (48%), and Cabo Verde (50%), indicating that stockouts are not an exceptional occurrence but a routine feature of public health care for most Africans. Notably, several middle-income or relatively well-resourced countries, including Morocco (81%), Botswana (83%), and Namibia (83%), record rates well above the continental average, suggesting that the problem is not confined to the continent's lower-income settings.

Figure 9: Encountered a lack of medicines or supplies | 38 countries | 2024/2025



Respondents who had contact with a public clinic or hospital during the previous year were asked: *And have you encountered any of these problems with a public clinic or hospital during the past 12 months: Lack of medicines or other supplies? (% who say "once or twice," "a few times," or "often") (Respondents who did not have contact with a public clinic or hospital are excluded.)*

Long wait times at public health facilities, the most pervasive and geographically widespread service-quality problem reported across the continent, are particularly common in Morocco (95%), Tunisia (94%), Gabon (93%), Mauritius (93%), Chad (91%), and Namibia (90%) (Figure 10). Notably, the presence of higher-income countries such as Morocco,

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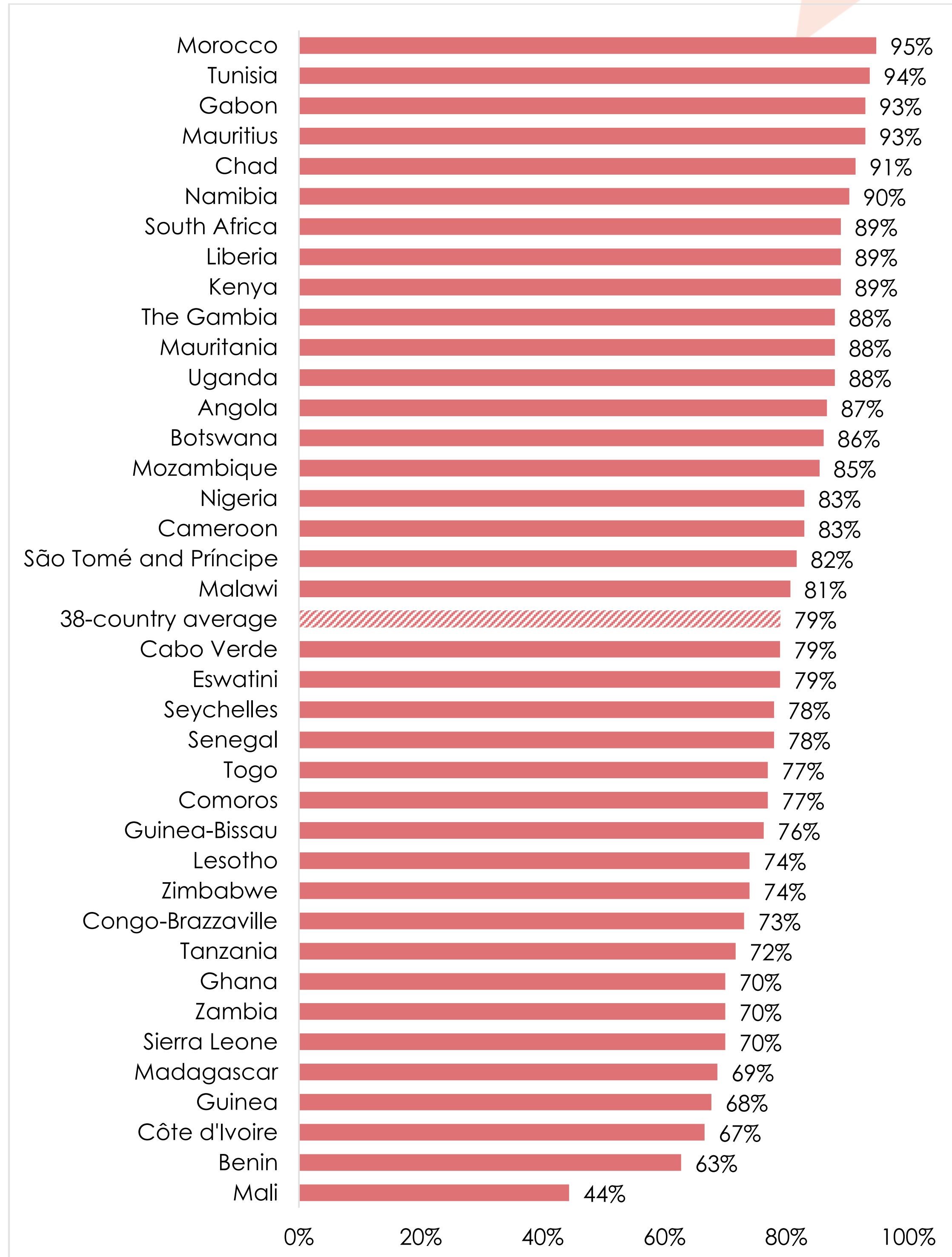
Tunisia, Gabon, Mauritius, and South Africa (89%) near the top of the distribution demonstrates that long wait times are not simply a function of resource scarcity. While slow service may signal constraints in facility capacity in some contexts, in others it may reflect strong demand for public health services where citizens expect to receive care within a reasonable time.

Figure 10: Experienced long wait times | 38 countries | 2024/2025



***Respondents who had contact with a public clinic or hospital during the previous year were asked:** And have you encountered any of these problems with a public clinic or hospital during the past 12 months: Long waiting times? (% who say "once or twice," "a few times," or "often") (Respondents who did not have contact with a public clinic or hospital are excluded.)*

