World Health Organization

African Region

Towards Immunization Agenda 2030 targets

Two decades of immunization efforts in the WHO African Region

World Health Organization

African Region

Towards Immunization Agenda 2030 targets

Two decades of immunization efforts in the WHO African Region

ISBN: 9789290315896

Suggested citation. Towards Immunization Agenda 2030 targets: two decades of immunization efforts in the WHO African Region. Brazzaville: WHO Regional Office for Africa, 2026. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

Designed in Brazzaville, Congo

Contents

Foreword iv
Preface v
Acknowledgements vi
Abbreviations vii
Executive summary viii
Prevent disease viii
Promote equity viii
Strong immunization programmes viii
Introduction 1
Impact goal 1. Prevent disease 3
1.1 Lives saved 3
1.2 Disease targets met 4
1.3 Reduce outbreaks 5
Impact goal 2. Promote equity 10
2.1 Reducing 'zero-dose' children 10
2.2 Supporting new or underutilized vaccine introductions 12
Impact goal 3. Build strong immunization programmes 16
3.1 Deliver across the life course 16
Annexes 23
Annex 1. Average immunization coverage (%) for seven new or underutilized vaccines, WHO African Region and global average, year of implementation to 2024 24
Annex 2. Average immunization coverage (%) for six new or underutilized vaccines by subregion, WHO African Region, year of implementation to 2024 25
Annex 3. Average immunization coverage (%) for seven routine vaccines, WHO African Region and global average, 2000–2024 26
Annex 4. Average immunization coverage (%) for seven routine vaccines by subregion, WHO African Region, 2000–2024 28
Data sources 30
Endnotes 31

Foreword

WHO has been a core member of Gavi, The Vaccine Alliance, since its creation in 2000. Since then, we have supported 41 African countries, disbursed more than US$15 billion (57% of overall Gavi disbursements), and reached more than 500 million children through routine immunization. We have averted more than 13.7 million future deaths on the continent.

2025 marked the end of our fifth five-year strategic cycle; arguably our most demanding. The period 2021–2025 was marked by major global health shocks and the need to deliver at scale, including in fragile and conflict-affected settings. However, this period was not without its positives. More children than ever were reached with routine immunization; Gavi led COVAX, a global initiative to ensure equitable access to COVID-19 vaccines; the new malaria vaccine was introduced and HPV vaccine access scaled up; as well as increases in co-financing among Gavi-funded countries.

As we start 2026, the Alliance enters its new, sixth cycle, the 2026–2030 strategy, with four goals: introduce and scale-up vaccines; strengthen health systems to increase equity in immunization; improve programmatic and financial sustainability of immunization programmes; and ensure healthy markets for vaccines and related products. Underpinning this drive is our reform programme, the Gavi Leap, which brings a radical simplification of our systems and processes and a historic transfer of decision-making power to countries over how resources are allocated.

Our relationship with the WHO African Region is rooted in a shared understanding of the critical importance of immunization as one of the most cost-effective public health interventions. We share the vision of leaving no-one behind with immunization and the need to increase equitable and sustainable use of vaccines. This report provides an overview of progress in the WHO African Region towards achieving the three impact goals of the Immunization Agenda 2030, using information on 14 different antigens covering 12 vaccine-preventable diseases. These three impact goals closely mirror the Alliance's overall vision for the African Region – prevent disease; promote equity; and build strong immunization programmes. The status of immunization in the Region is both complex and diverse, reflecting notable achievements alongside persistent challenges.

2026 and the next four years towards the shared sustainable development targets of 2030, look likely to be marked by continuing disruption to the global health architecture, with ongoing threats to sustainable funding. However, with threats come opportunities, and Gavi, the Vaccine Alliance, is committed to playing a responsible role in any reform agenda while maintaining a laser focus on disease prevention, control, and elimination through vaccination. I will end on a high note, by congratulating three African Region Member States, Seychelles, Mauritius and Cabo Verde for their remarkable achievement in the elimination of measles and rubella. These are the results that make our combined efforts worthwhile.

Dr Sania Nishtar
Chief Executive Officer
Gavi, the Vaccine Alliance

Preface

Immunization is probably the single most effective public health intervention, averting more than 4 million deaths annually across the globe. Immunization programmes not only impact vaccine-preventable diseases, but also provide an entry into health system strengthening through the integration of other basic health services at primary care level. Across Africa, mothers keep their children's immunization records carefully, providing visible proof of growth and recording many other milestones.

It is in this context that the World Health Assembly, in 2020, endorsed the Immunization Agenda 2030 (IA2030), a political declaration by countries and partners, to ensure the continued life saving impact of vaccines across the Region. A year later, this framework was endorsed by the Regional Committee for Africa, aligning regional vision with the global strategy.

The three impact goals of the IA2030 – preventing disease, promoting equity and building strong immunization programmes – are now up to us at the WHO Regional Office for Africa and through our 47 country offices, alongside our many partners in this endeavour. We could not do this alone, and are more than grateful to Gavi, the vaccine alliance, as well as other partners.

This report, building on data from the annual WHO and UNICEF estimates of national immunization coverage (WUENIC) shows the current status of these impact goals in our Region – a context of notable achievements, as well as persistent challenges. It also provides the baseline from which the Vaccine Preventable Disease (VPD) Strategy (2026–2030) will kick off - accelerating access to immunization services across the Region, aiming to combat inequality and close immunity gaps.

But we must not forget that behind the numbers in the report, are children and their parents. While we need to use metrics as an objective measure of progress, it is important that we also remember that the real measure of progress is the wellbeing and overall health of our communities. This is what stewardship means.

Dr Mohamed Yakub Janabi
Regional Director
WHO Regional Office for Africa

Acknowledgements

The WHO Regional Office for Africa would like to thank the following members of the DPC Cluster for their work in drafting this report.

The document was prepared and written by Nicola Richards under the guidance of Bridget Farham and Benido Impouma, of the Health Promotion, Disease Prevention and Control (DPC) Cluster, WHO Regional Office for Africa. The report was reviewed by Akpaka Kalu, Lynda Rey and Ado Bwaka, Aschalew Teka Bekele, Balcha Masresha, Han Yue, Johnson Ticha, Nosheen Safdar, and Vivian Mugarisi.

The WHO Regional Office for Africa would also like to thank Thabani Maphosa, Leonie Viering, Nikita Bhide, Olly Cann, Richard Mihingo and Alex de Jonquieres for their contributions to the final document.

Abbreviations

AMVIRA	Accelerated Malaria Vaccine Introduction and Rollout in Africa
BCG	Bacillus Calmette-Guérin vaccine
cVDPV	circulating vaccine-derived poliovirus
DTP	diphtheria, tetanus and pertussis vaccine
EPI	Expanded Programme on Immunization
EtR	evidence to recommendation
Gavi	Gavi, the Vaccine Alliance
HepB	hepatitis B vaccine
HepB-BD	hepatitis B birth dose vaccine
Hib	*Haemophilus influenzae* type b
HPV	human papillomavirus vaccine
IA2030	Immunization Agenda 2030
IPV	inactivated polio-containing vaccine
JRF	Joint Reporting Form
MCV	measles-containing vaccine
Men5CV	pentavalent meningococcal conjugate vaccine
MenA	meningococcal A conjugate vaccine
MVIP	Malaria Vaccine Implementation Programme
NITAG	National Immunization Technical Advisory Group
NMAT	NITAG Maturity Assessment Tool
PCV	pneumococcal conjugate vaccine
POL	oral polio vaccine
RCV	rubella-containing vaccine
RotaC	rotavirus vaccines completed dose
UNICEF	United Nations Children's Fund
VPD	vaccine-preventable diseases
WHO	World Health Organization
WUENIC	WHO/UNICEF estimates of national immunization coverage
YF	yellow fever vaccine

Executive summary

As with many health issues, the status of immunization in the WHO African Region is both complex and diverse, reflecting notable achievements alongside persistent challenges. Overall, the Region is currently off-track for six of the seven Immunization Agenda 2030 (IA2030) impact goal targets. Coverage for four tracer vaccines remains below the 90% target.[i]
In many Member States, national and subnational immunization coverage rates have stagnated, and the Region continues to lag behind others in access to vaccines. While the impact of the COVID-19 pandemic is evident in coverage data from 2020 - 2022, stagnation and decline for most vaccines had already begun as early as 2010.
As of 2024, coverage for four vaccines was very low (<50%), while 10 had low coverage (50–79%), with only one vaccine reporting coverage between 80–89%. No vaccines reported coverage over 90% (Fig. 1).