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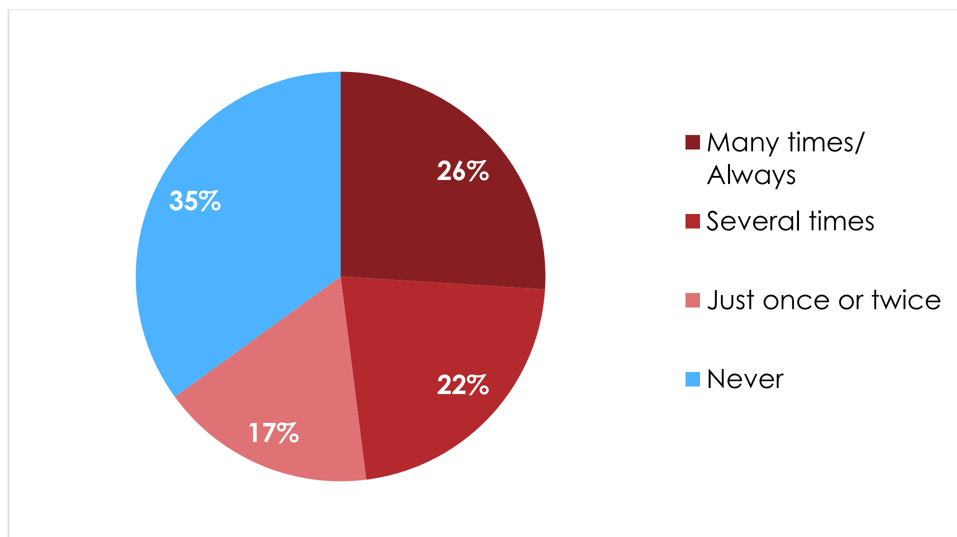
Going without medical care

Access to health care is an essential aspect of well-being, and deprivation of needed care a central measure of material deprivation captured in Afrobarometer's Lived Poverty Index (LPI) (Mattes & Lekalake, 2025). The LPI averages how often people say they or their family members went without medicines/medical treatment and four other basic necessities (enough food, enough clean water, enough cooking fuel, and a cash income) during the previous year.

Across 38 countries, nearly two-thirds (65%) of citizens report that they or a family member went without medicines or medical treatment at least once during the previous year, including 26% who say this happened "many times" or "always" (Figure 11).

Figure 11: Went without medical care | 38 countries | 2024/2025



Respondents were asked: *Over the past year, how often, if ever, have you or anyone in your family gone without medicines or medical treatment?")*

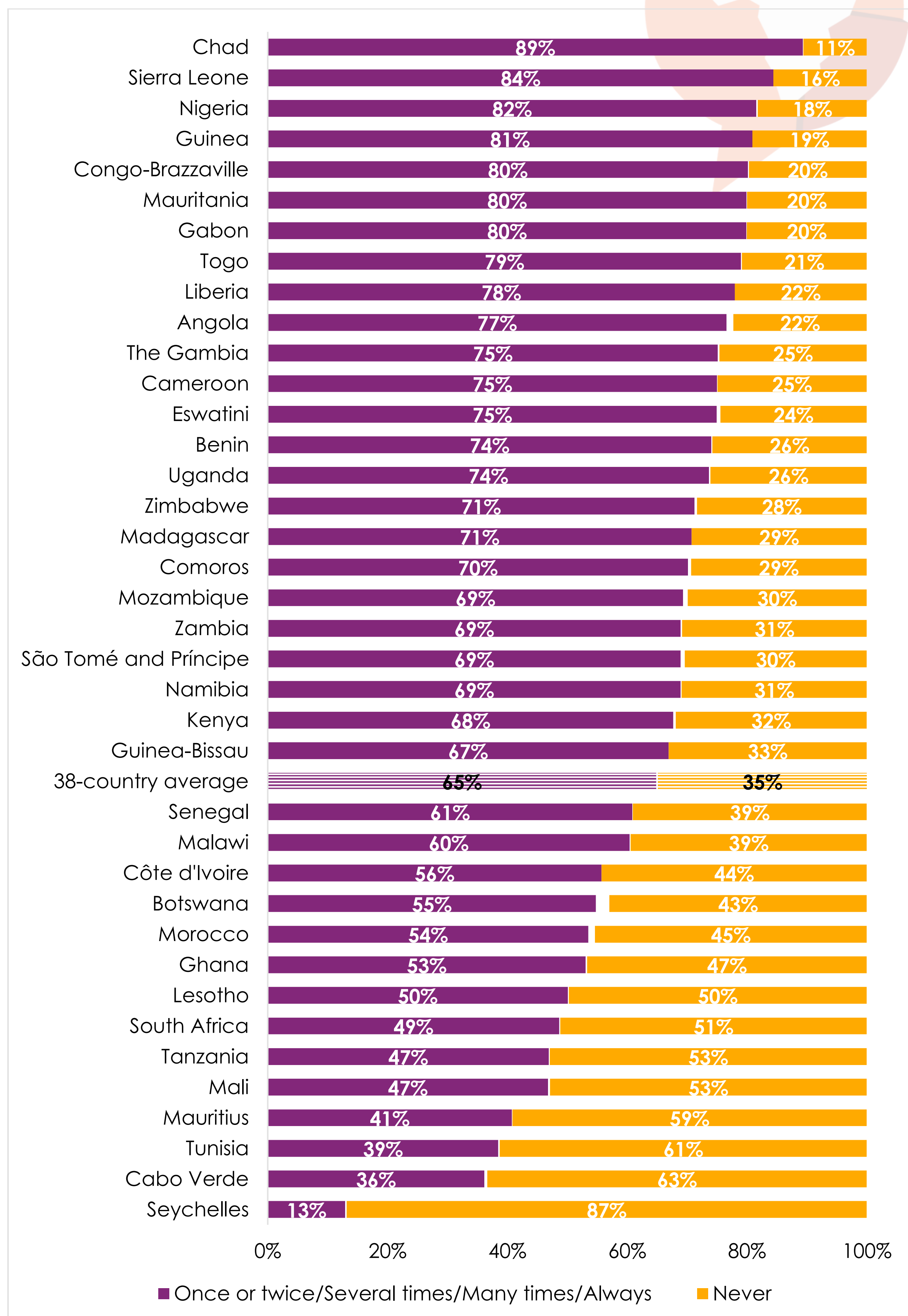
In 30 of 38 countries, majorities report going without medical care at least once during the previous year, ranging up to more than eight in 10 respondents in Chad (89%), Sierra Leone (84%), Nigeria (82%), and Guinea (81%) (Figure 12).

Seychelles, which provides universal free medical care for all, is an outlier with only 13% of respondents reporting the experience of going without care. The other top performers still record more than one-third of citizens going without care, led by Cabo Verde (36%), Tunisia (39%), and Mauritius (41%).

Given that only 35% of Africans say no one in their family went without health care during the previous year, medical deprivation has to be considered a regular feature of life on the continent. These findings point to a significant gap between the health needs of African families and the medicines and treatment available to them through public health systems.

Do your own analysis of Afrobarometer data – on any question, for any country and survey round. It's easy and free at www.afrobarometer.org/online-data-analysis.

Figure 12: Went without medical care at least once | 38 countries | 2024/2025



Respondents were asked: *Over the past year, how often, if ever, have you or anyone in your family gone without medicines or medical treatment?*

Health insurance

Health insurance or medical aid is critical because it protects households from catastrophic out-of-pocket health expenses. By pooling risk and spreading costs across members, insurance schemes improve access to health care, reduce financial barriers to treatment, and encourage preventive care. Strong health-insurance systems also enhance health-system sustainability by providing more predictable funding, strengthening service delivery, and supporting progress toward UHC (Ifeagwu, Yang, Parkes-Ratanshi, & Brayne, 2021; Regional Committee for Africa, 2022).

Although universal health coverage and completely free services for all citizens are rare on the continent, Seychelles (Adam, 2018) and Mauritius (Jeetoo & Jaunky, 2021) do provide universal access to free public health services. In fact, free UHC is a constitutional mandate in Seychelles. Health-care services are also heavily subsidised and generally free for the poorest in society in some countries, including Botswana (Tapera, Moseki, & January, 2018) and Cabo Verde (World Health Organization, 2019). Other countries such as Malawi, Uganda, Zambia, and Tanzania also offer limited free health care services in public facilities, often targeting children and pregnant women.

Excluding Seychelles and Mauritius, only 20% of respondents across 36 countries report having any form of medical-aid coverage (Figure 13).[3] This means that an overwhelming majority (79%) are uninsured and thus must resort to out-of-pocket payments for their health-care needs.

Health-insurance coverage varies dramatically across the continent. Gabon, with an extensive social-insurance scheme (World Health Organization Bulletin, 2013), stands out with by far the highest rate of insured respondents (83%). Ghana (72%), Morocco (71%), and Tunisia (70%) follow, each recording coverage for at least seven in 10 adults. Cabo Verde also records relatively high coverage (63%).

Kenya (39%) and Côte d'Ivoire (31%) also report above-average levels of medical-aid coverage, but they still leave a majority of their populations uninsured.

Health-insurance coverage drops into the single digits in 15 of the 36 countries. In Lesotho, Sierra Leone, Malawi, Uganda, and São Tomé and Príncipe, fewer than one in 20 respondents say they have medical aid.

The continental picture is thus one of extreme health-financing vulnerability. With most households relying on out-of-pocket payments, illness is a potential financial shock, underscoring an urgent need for more inclusive and better-funded health-insurance systems across Africa.

Among those who do have health insurance, the largest share (49%) are covered through national health-insurance systems, reflecting the growing – though still uneven – effort by African governments to expand public coverage (Figure 14).

A further 23% hold private health insurance, highlighting that for a subset of citizens, private plans remain an important source of protection. Public-sector schemes cover 16% of insured people, while community-based or mutual health-insurance schemes, which are often designed to reach informal workers and low-income households, remain a minority source of coverage, representing 9% of the insured population.

These patterns show that even among the insured, access to health protection is shaped by state capacity. The heavy reliance on national health-insurance schemes suggests that where governments have made deliberate investments in health financing, coverage can expand; however, the relatively small role of community and mutual schemes also indicates

[3] This question was not asked in Seychelles, which provides free UHC. Mauritius is excluded for the same reason. As a result, the proportions reported here likely understate true medical-aid coverage across the continent.

missed opportunities to reach the large informal sector, where most Africans earn their livelihoods.

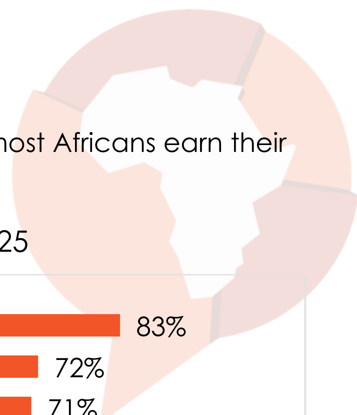
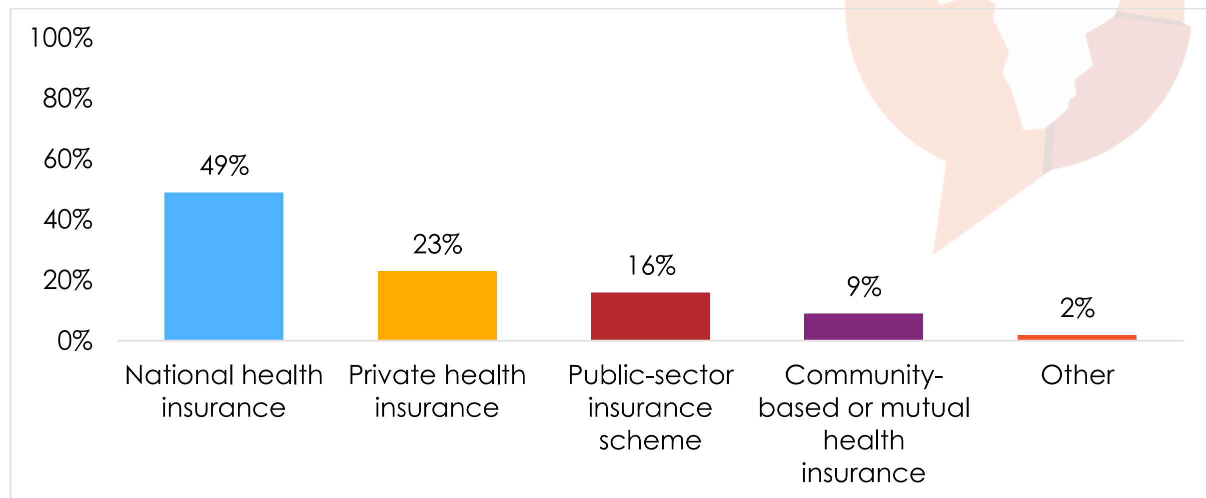