Prevent disease

- In 2024, vaccination saved at least 1.9 million lives from 13 different vaccine-preventable diseases (VPDs) in the African Region.[5]
  The majority of these deaths (42%) were averted due to the measles vaccine.
- The Region has maintained its wild poliovirus free status since 2020 and has achieved elimination of maternal and neonatal tetanus in 43 of the 47 Member States.
- Despite these efforts, the Region has experienced a resurgence of vaccine-preventable disease outbreaks, including large and/or protracted outbreaks of cholera, measles, meningococcus, and circulating vaccine-derived poliovirus (cVDPV) between 2022 and 2024. As a result of these outbreaks, some 200 000 preventable deaths occurred in 2023 in the Region alone.
- Routine vaccination activities are slowly rebounding after the pandemic. Between 2022 and October 2023, 22 Member States conducted 28 mass vaccination campaigns, including six outbreak response campaigns. Over 117 million children were vaccinated, with 14 campaigns reaching over 95% coverage.

Promote equity

- The number of zero-dose children in the Region declined from 10.1 million in 2015 to 6.2 million in 2019; only to rise again during 2020–2022 due to COVID-19-related disruptions.
- Although recent data show a renewed decline in zero-dose children post-pandemic, the overall trend remains upward and well above the IA2030 target of a 50% reduction.
- The introduction of new vaccines into routine immunization schedules continues to expand, with 33 Member States introducing the first dose of rubella-containing vaccine (RCV1); 44 introducing the second dose of measles-containing vaccine (MCV2); and 30 introducing the first dose of the human papillomavirus vaccine (HPV1). Nearly all yellow fever high-risk countries have introduced routine yellow fever vaccination at the national level.
- In a significant milestone, as of September 2025, 21 Member States have received approval to introduce the malaria vaccine, with rollout ongoing in 15 countries.

Strong immunization programmes

- Between 2000 and 2024, Bacillus Calmette-Guérin (BCG) coverage in the WHO African Region increased from 69% to 83%.
  The average annual increase of 0.6% was equal highest with the South-East Asia Region and double the global average of 0.3%.
  Despite this progress, much of the gains in the African Region occurred between 2000 and 2009, with a noticeable plateau from 2010 onwards.

[i] Diphtheria tetanus pertussis, third dose (DTP3); measles-containing vaccine, second dose (MCV2); pneumococcal conjugate vaccine, third dose (PCV3); and human papillomavirus (HPV) vaccine.

- Coverage for the third dose of the diphtheria-tetanus-pertussis vaccine (DTP3) increased from 52% to 76% between 2000 and 2024. Considerable gains were recorded between 2000 and 2009, when coverage increased from 52% to 73%. Despite these relative gains, the WHO African Region continues to have the lowest DTP3 coverage globally.
- Coverage for the first dose of the measles-containing vaccine (MCV1) has stagnated at around 70% over the past 10 years, a trend that predates the COVID-19 pandemic. In contrast, MCV2 coverage steadily increased to a high of 55% in 2024. However, both remain well below the IA2030 target of ≥90% (ideally over 95% to interrupt measles transmission).
- Between 2008 and 2024, immunization coverage for the third dose of pneumococcal conjugate vaccine (PCV3) in the African Region increased by an average of 4% per year. Most of these gains occurred between 2010 and 2016, when coverage rose from 3% to 67% (an average annual increase of 9%). Since then, coverage has plateaued at around 70%.
- HPV immunization coverage among female adolescents increased rapidly between 2018 and 2020, however, progress has since slowed. In 2024, coverage stood at 28% for the first dose.
- At the subregional level:
    - While Central Africa demonstrates some of the largest relative improvements in coverage over the past 25 years, the subregion had some of the lowest coverage levels in the African Region in 2024, with three vaccines reporting very low coverage (<50%), and nine reporting low coverage (50–79%) (Fig. 2). While coverage for DTP3 increased from 39% to 67%, it remains the lowest among the subregions. Coverage for MCV1 and MCV2 indicate progress but considerable immunity gaps remain.
    - East and Southern Africa is a generally high-performing subregion, however, coverage for two vaccines remains very low (<50%), while coverage for another six remains low (50–79%) as of 2024 (Fig. 3). Coverage for DTP3 and MCV1, while high at 80% and 78% respectively, are still below elimination targets. Coverage for MCV2 increased from 6% to 63% between 2000 and 2024, indicating progress in second-year-of-life immunization.
    - As of 2024 in Western Africa, coverage for four vaccines remains very low (<50%), while coverage for another eight remains low (50–79%), and only one vaccine has coverage above 80% (Fig. 4). While coverage for DTP3, MCV1, and MCV2 all improved between 2000 and 2024, considerable immunity gaps remain. Improved access to the HepB-BD is clearly noticeable – with coverage increasing from 0–44%, the highest level among the three subregions.

Fig. 1. Average immunization coverage for 14 routine, new, or underutilized vaccines, WHO African Region, 2000–2024

	2000	2002	2004	2006	2008	2010	2012	2014	2016	2018	2020	2022	2024
BCG	69%	68%	72%	76%	81%	82%	80%	78%	80%	82%	82%	80%	83%
DTP3	52%	53%	59%	65%	70%	71%	70%	71%	73%	75%	74%	72%	76%
HepB-BD	0%	0%	2%	3%	5%	9%	9%	9%	10%	12%	15%	17%	17%
HepB3	5%	24%	32%	45%	64%	70%	69%	70%	73%	75%	74%	72%	76%
Hib3	3%	12%	16%	21%	37%	60%	63%	70%	73%	75%	74%	72%	76%
HPV1	.	.	.	.	.	0%	0%	0%	1%	2%	17%	22%	28%
IPV1	.	.	.	.	.	.	.	0%	40%	62%	74%	72%	77%
MCV1	53%	54%	58%	63%	67%	72%	70%	69%	68%	70%	70%	67%	71%
MCV2	5%	5%	4%	4%	4%	4%	6%	10%	22%	25%	39%	43%	55%
PCV3	.	.	.	.	0%	3%	11%	47%	67%	72%	71%	68%	65%
POL3	54%	59%	62%	66%	71%	72%	70%	70%	72%	74%	72%	70%	75%
RCV1	0%	0%	0%	0%	0%	0%	0%	9%	12%	32%	36%	35%	37%
ROTAc	.	.	.	0%	0%	2%	5%	29%	42%	46%	51%	53%	65%
YF	9%	11%	25%	35%	39%	40%	35%	40%	40%	47%	46%	43%	50%

Fig. 2. Average immunization coverage for 13 routine, new, and underutilized vaccines, Central Africa (WHO African Region), 2000–2024

	2000	2002	2004	2006	2008	2010	2012	2014	2016	2018	2020	2022	2024
BCG	48%	59%	68%	73%	77%	81%	82%	79%	80%	80%	81%	78%	81%
DTP3	39%	45%	54%	61%	63%	62%	67%	68%	67%	68%	67%	65%	67%
HepB-BD	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
HepB3	0%	0%	5%	17%	61%	61%	67%	67%	67%	68%	67%	65%	67%
Hib3	0%	0%	5%	6%	15%	61%	66%	67%	67%	68%	67%	65%	67%
IPV1	.	.	.	.	.	.	.	0%	45%	61%	69%	66%	68%
MCV1	35%	49%	57%	61%	63%	66%	69%	66%	61%	61%	60%	58%	59%
MCV2	0%	0%	0%	0%	0%	0%	0%	4%	7%	9%	14%	15%	47%
PCV3	.	.	.	.	0%	0%	29%	49%	60%	62%	61%	55%	58%
POL3	35%	41%	48%	55%	63%	65%	66%	68%	65%	68%	68%	63%	66%
RCV1	0%	0%	0%	0%	0%	0%	0%	0%	0%	22%	23%	22%	23%
ROTAc	.	.	.	0%	0%	0%	0%	15%	25%	25%	36%	51%	52%
YF	12%	11%	35%	48%	52%	49%	54%	51%	47%	55%	54%	50%	52%

Fig. 3. Average immunization coverage for 13 routine, new, and underutilized vaccines, East and Southern Africa (WHO African Region), 2000–2024