Figure 13: Medical-aid coverage | 36 countries | 2024/2025

Country	%
Gabon	83%
Ghana	72%
Morocco	71%
Tunisia	70%
Cabo Verde	63%
Kenya	39%
Côte d'Ivoire	31%
36-country average	20%
Mauritania	20%
Comoros	19%
South Africa	18%
Tanzania	16%
Zambia	15%
Senegal	15%
Namibia	15%
Mali	14%
Guinea-Bissau	14%
Zimbabwe	13%
Botswana	12%
Togo	11%
The Gambia	11%
Liberia	10%
Guinea	9%
Cameroon	9%
Congo-Brazzaville	7%
Nigeria	7%
Angola	7%
Eswatini	6%
Chad	6%
Mozambique	5%
Madagascar	5%
Benin	5%
São Tomé and Príncipe	4%
Uganda	4%
Malawi	4%
Sierra Leone	4%
Lesotho	2%

Respondents were asked: *Do you have any medical-aid coverage that helps pay your medical bills if you get sick?*

Figure 14: Type of medical-aid coverage | 36 countries | 2024/2025

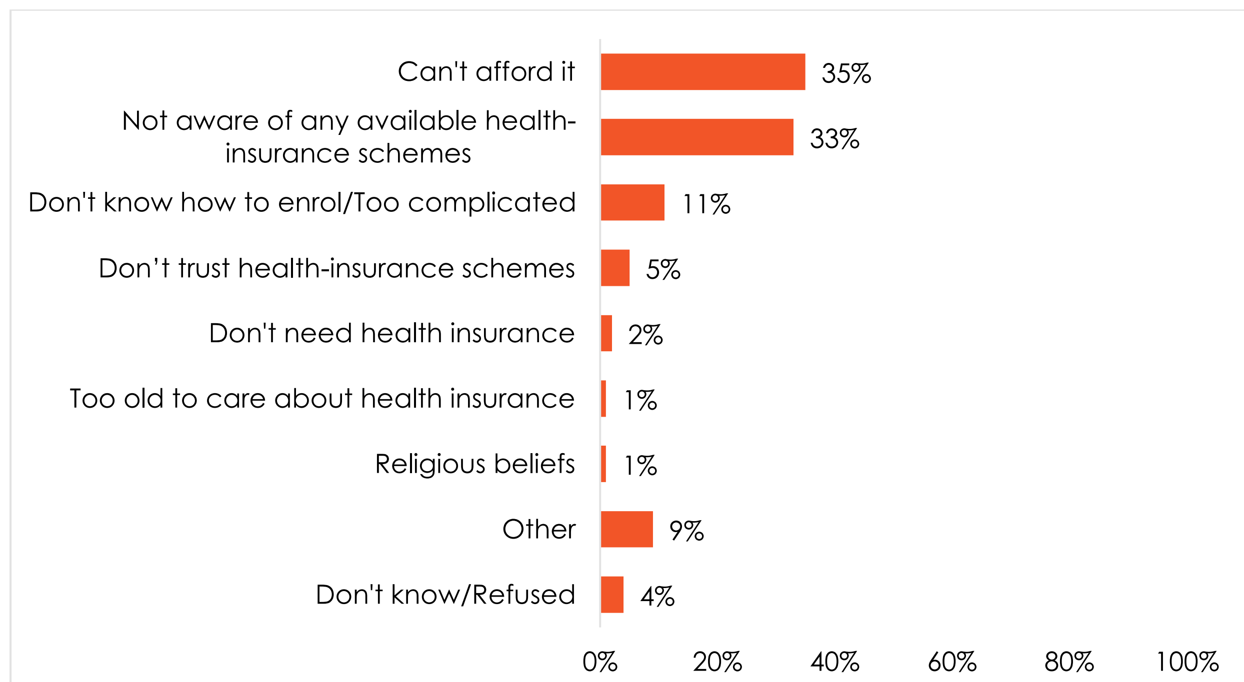


Respondents who say they have medical-aid coverage were asked: *What type of medical-aid coverage do you have? (Respondents who don't have medical-aid coverage are excluded.)*

Why are so many Africans uninsured? Cost is the greatest obstacle: More than one-third (35%) of uninsured Africans say they cannot afford health insurance (Figure 15). This underscores how financial vulnerability intersects with health risks: Those who most need protection are often least able to pay for it.

The second-most-common barrier is that people don't know of any health-insurance schemes they could sign up for (33%). This may be because none are available, but in many cases, it is likely to reflect a lack of awareness of plans that are in fact available, suggesting shortcomings in communication, outreach, and education around existing programmes. Another 11% say they don't know how to enrol or find the process too complicated.

Figure 15: Reason for no medical aid | 36 countries | 2024/2025



Respondents who say they don't have medical-aid coverage were asked: *What is the main reason you don't have medical-aid coverage? (Respondents who say they have medical-aid coverage are excluded.)*

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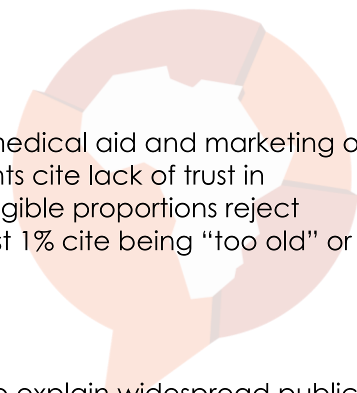
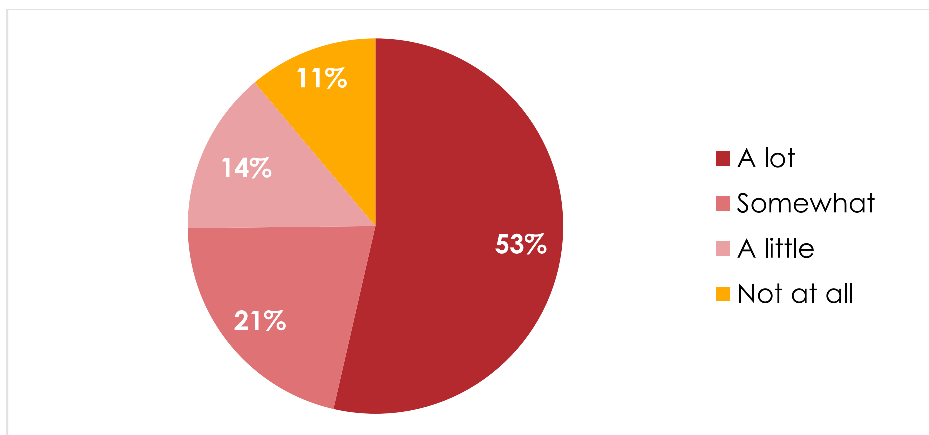


These findings highlight major gaps in the supply of affordable medical aid and marketing of aid products even where interest may exist. Very few respondents cite lack of trust in insurance schemes (5%) or other unspecified reasons (9%). Negligible proportions reject insurance on principle: Only 2% say they "don't need" it, and just 1% cite being "too old" or religious beliefs.