	2000	2002	2004	2006	2008	2010	2012	2014	2016	2018	2020	2022	2024
BCG	76%	77%	79%	81%	83%	85%	87%	86%	86%	83%	84%	85%	86%
DTP3	60%	63%	67%	71%	73%	76%	79%	81%	81%	81%	79%	78%	80%
HepB-BD	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	1%
HepB3	10%	46%	52%	58%	72%	76%	77%	79%	81%	81%	79%	78%	80%
Hib3	7%	23%	30%	33%	54%	75%	77%	79%	81%	81%	79%	78%	80%
IPV1	.	.	.	.	.	.	.	0%	26%	61%	79%	79%	82%
MCV1	59%	61%	64%	68%	72%	76%	80%	79%	76%	78%	77%	76%	78%
MCV2	6%	4%	5%	5%	6%	5%	5%	11%	31%	37%	49%	59%	63%
PCV3	.	.	.	.	0%	8%	30%	71%	76%	79%	78%	76%	78%
POL3	63%	68%	70%	73%	76%	77%	80%	81%	80%	80%	75%	77%	79%
RCV1	0%	0%	0%	0%	0%	0%	0%	13%	19%	43%	51%	49%	50%
ROTAc	.	.	.	0%	0%	5%	9%	51%	66%	72%	76%	64%	74%
YF	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	1%	7%

Fig. 4. Average immunization coverage for 13 routine, new, and underutilized vaccines, Western Africa (WHO African Region), 2000–2024

	2000	2002	2004	2006	2008	2010	2012	2014	2016	2018	2020	2022	2024
BCG	63%	60%	64%	70%	78%	76%	74%	70%	78%	81%	83%	84%	89%
DTP3	45%	45%	52%	59%	67%	69%	60%	63%	69%	73%	71%	71%	76%
HepB-BD	0%	0%	5%	7%	12%	21%	21%	22%	24%	29%	39%	43%	44%
HepB3	1%	9%	26%	43%	62%	66%	63%	63%	69%	73%	71%	71%	76%
Hib3	0%	6%	6%	15%	28%	41%	47%	63%	69%	73%	71%	71%	76%
IPV1	.	.	.	.	.	.	.	0%	49%	63%	72%	69%	76%
MCV1	47%	47%	53%	59%	64%	67%	61%	60%	64%	67%	67%	63%	69%
MCV2	4%	5%	5%	6%	6%	6%	10%	13%	19%	20%	42%	39%	50%
PCV3	.	.	.	.	0%	1%	10%	23%	62%	70%	68%	68%	55%
POL3	47%	54%	58%	62%	69%	68%	62%	61%	68%	72%	71%	67%	75%
RCV1	0%	0%	0%	0%	0%	0%	0%	0%	2%	8%	12%	11%	11%
ROTAc	.	.	.	0%	0%	0%	0%	8%	11%	12%	13%	14%	14%
YF	4%	4%	12%	16%	17%	16%	16%	15%	14%	15%	15%	13%	14%

Figure notes: Given the low number of countries reporting coverage data on HPV1 to WUENIC, it has not been included in subregional analyses.

"." = vaccine not introduced in the reporting period.


©WHO

Introduction

Introduction

Immunization activities. Kilifi, Kenya

Immunization is one of the most impactful and cost-effective public health interventions available, averting over 4 million deaths globally every year. In addition to offering protection from preventable diseases, immunization brings children and families into contact with health systems, providing an avenue for the delivery of other basic health services and laying the foundation for primary health care. As such, ensuring universal access to vaccines is a critical entry point for universal health coverage.

Over the past 50 years, vaccines have saved an estimated 51.2 million lives in the African Region. For every infant life saved during that period, nearly 60 years of life have been gained. These achievements have been possible under the Expanded Programme on Immunization (EPI), a World Health Organization (WHO) initiative launched in 1974 to promote equitable access to life-saving vaccines for every child. With continued support from WHO, UNICEF, Gavi, the Vaccine Alliance, and other partners, most Member States in the WHO African Region

now provide antigens for 13 vaccine-preventable diseases (VPDs), up from the initial six when the EPI was introduced.

In less than a generation, the African Region has made tremendous strides in increasing access to immunization and reducing child deaths. Notable achievements include a substantial decline in measles-related deaths, with an estimated 19.5 million deaths averted since 2000. Meningitis deaths dropped by 39% in 2019 compared to 2000. Maternal and neonatal tetanus has nearly been eliminated, and in a historic public health achievement, in 2020 the African Region was declared free of indigenous wild poliovirus following years of relentless work to protect every child from the virus.

At the 28th African Union Summit in 2017, Heads of State from across Africa endorsed the Addis Ababa Declaration on universal access to immunization as a cornerstone for health and development. Calling on Member States and partners to increase efforts to mobilize resources and secure new investments to strengthen national immunization programmes, the declaration reaffirmed the imperative of reducing vaccine-preventable diseases. Since then, the Region has made significant progress in introducing new vaccines, enhancing VPD surveillance systems, and implementing numerous high-quality vaccination campaigns and coordinated multi-country outbreak responses.

In 2020, the World Health Assembly, with the support of countries and partners, endorsed a new global vision and strategy: Immunization Agenda 2030 (IA2030). This ambitious strategy aims to maximize the life-saving impact of vaccines and, if fully implemented, could save an additional 50 million lives over the next decade. In August 2021, the Regional Committee for Africa endorsed the framework for implementation of the IA2030 in the WHO African Region, aligning regional vision with the global strategy.

The IA2030 Framework for Action articulates three impact goals, along with several targets and strategic priority indicators:

- **Goal 1. Prevent disease** – Reduce mortality and morbidity from vaccine-preventable diseases for everyone throughout the life course.
- **Goal 2. Promote equity** – Leave no one behind, by increasing equitable access and use of new and existing vaccines.
- **Goal 3. Build strong immunization programmes** – Ensure good health and well-being for everyone by strengthening immunisation within primary health care and contributing to universal health coverage and sustainable development.

This report provides an overview of progress in the WHO African Region toward achieving the three impact goals of IA2030. It draws on annual WHO and UNICEF estimates of national immunization coverage (WUENIC) data and includes information on 14 different antigens covering 12 vaccine-preventable diseases.

The WHO African Region is making progress toward IA2030 goals by expanding immunization coverage, improving equity, and strengthening health systems to protect populations across the life course.

Impact goal 1. Prevent disease

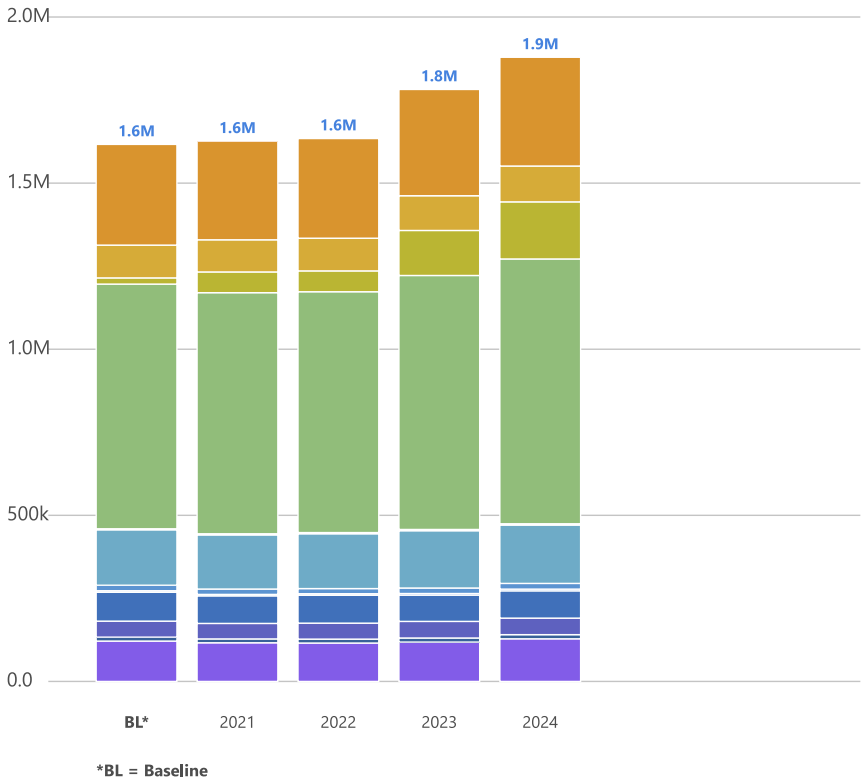
Immunization in Ethiopia

1.1 Lives saved

Progress towards impact goal 1 is measured by future deaths averted through vaccination, reflecting the impact of immunization on reducing morbidity and mortality. In 2024, modelling by the Global IA2030 Monitoring and Evaluation Team estimated that vaccination efforts in the WHO African Region saved approximately 1.9 million lives across 13 different vaccine-preventable diseases (Fig. 5). Five diseases – measles, hepatitis B, human papillomavirus, pertussis, and Yellow Fever – accounted for 85% of averted deaths.