Health-care vulnerability

The extremely low levels of health-insurance coverage may help explain widespread public concern about access to medical care. On average across 38 countries, more than half (53%) of Africans say they worry "a lot" that they or a family member might fall ill and be unable to obtain or afford the medical treatment they need (Figure 16). Another one-fifth (21%) report that they worry "somewhat," while 14% say they worry "a little." Only about one in eight (12%) express no concern about being unable to obtain or pay for care.

Figure 16: Worry about being unable to obtain or afford medical care | 38 countries | 2024/2025



Respondents were asked: *How much do you personally worry that you or someone in your family will get sick and will be unable to obtain or afford needed medical care?*

Anxiety about being unable to obtain or pay for needed health care is particularly high in Eswatini and Angola, where more than three-fourths of citizens (81% and 77%, respectively) say they worry "a lot" (Figure 17). Majorities in 24 of the 38 countries express this high level of concern.

In contrast, only 28% of Moroccans say they worry "a lot," though another 45% say they worry "somewhat."

Even in Seychelles and Mauritius, where free UHC policies are in place, only 33% and 25%, respectively, say they don't worry "at all" about being able to obtain or afford medical care.

Concern about the inability to access or afford medical care cuts across demographic lines and intensifies notably among the most economically vulnerable (Figure 18).

High levels of anxiety (worry "a lot") are somewhat more common among women than men (55% vs. 52%). They are also more widespread among rural than urban residents (57% vs. 50%), matching the well-documented disparities in health-care access between rural areas and cities.

Worry is fairly consistent across age cohorts, but education level reveals a notable pattern: Respondents with primary schooling or less (57%-58%) are most likely to report worrying "a lot," while those with post-secondary education are least likely to do so (42%). This pattern likely reflects the most striking variation – across economic status. Among those experiencing no lived poverty, only 34% worry "a lot" about health-care affordability. This share rises steadily to

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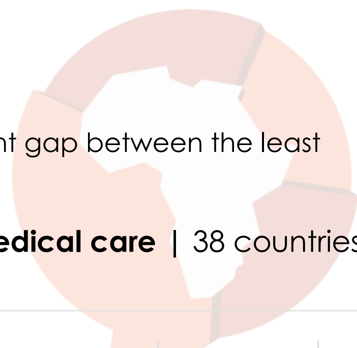

66% among those with high lived poverty, a 32-percentage-point gap between the least and most economically vulnerable groups.

Figure 17: Worry about being unable to obtain or afford medical care | 38 countries | 2024/2025

Country	A lot	Somewhat	A little	Not at all
Eswatini	81%	6%	7%	6%
Angola	77%	9%	8%	4%
Cabo Verde	75%	5%	9%	11%
São Tomé and Príncipe	74%	11%	11%	4%
Zimbabwe	70%	13%	9%	8%
Guinea-Bissau	67%	14%	10%	7%
Liberia	67%	19%	10%	5%
Mozambique	66%	13%	15%	6%
Tunisia	65%	16%	8%	11%
Uganda	62%	20%	11%	8%
Gabon	59%	21%	14%	6%
Mali	58%	12%	12%	18%
Botswana	58%	19%	11%	11%
Kenya	57%	21%	11%	10%
Sierra Leone	57%	24%	13%	6%
Malawi	57%	16%	12%	15%
Guinea	56%	23%	9%	12%
Madagascar	55%	29%	9%	7%
Namibia	55%	23%	10%	11%
Lesotho	54%	11%	14%	21%
38-country average	53%	21%	14%	11%
Zambia	53%	13%	18%	15%
Chad	53%	28%	11%	6%
Côte d'Ivoire	52%	20%	17%	11%
Congo-Brazzaville	51%	24%	15%	10%
South Africa	50%	19%	15%	16%
Benin	49%	26%	17%	7%
The Gambia	48%	21%	16%	12%
Cameroon	47%	25%	19%	8%
Nigeria	47%	27%	17%	9%
Senegal	46%	25%	12%	17%
Togo	39%	30%	22%	9%
Ghana	39%	24%	19%	18%
Comoros	37%	28%	18%	18%
Mauritania	35%	40%	19%	6%
Tanzania	30%	35%	12%	23%
Seychelles	29%	14%	23%	33%
Mauritius	29%	20%	25%	25%
Morocco	28%	45%	19%	8%

0% 20% 40% 60% 80% 100%

■ A lot ■ Somewhat ■ A little ■ Not at all

***Respondents were asked:** How much do you personally worry that you or someone in your family will get sick and will be unable to obtain or afford needed medical care?*

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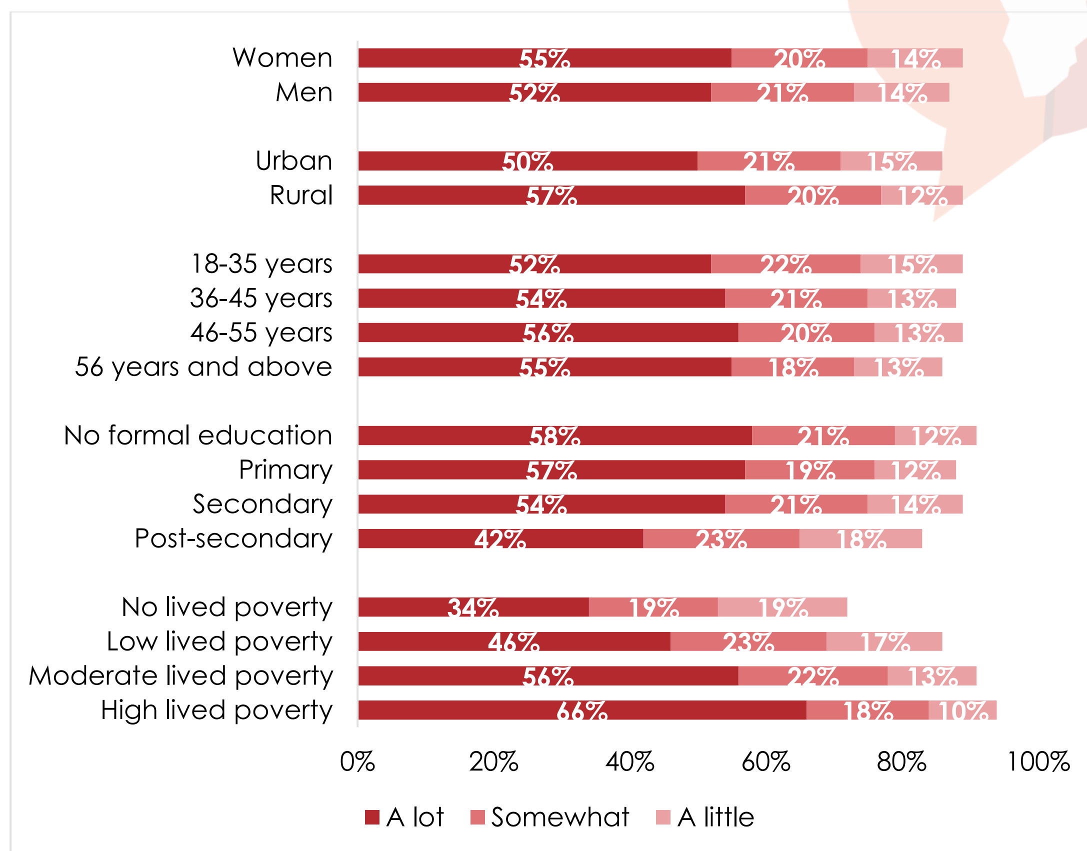
Figure 18: Worry about being unable to obtain or afford medical care
| by demographic group | 38 countries | 2024/2025



Respondents were asked: *How much do you personally worry that you or someone in your family will get sick and will be unable to obtain or afford needed medical care?*

These findings reinforce the critical importance of health insurance and risk-pooling mechanisms in the African context. Worry about health-care affordability is not a marginal concern but a near-universal anxiety, felt most acutely by those least equipped to cope with catastrophic health expenditures.

Government performance on improving basic health services

In addition to documenting policy priorities and citizen experiences with public services, Afrobarometer seeks citizens' evaluations of their governments' performance in delivering those services. Across the continent, citizens offer sharply divergent views on how successfully their governments are improving basic health services. On average, 45% say they are doing "fairly well" or "very well," but a majority (54%) see their governments as failing on health care (Figure 19).

A few countries cluster at the positive end of the scale, where more than six in 10 say the government is handling health services well. Tanzania (68%) and Mali (67%) lead this group, followed closely by Benin (64%), Mauritius (63%), Côte d'Ivoire (62%), and Zambia (62%).

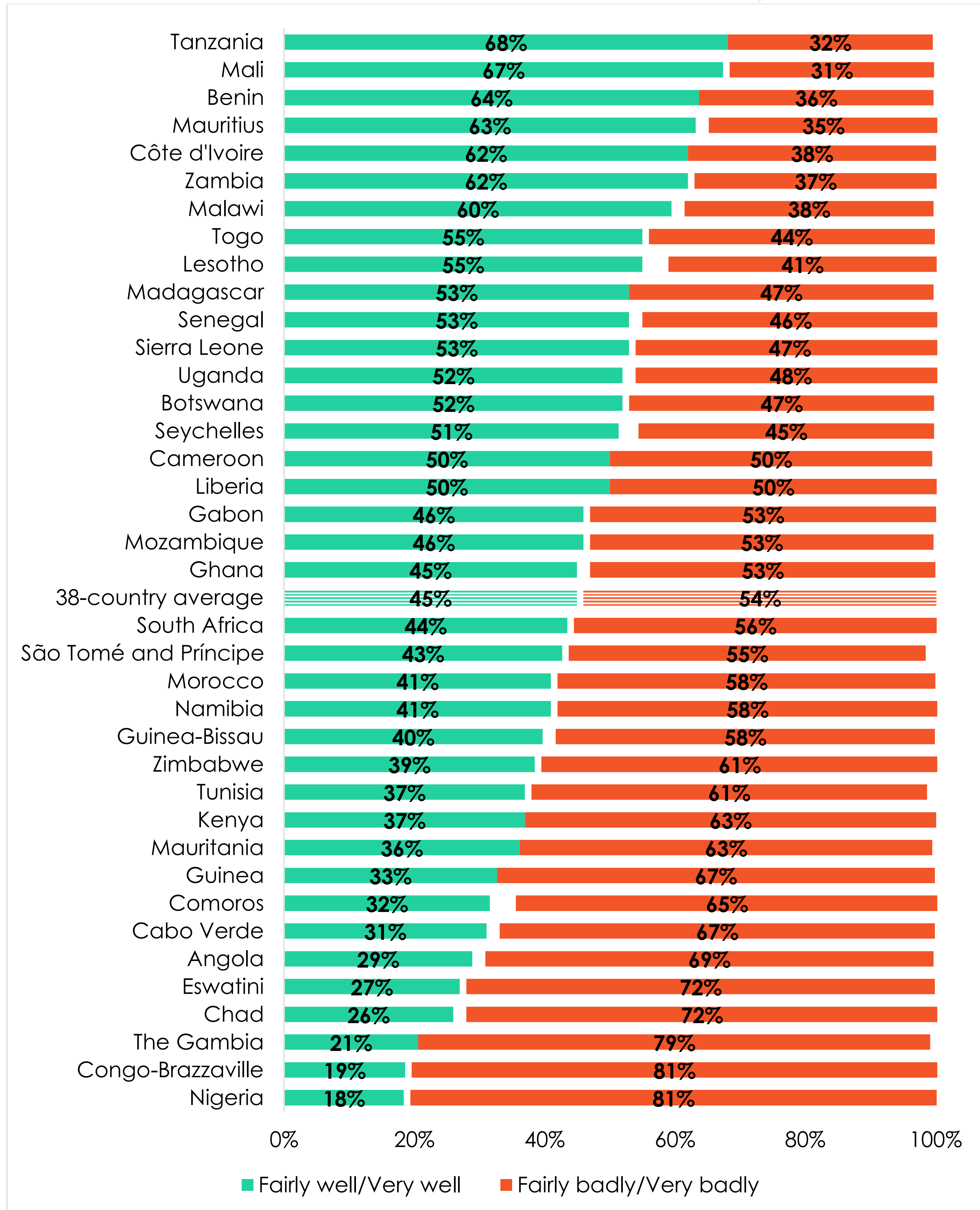
A larger set of countries sit in the middle of the distribution, where public opinion is more evenly divided. These mixed evaluations suggest uneven service delivery – adequate for some households and inadequate for others – reflecting the variability that citizens encounter in their interactions with public health facilities.