In 2024, vaccination in the WHO African Region saved an estimated 1.9 million lives, with five diseases accounting for the majority of deaths averted.

Fig. 5 Estimated number of future deaths averted through immunization, WHO African Region, baseline (2019)–2024



Source: Immunization Agenda 2030 Scorecard (https://scorecard.immunizationagenda2030.org/ig1.1?reg=AFR, accessed 2 October 2025).

1.2 Disease targets met

IA2030 target 1.2. All countries achieve the disease control, elimination and eradication targets

Progress on the four diseases targeted for eradication and elimination in the WHO African Region remains mixed (Fig. 6). In August 2020, the Region was certified as free of wild poliovirus. Since 1996, polio eradication efforts have protected up to 1.8 million children from life-long paralysis and saved approximately 180 000 lives.[6]

Despite competing priorities in a challenging context, significant progress has been made towards eliminating maternal and neonatal tetanus. As of December 2024, a total of 43 countries in the Region have been validated for elimination, up from 30 in 2013. For the four countries yet to achieve elimination,[ii] WHO has intensified its support, focusing on promoting clean delivery practices, systematically immunizing pregnant women and women of reproductive age with tetanus toxoid-containing vaccines, and providing at least three doses of tetanus toxoid to women in high-risk areas through supplemental immunization activities.

Even though no country in the Region has yet been verified for measles and rubella elimination, six countries and areas have made sustained progress and are likely to achieve verification in the next 3–5 years. In 2023 and 2024, several countries[iii] reported consistently low incidence rates (fewer than five cases per million population), indicating progress towards the elimination of transmission.

[ii] Angola, Central African Republic, Nigeria, and South Sudan.
[iii] Botswana, Cabo Verde, Eritrea, Eswatini, Mauritius, Rwanda, Sao Tome and Principe, Seychelles, and Zimbabwe.

Fig. 6. Achievement of vaccine-preventable disease control, elimination, and eradication targets, WHO African Region, 2024

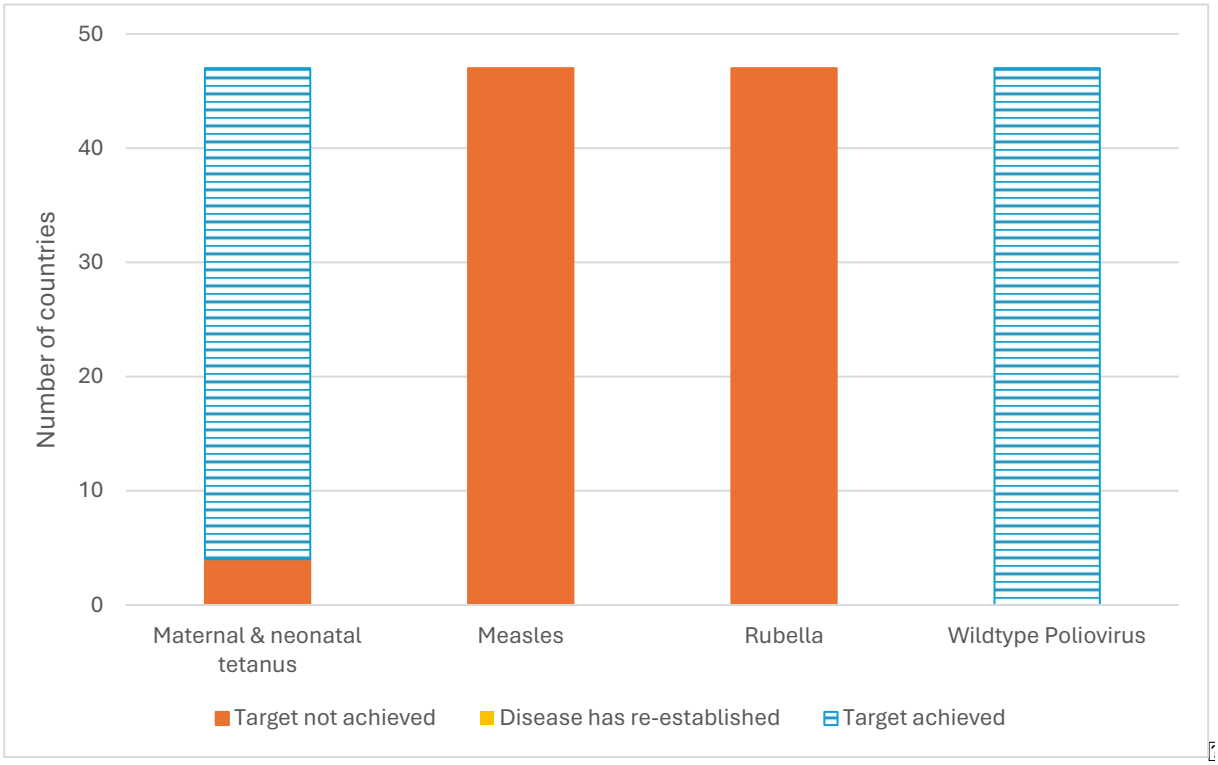


Figure notes: Maternal and neonatal tetanus – elimination as a public health problem; measles – elimination of transmission; rubella – elimination of transmission; wild-type poliovirus – eradication.

Source: Immunization Agenda 2030 Scorecard (https://scorecard.immunizationagenda2030.org/ig1.2?reg=AFR, accessed 2 October 2025).

1.3 Reduce outbreaks

IA2030 target 1.3. All selected VPDs show a declining trend in the number of large or disruptive outbreaks

The African Region experienced a resurgence of vaccine-preventable disease outbreaks, with large and/or protracted outbreaks of cholera, measles, meningococcus and circulating vaccine-derived poliovirus (cVDPV) reported across the continent between 2022 and 2024 (Fig. 7). Many of these outbreaks resulted from delays in implementing preventive vaccination campaigns on top of chronic gaps in routine immunization coverage. Cholera outbreaks in the Democratic Republic of the Congo and Somalia in 2023 demonstrated how protracted complex emergencies characterized by conflict- and violence-related displacement, climate shocks and food insecurity, can escalate into acute public health crises.

Delays in preventive vaccination and persistent routine immunization gaps have fueled major vaccine-preventable disease outbreaks in the African Region, particularly in fragile and emergency settings.

Fig. 7. Number of large or disruptive vaccine-preventable disease outbreaks, WHO African Region, baseline – 2024

Source: Immunization Agenda 2030 Scorecard (https://scorecard.immunizationagenda2030.org/ig1.3?reg=AFR, accessed 2 October 2025).

In response to these outbreaks, WHO has worked with ministries of health to implement outbreak response measures and/or accelerate preventive vaccination efforts. In 2024, WHO supported reactive mass vaccination campaigns against meningitis in Niger and Nigeria, reaching almost 5 million individuals with the Men5CV vaccine.[7] In Niger's Zinder region, 100% of the targeted 528 000 children and young adults were vaccinated, resulting in a significant reduction in cases. Similarly, in Nigeria's Jigawa State, full coverage was achieved, accompanied by a drastic reduction in cases post-campaign. To date, over 350 million at-risk individuals in the meningitis belt have been vaccinated against *group A Meningococcal meningitis*.

In 2023, a total of 12 Member States in the Region conducted measles/measles-rubella mass vaccination campaigns: one in response to an outbreak and 11 as preventive supplementary immunization activities. Over 65.6 million children were vaccinated, with six campaigns reaching over 95% administrative coverage.[8] In Malawi, WHO provided technical and financial support for an integrated typhoid, measles and polio vaccination campaign, which reached over 7.2 million children with a 79% coverage rate.[9]

In response to localized outbreaks of measles across the Region in 2024, WHO supported outbreak response activities in Cameroon, Ethiopia and Kenya, while 14 priority countries[iv] were supported to implement measles outbreak preparedness plans. Technical assistance was provided to several middle-income countries[v] to implement critical activities to strengthen measles surveillance, investigate outbreaks, and coordinate support for the implementation of mass campaigns; with measles surveillance activities supported in another 13 countries[vi] Measles STOP team members were deployed through WHO in Angola, Central African Republic, Chad, Equatorial Guinea, Ethiopia, Gabon, Guinea, Liberia, Madagascar, Niger, Nigeria, Sierra Leone and South Sudan.

WHO has supported countries across the African Region to respond rapidly to vaccine-preventable disease outbreaks through mass and preventive vaccination campaigns. High-coverage interventions against meningitis and measles in 2023–2024 reached millions of people, significantly reduced cases in affected areas, and strengthened outbreak preparedness, surveillance and response capacity across the Region.

[iv] Cameroon, Central African Republic, Chad, Democratic Republic of Congo, Ethiopia, Gabon, Guinea, Ethiopia, Liberia, Madagascar, Mali, Nigeria, Sierra Leone and South Sudan.
[v] Angola, Botswana, Eswatini, Gabon, Namibia and South Africa.
[vi] Burkina Faso, Cameroon, Chad, Ethiopia, Ghana, Guinea, Kenya, Liberia, Mali, Madagascar, Malawi, Sierra Leone and Zimbabwe.

Success story

The power of partnerships

Angola cholera vaccination

The World Health Organization (WHO), Global Fund to Fight AIDS, Tuberculosis and Malaria (the "Global Fund"), and Gavi, the Vaccine Alliance ("Gavi"), all play vital roles in the achievement of Sustainable Development Goal (SDG) 3: Ensure healthy lives and promote well-being for all at all ages. Like all SDGs, SDG 3 cannot be reached by a narrow lens; rather, it requires international collaboration and global solidarity, embodied within and across these three life-saving and impactful organizations.

The Global Fund and Gavi are the two largest global health funds, whose impact, work and accountability are enabled through the technical guidance, assistance, and pre-qualification of health products provided by WHO. WHO, as the health cluster lead of the United Nations (UN), coordinates health-related actions across the UN and other partners. While these three organizations each serve a different purpose, they work together in close partnership to achieve health and development goals. Close and effective collaboration between the three organizations ensures synergy

and complementarity at global, regional, and national levels.

The power of partnerships such as these is immense. Between 2000 and 2022, Gavi partnered with 40 African countries to support vaccines against 18 infectious diseases (including COVID-19, Ebola, and malaria), investing over US$ 11.9 billion – over half (58%) of their overall budget.[10] With this level of support, Gavi and partners have helped vaccinate a whole generation – over 1 billion children since 2000 – preventing more than 18.8 million future deaths. If fully funded, the work of WHO, the Global Fund, and Gavi could protect another 500 million children over the next five years, saving over 8 million lives.[11]

Moving forward, a shrinking fiscal space means that countries face greater challenges in ensuring sufficient resources are allocated for health services and systems. Coupled with a volatile geo-political context and multiple competing demands on donor budgets, seamless cooperation between the Global Fund, Gavi, and WHO is more important than ever. There is a shared commitment to making this work as impactful as possible, minimizing waste and ensuring complementarity of action.

Strong collaboration between WHO, the Global Fund and Gavi is essential to achieving SDG 3. By combining technical leadership, financing and coordinated action, these partners have helped save millions of lives through vaccination and disease control—and sustained, seamless cooperation will be critical to protect future generations amid growing financial and geopolitical constraints.

Impact goal 2. Promote equity

Burkina Faso: vaccination campaign against measles and rubella

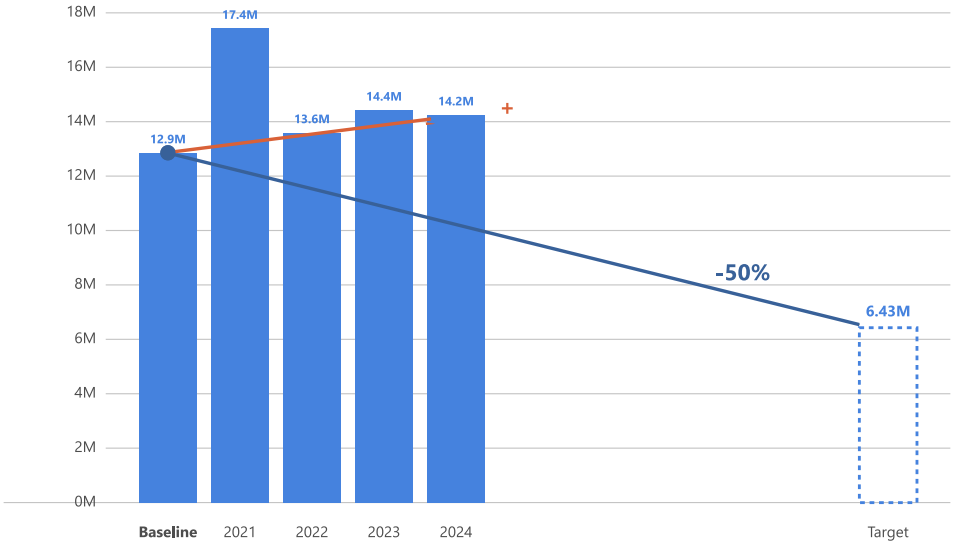
2.1 Reducing 'zero-dose' children

IA2030 target 2.1. Achieve a 50% reduction in the number of zero-dose children

Immunization services are an essential part of primary health care systems and a vital component of the right to health. However, some populations – often the poorest, most marginalized, and most vulnerable – have little or no access to these services. Globally, nearly 20 million infants do not receive a full course of even the most basic vaccines, and many more miss out on newer vaccines.[12] Of these, an estimated 14.2 million "zero-dose" children receive no vaccines at all through global immunization programmes.

As a result of improved immunization coverage, the number of zero-dose children in the WHO African Region decreased from a high of almost 8.75 million in 2013 to 6.2 million in 2019. However, this progress was reversed during 2021–2022 due to COVID-19-induced disruptions (Fig. 8). Although recent data show a renewed decline in zero-dose numbers post-pandemic, the overall trend remains upward and well above the IA2030 target of a 50% reduction.

Fig. 8. Number of zero-dose children in the WHO African Region, baseline (2019)–2024



Source: Immunization Agenda 2030 Scorecard (https://scorecard.immunizationagenda2030.org/ig2.1?reg=AFR, accessed 2 October 2025.

The backsliding of immunization coverage during the COVID-19 pandemic, combined with delayed catch-up efforts since 2020, has resulted in a large and growing immunity gap. Urgent action is needed to close this gap and ensure that millions of missed children are vaccinated, thereby mitigating the already visible consequences. The Essential Immunization Recovery Plan (a joint initiative between WHO, UNICEF, Gavi, the Vaccine Alliance, and the Immunization Agenda 2030 Partnership) sets out a path to getting immunization back on track. The plan is structured around three key approaches – Catch-Up, Restore and Strengthen.

The first component, the "Big Catch-Up", focuses on reaching over 86 million children who missed out on essential immunizations between 2019 and 2022, including approximately 61 million zero-dose children. However, not all countries have resumed delayed activities such as campaigns, and many planned interventions remain unimplemented. This initiative aims to urgently address gaps in individual and population immunity among birth cohorts that have grown month-on-month since early 2020. Twenty countries, home to 75% of the world's zero-dose children, were initially identified for prioritization, including nine from within the African Region.

In support of the initiative across the African Region, WHO revived three Regional Working Groups (RWGs). Designed to provide coordinated technical support, the RWGs identified an additional 15 priority countries for intensive support. WHO and partners collaborated closely to extend comprehensive support to these prioritized countries,[vii] who received support for the development, implementation, and monitoring of their essential immunization recovery plans. Beyond technical support, the RWG model proved instrumental in amplifying advocacy efforts and mobilizing resources. RWGs facilitated enhanced communication, enabling effective resource allocation and garnering increased support for immunization programs.

> **WHO's Regional Working Groups boosted support, advocacy, and resource mobilization for priority countries' immunization recovery.**

[vii] Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Cote d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gambia, Guinea, Guinea Bissau, Kenya, Madagascar, Mali, Mauritania, Mozambique, Niger, Nigeria, South Sudan, United Republic of Tanzania, Togo, and Zambia.