At the other end of the spectrum, dissatisfaction is both widespread and intense. About eight in 10 citizens give their governments failing marks on health-service delivery in Nigeria (81%),

Congo-Brazzaville (81%), and The Gambia (79%). Large majorities in Chad (72%), Eswatini (72%), and Angola (69%) agree.

These patterns illustrate a striking continental divide in perceptions of government stewardship of the health sector. While some governments enjoy relatively high levels of public applause, many others face deep public criticism.

Figure 19: Government performance on improving basic health services | 38 countries | 2024/2025



Respondents were asked: *How well or badly would you say the current government is handling the following matters, or haven't you heard enough to say: Improving basic health services?*

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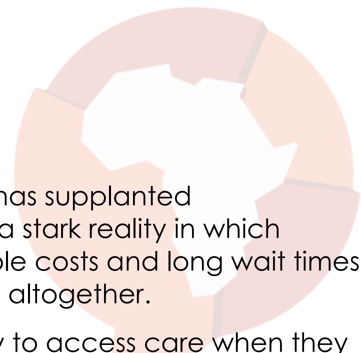

Conclusion

Afrobarometer surveys in 38 African countries show that health has supplanted unemployment as citizens' top policy priority. Findings describe a stark reality in which majorities encounter systemic barriers to care – from unaffordable costs and long wait times to shortages of medicines – or have to go without medical care altogether.

A majority of Africans feel profoundly insecure about their ability to access care when they need it, highlighting the fragility of current health-financing arrangements in contexts where insurance coverage remains limited, out-of-pocket payments are common, and public health systems struggle to provide reliable services.

Against this backdrop, large majorities in most countries call upon their governments to guarantee health care for all, even at the cost of higher taxes, signalling a robust social mandate for reform.

As external financing landscapes shrink and domestic fiscal pressures intensify, the findings presented in this paper underscore a critical juncture in the African health landscape: The future resilience of African health systems will depend not only on institutional redesign and expanded funding, but also on governments' ability to translate strong public expectations into equitable, accessible, and financially sustainable health systems, grounded in citizens' lived realities.

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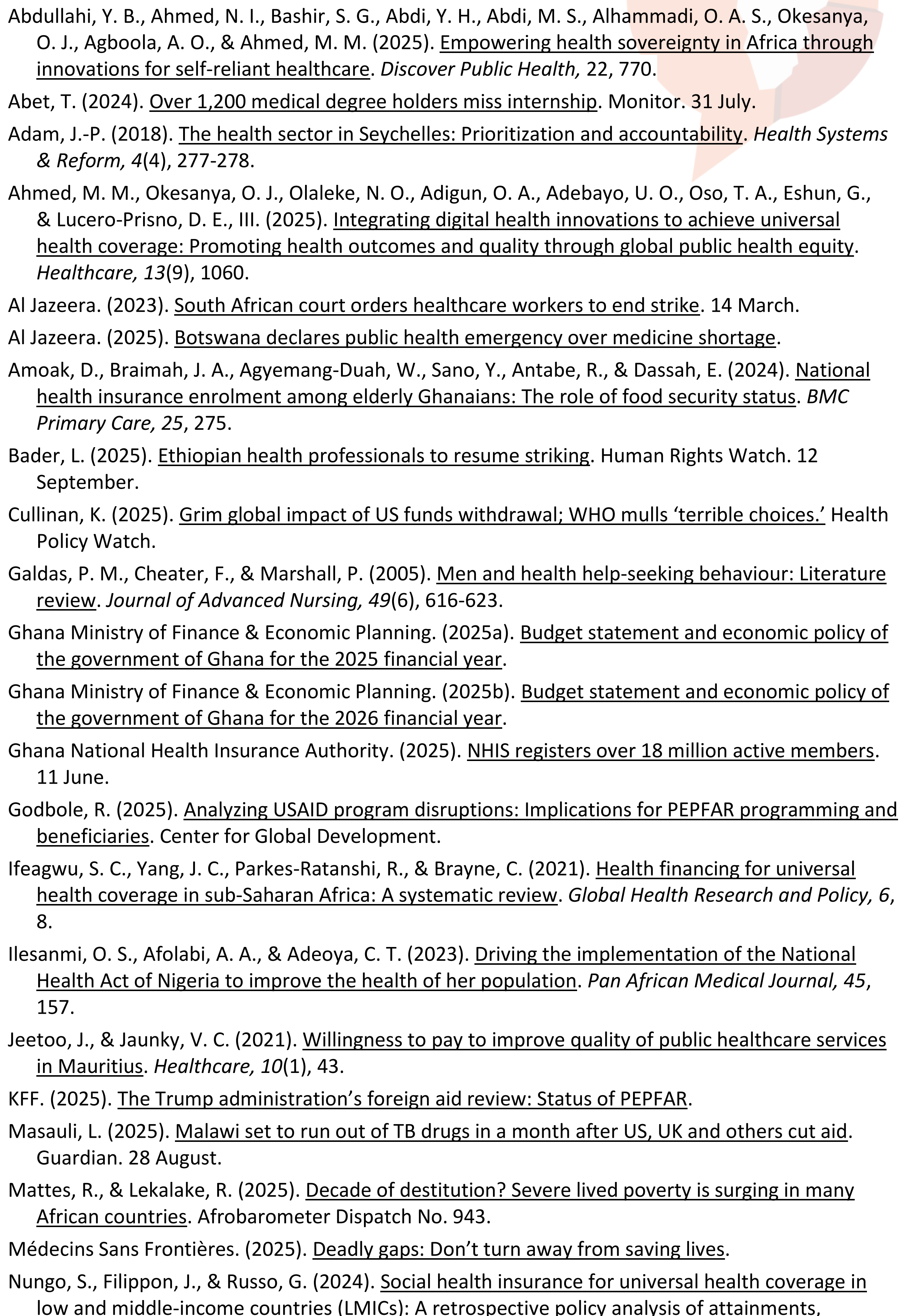