2.2 Supporting new or under-utilized vaccine introductions

IA2030 target 2.2. Vaccine introduction in low- and middle-income countries

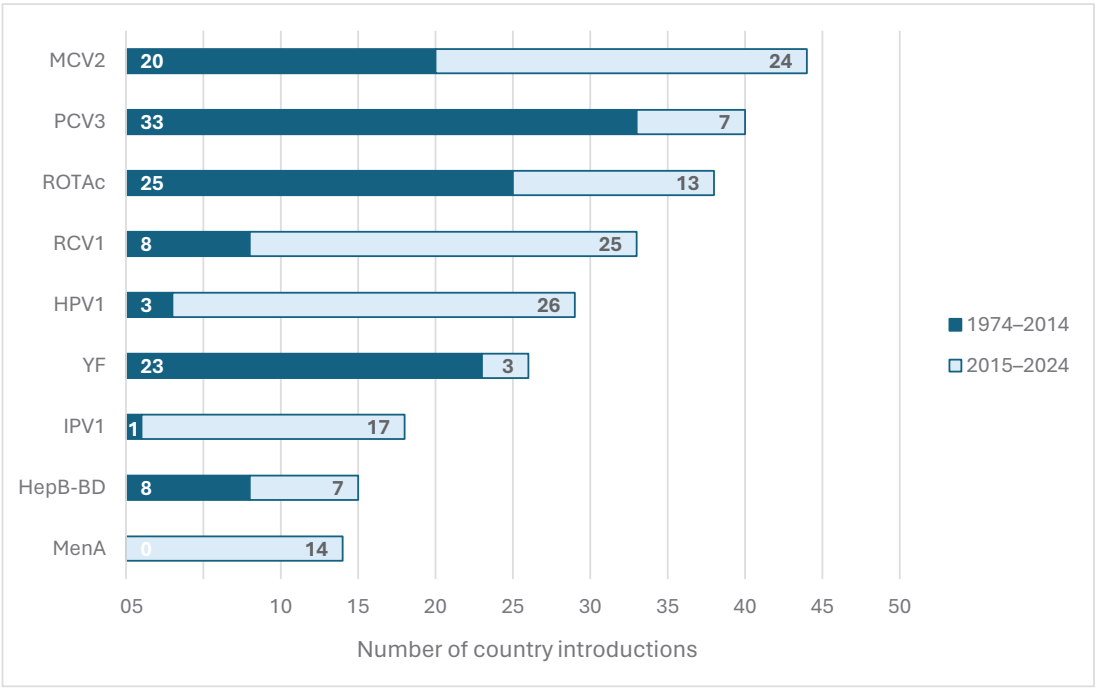
The African Region is on track to meet the IA2030 target for introducing new or underutilized vaccines, driven by increasing uptake in low-income countries. Under the Regional Strategic Plan for Immunization 2014–2020, the WHO Regional Office for Africa recommended that all 47 Member States introduce 10 new or underutilized vaccines, including six administered before the first birthday,[viii] and four beyond the first year of life.[ix]

By 2024, the Region had achieved 247 out of a possible 470 introductions: 33 Member States introduced RCV1; 44 introduced MCV2; and 29 introduced HPV1 (Fig. 9). All Member States that introduced the MenA vaccine did so after 2015. Additionally, 94% of Member States that introduced IPV1 and 87% of those that introduced HPV did so within the past eight years. The hepatitis B vaccine is now part of the routine immunization schedule in all 47 Member States, and as of 2022, 16 countries and areas provide a birth dose of the vaccine to all newborns.

Analysis of coverage data for eight of these vaccines, as reported through WUENIC, shows that IPV1 had the highest regional coverage in 2024, at 77% (Fig. 10). In contrast, coverage for the birth dose of the hepatitis B vaccine (HepB-BD) was the lowest, at just 17%. Coverage for PCV3 in the WHO African Region appears to be converging on the global average, while coverage for HPV1 surpassed the global average in 2020 (see Annex 1). Coverage for YF, implemented in only three of the six WHO regions, has remained closely aligned with the global average over the past two decades. The trend for RotaC remains mixed, while coverage for HepB-BD, IPV1 and MCV2 have consistently lagged behind global averages.

In 2024, IPV1 coverage was highest (77%) and HepB birth dose lowest (17%) in the African Region.

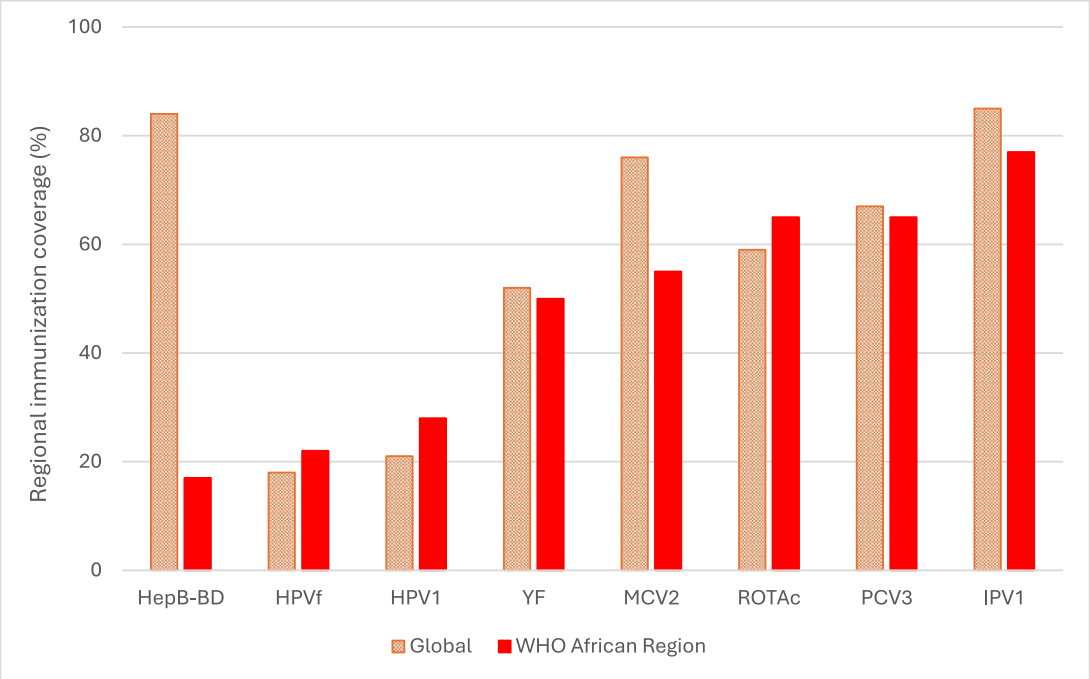
Fig. 9. Number of countries introducing new or underutilized vaccines, WHO African Region, 1974–2014 & 2015–2024



[viii] Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Cote d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gambia, Guinea, Guinea Bissau, Kenya, Madagascar, Mali, Mauritania, Mozambique, Niger, Nigeria, South Sudan, United Republic of Tanzania, Togo, and Zambia. Hepatitis B, birth dose (HepB-BD); pneumococcal conjugate, third dose (PCV3); meningococcal A conjugate (MenA); rotavirus, last dose (RotaC); rubella-containing vaccine, first dose (RCV1); and yellow fever (YF).

[ix] DTP booster; inactivated polio-containing vaccine, first dose (IPV1); measles-containing vaccine, second dose (MCV2); and human papillomavirus, first dose (HPV1).

Fig. 10. Average immunization coverage (%) for eight new or underutilized vaccines, WHO African Region (red bars) and global average (orange bars), 2024



At the subregional level, of the six new or underutilized vaccines analyzed, East and Southern Africa recorded the highest coverage for IPV1, MCV2, PCV3, and ROTAc; with Western Africa recording the highest coverage for HepB-BD, and Central Africa for YF (Fig. 11).

Progress for IPV1, PCV3, and ROTAc all show a similar pattern across the subregions, with substantial growth in coverage during the first half of the period, followed by an extended period of stagnation (see Annex 2). In contrast, coverage for MCV2 did not begin to improve substantially until around 2012. For the birth dose of the HepB vaccine (HepB-BD), while Western Africa has increased coverage from 0% in 2000 to 44% in 2024, progress in the other two subregions remains limited. For both Central and Western Africa, the greatest gains in YF coverage were made soon after vaccine implementation, while for East and Southern Africa, noticeable improvements have only recently been recorded.