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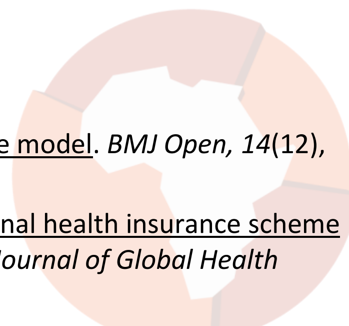

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Table A.1: Afrobarometer Round 10 fieldwork dates and previous survey rounds

Country	Round 10 fieldwork	Previous survey rounds
Algeria	N/A	2013, 2015
Angola	March-April 2024	2019, 2022
Benin	Jan.-Feb. 2024	2005, 2008, 2011, 2014, 2017, 2020, 2022
Botswana	July 2024	1999, 2003, 2005, 2008, 2012, 2014, 2017, 2019, 2022
Burkina Faso	N/A	2008, 2012, 2015, 2017, 2019, 2022
Burundi	N/A	2012, 2014
Cabo Verde	Aug.-Sept. 2024	2002, 2005, 2008, 2011, 2014, 2017, 2019, 2022
Cameroon	Feb.-March 2024	2013, 2015, 2018, 2021, 2022
Chad	Feb.-April 2025	N/A
Comoros	May-June 2025	N/A
Congo-Brazzaville	Sept.-Oct. 2024	2023
Côte d'Ivoire	Jan. 2024	2013, 2014, 2017, 2019, 2021
Egypt	N/A	2013, 2015
Eswatini	April-May 2025	2013, 2015, 2018, 2021, 2022
Ethiopia	N/A	2013, 2020, 2023
Gabon	April-May 2024	2015, 2017, 2020, 2021
Gambia, The	April-May 2024	2018, 2021, 2022
Ghana	Aug. 2024	1999, 2002, 2005, 2008, 2012, 2014, 2017, 2019, 2022
Guinea	May-June 2024	2013, 2015, 2017, 2019, 2022
Guinea-Bissau	July-Sept. 2025	N/A
Kenya	April-May 2024	2003, 2005, 2008, 2011, 2014, 2016, 2019, 2021
Lesotho	March 2024	2000, 2003, 2005, 2008, 2012, 2014, 2017, 2020, 2022
Liberia	July-Aug. 2024	2008, 2012, 2015, 2018, 2020, 2022
Madagascar	Oct.-Nov. 2024	2005, 2008, 2013, 2015, 2018, 2022
Malawi	Aug. 2024	1999, 2003, 2005, 2008, 2012, 2014, 2017, 2019, 2022
Mali	Oct.-Nov. 2024	2001, 2002, 2005, 2008, 2013, 2014, 2017, 2020, 2022
Mauritania	Dec. 2024-Jan. 2025	2022
Mauritius	April-May 2024	2012, 2014, 2017, 2020, 2022
Morocco	Feb.-March 2024	2013, 2015, 2018, 2021, 2022
Mozambique	July-Sept. 2025	2002, 2005, 2008, 2012, 2015, 2018, 2021, 2022
Namibia	March 2024	1999, 2003, 2006, 2008, 2012, 2014, 2017, 2019, 2021
Niger	N/A	2013, 2015, 2018, 2020, 2021
Nigeria	June-July 2024	2000, 2003, 2005, 2008, 2013, 2015, 2017, 2020, 2022
São Tomé and Príncipe	Sept.-Nov. 2024	2015, 2018, 2022
Senegal	Feb.-March 2025	2002, 2005, 2008, 2013, 2014, 2017, 2021, 2022
Seychelles	Aug. 2024	2022
Sierra Leone	March-April 2025	2012, 2015, 2018, 2020, 2022
South Africa	June-Aug. 2025	2000, 2002, 2006, 2008, 2011, 2015, 2018, 2021, 2022
Sudan	N/A	2013, 2015, 2018, 2021, 2022
Tanzania	June-July 2024	2001, 2003, 2005, 2008, 2012, 2014, 2017, 2021, 2022
Togo	July 2024	2012, 2014, 2017, 2021, 2022
Tunisia	Feb.-March 2024	2013, 2015, 2018, 2020, 2022
Uganda	Jan.-Feb. 2024	2000, 2002, 2005, 2008, 2012, 2015, 2017, 2019, 2022
Zambia	July 2024	1999, 2003, 2005, 2009, 2013, 2014, 2017, 2020, 2022
Zimbabwe	June 2024	1999, 2004, 2005, 2009, 2012, 2014, 2017, 2021, 2022

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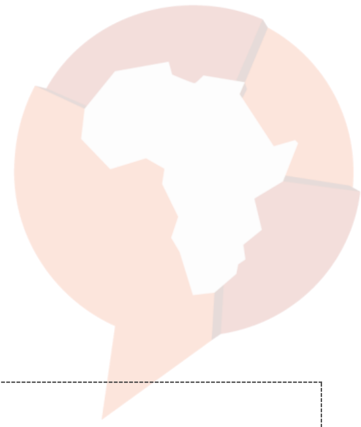

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Financial support for Afrobarometer is provided by Sweden via the Swedish International Development Cooperation Agency, the Norwegian Agency for Development Cooperation via the World Bank Think Africa Project, the Mo Ibrahim Foundation, the Open Society Foundations - Africa, Luminate, the Ford Foundation, the William and Flora Hewlett Foundation, the Mastercard Foundation, the David and Lucile Packard Foundation, the Obama Foundation, the Rockefeller Foundation, European Union Commission, the World Bank Group, the Population Institute, the Centre for International Governance Innovation, the International Development Research Centre (IDRC), the Royal Embassy of Denmark in Uganda/Danida, the Embassy of the Kingdom of the Netherlands in Uganda, and the German Federal Ministry for Economic Cooperation and Development (BMZ) supported by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH.

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