Fig. 11. Average immunization coverage (%) for six new or underutilized vaccines by subregion, WHO African Region, 2024

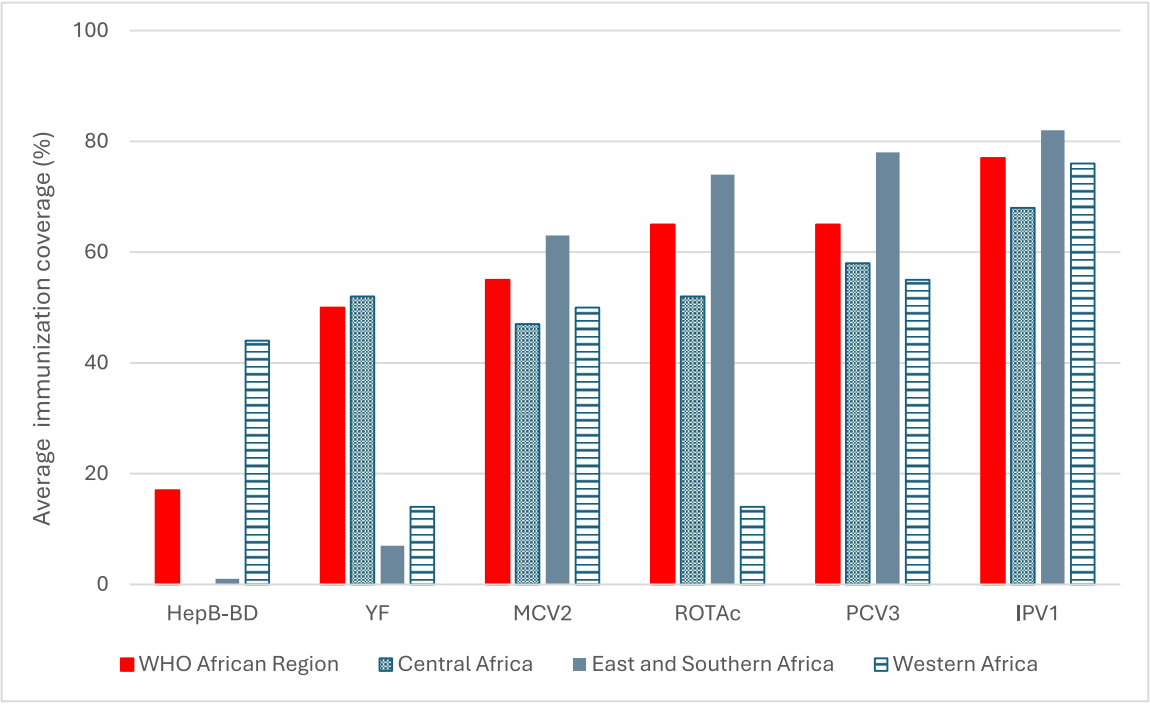


Figure notes: Given the low number of countries reporting coverage data on HPV1 and HPVf to WUENIC, they have not been included in subregional analyses.

Success story

The malaria vaccine: a game changer for the Region

Malaria vaccination campaign in Binava and Toumadi, Côte d'Ivoire: Malaria Vaccines 18-19 July 2024

Despite being preventable and curable, malaria remains a major health and development crisis in the African Region. It remains one of Africa's deadliest diseases, causing unacceptably high levels of illness and death, especially in sub-Saharan Africa and among children under five years of age.[13] During 2022 alone, an average of 52 children died from malaria every hour – almost one death per minute.[14]

Malaria is a disease of poverty and marginalization, disproportionately affecting chronically disadvantaged populations. Although remarkable progress has been made in reducing the overall burden of malaria over the past two decades using WHO-recommended core tools, certain population groups continue to experience higher rates of malaria-related morbidity and mortality, with limited access to life-saving interventions. Emerging resistance to insecticides and antimalarial drugs, coupled with the expanding geographical reach of malaria-carrying mosquitoes due to warmer and wetter climates, is eroding the effectiveness of current tools.

Overall, global progress against malaria has stalled in recent years. Despite notable gains since 2000, the milestones in the Global technical strategy for malaria are unlikely to be met. In the WHO African Region, where progress has been reversed in at least 13 countries and stalled in others, both the malaria morbidity and mortality milestones for 2025 are off track, by 52% and 50%, respectively.[15] In light of these challenges, new and complementary tools are urgently needed to further drive down the disease burden and move closer to a malaria-free world. One such innovation is the malaria vaccine, beginning with RTS,S/AS01 (RTS,S). The product of over 30 years of research and development, the vaccine was developed specifically for African children, who are most at risk of dying from malaria caused by *Plasmodium falciparum*, the most prevalent and deadly malaria parasite in the Region.

In 2019, the Malaria Vaccine Implementation Programme (MVIP) was launched in Ghana, Kenya and Malawi to increase access to RTS,S for the most vulnerable populations and save lives. In the first two years of the programme, over 2.3 million doses of the vaccine were administered through routine immunization systems. Critically, over four years of follow-up revealed a 39% reduction in malaria cases among vaccinated children; a 29% reduction in hospital admissions due to severe malaria; and a 29% decrease in the need for blood transfusions to treat life-threatening malaria anaemia.[16]

Data from these pilot programmes provided critical insights into vaccine acceptability and uptake, informing WHO's 2023 recommendation of a second malaria vaccine: R21/Matrix-M (R21). Results from a Phase 3 trial of the R21 vaccine showed a strong safety profile in clinical settings and up to 75% efficacy in reducing malaria among children.[17] Based on these critical milestones, malaria vaccine rollout is accelerating across the Region.

In November 2023, the first shipment of RTS,S vaccine arrived in Cameroon, a country not previously involved in the pilot programme. On 22 January 2024, Cameroon launched RTS,S into its routine national immunization schedule, becoming the first country outside the MVIP to do so. On the very next day, Liberia received over 112 000 doses of the RTS,S vaccine – its first ever shipment. These developments marked the start of a major initiative led by the WHO Regional Office for Africa: the Accelerated Malaria Vaccine Introduction and Rollout in Africa (AMVIRA) initiative.

Under AMVIRA, at least 28 countries in Africa plan to introduce the malaria vaccine into their childhood immunization programmes and national malaria control strategies. To guide the allocation of limited vaccine supplies, WHO has developed a framework that prioritizes areas with the highest malaria burden and greatest need. AMVIRA has pioneered a Malaria Vaccine Introduction Readiness Assessment Tool, strategically designed to comprehensively support malaria vaccine deployment across national and district levels. The tool employs a multi-dimensional analytical approach, systematically operationalizing key implementation preparedness domains. By leveraging specialized expertise in immunization, data science, risk communication and safety, AMVIRA is playing a pivotal role in facilitating systematic, evidence-driven malaria vaccine introduction

In addition to AMVIRA, WHO is working with partners such as Gavi, the Vaccine Alliance, to increase supply by expanding manufacturing capacity for RTS,S and R21 and by supporting the development of additional first-generation and next-generation malaria vaccines. As rollout expands to all eligible countries, WHO will continue to deploy technical experts (where needed), implement robust monitoring and evaluation mechanisms to track progress, and ensure timely interventions to address emerging challenges.

The widespread introduction of malaria vaccines has the potential to be a game changer in malaria control efforts, as it could prevent hundreds of thousands of cases and save tens of thousands of lives each year. Once integrated into routine childhood immunization schedules, malaria vaccines could become the third most impactful Gavi-supported vaccine in terms of lives saved.[18] The advent of malaria vaccines represents an historic moment in the fight against malaria, and their implementation and rollout remain critical priorities for WHO.

Malaria vaccines are being rolled out across Africa, saving lives and reducing disease burden.

Impact goal 3. Build strong immunization programmes

Malawi: HPV awareness and vaccination for cervical cancer prevention, July 2024

3.1 Deliver across the life course

IA2030 target 3.1. Achieve 90% coverage for tracer vaccines

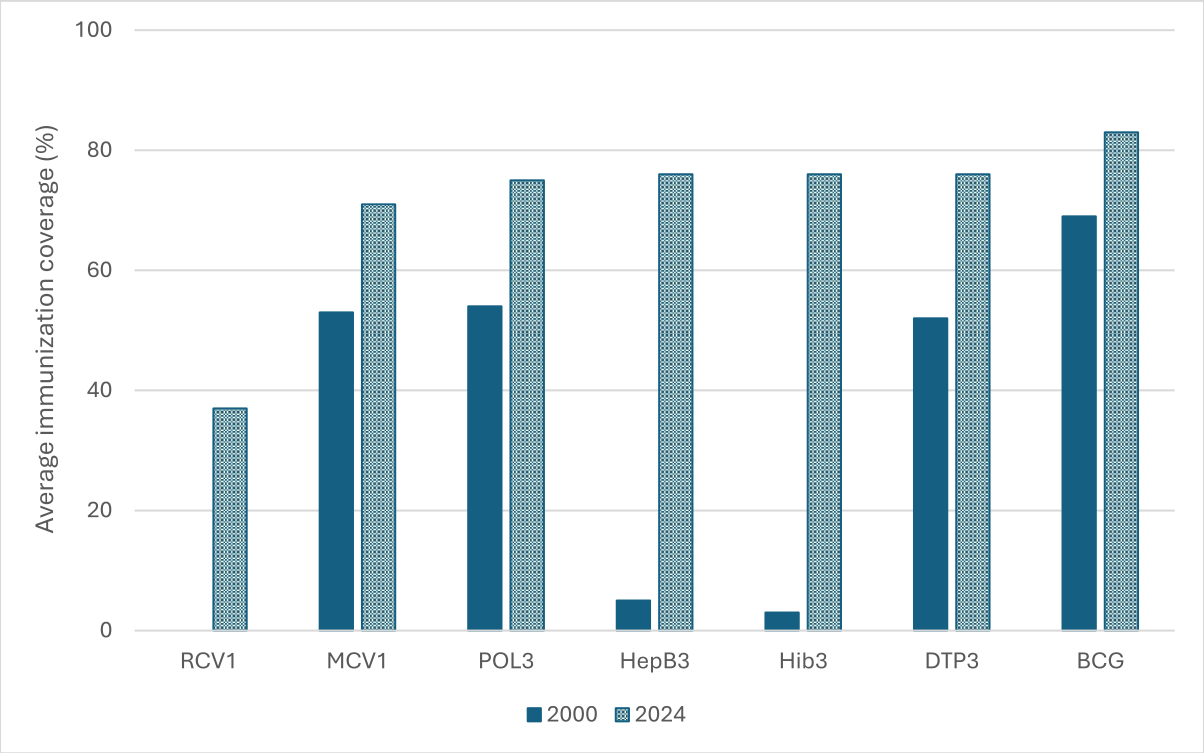
Impact goal 3 of IA2030 aims to promote health and well-being for all by strengthening immunization as a core component of primary health care, while contributing to universal health coverage and sustainable development. IA2030 measures vaccination coverage across various life stages, emphasizing the need for continuous immunization efforts throughout an individual's life – from infancy to adolescence and beyond. Four tracer vaccines are used to measure progress in this area. As shown in Figure 12, progress for the two routine vaccines (DTP3 and PCV3), while relatively high, are well below the 90% target and show limited improvement since 2019. Coverage for MCV2 and HPV1, as relatively new vaccines, show strong growth, but are also well below the target.

Fig. 12. Vaccination coverage across the life course, WHO African Region, baseline (2019)–2024

Source: Immunization Agenda 2030 Scorecard (https://scorecard.immunizationagenda2030.org/ig3.1?reg=AFR, accessed 2 October 2025).

In looking at routine immunization coverage more broadly, the WHO African Region is yet to achieve 90% coverage for any of the 13 vaccines (antigens) recommended by EPI for inclusion in routine immunization schedules (Fig. 13. Average immunization coverage (%) for seven routine vaccines, WHO African Region, 2000 and 2024). In 2024, BCG recorded the highest regional coverage among seven routine vaccines, at 83%. In contrast, RCV1, implemented in 33 countries, had the lowest coverage at 37%. Between 2000 and 2024, the Region achieved considerable gains in coverage for Hib3 (from 3% to 76%) and HepB3 (5–75%). However, most of these gains occurred between 2000 and 2005, with coverage levels plateauing between 2006 and 2011. Overall, coverage rates in the Region remained below the global average in 2024, a trend that has persisted over the past two decades (see Annex 3).

Fig. 13. Average immunization coverage (%) for seven routine vaccines, WHO African Region, 2000 & 2024



East and Southern Africa recorded the highest coverage rates for six of the seven routine vaccines in 2024: DTP3, HepB3, Hib3, MCV1, POL3, and RCV1, while Western Africa had the highest coverage for BCG (Fig. 14).

Central and Western Africa recorded substantial gains in DTP3 coverage between 2000 and 2009, with immunization coverage increasing by an average of 5.4% and 5.5% per year, respectively (see Annex 4). For East and Southern Africa, rapid growth continued until 2011. Since this time, growth for all subregions has been relatively modest, noting that the African Region introduced the combined DTP-HepB-Hib third dose vaccine in 2014, with combined coverage rates reported.

Progress for BCG, DTP3, MCV1, and POL3 all show a similar pattern across the subregions, with substantial growth in coverage during the first half of the period, followed by an extended period of stagnation. In contrast, coverage for RCV1 did not begin to substantially increase until around 2014. As with the other vaccines, after a period of rapid increase, coverage has plateaued, with major gaps in immunity.

Fig. 14. Average immunization coverage (%) for seven routine vaccines by subregion, WHO African Region, 2000 & 2024

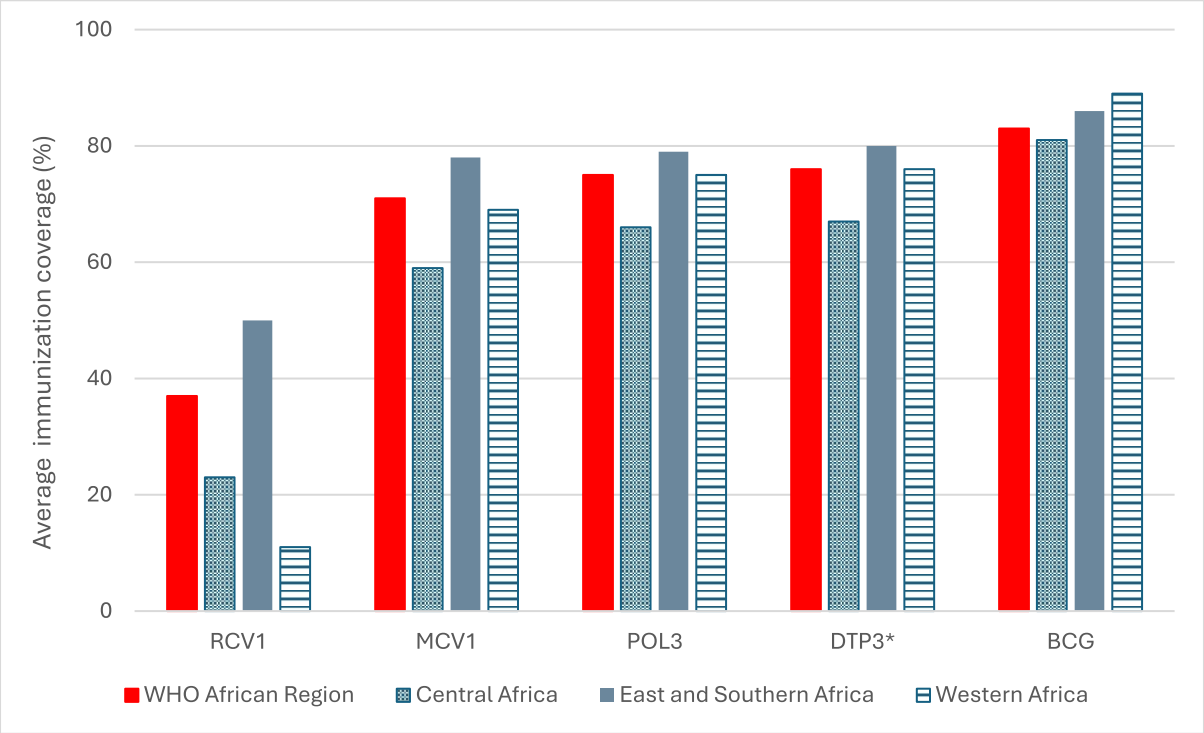


Figure notes: The WHO African Region introduced the combined DTP-HepB-Hib third dose vaccine in 2014. From that year onward, DTP3 coverage rates have reflected coverage for all three antibodies.

Success story

WHO in Africa: working to support regional immunization capacities

Democratic Republic of the Congo: Polio Vaccination Campaign - 25 October 2024

The Health Promotion, Disease Prevention and Control Cluster (DPC) is the largest public health programme in the African Region. Established within the World Health Organization's Regional Office for Africa, DPC is responsible for delivering on the region's strategic agenda of Sustainable Development Goal 3. This includes expanding universal health coverage, communicable and noncommunicable disease control, and endgame strategies for defeating neglected tropical diseases.

The vision of the Vaccine-Preventable Diseases (VPD) Programme, located within DPC, is an Africa with sustained disease eradication, elimination, or control for polio, measles, rubella, tetanus and hepatitis; reduced mortality from priority diseases; and countries empowered address diseases such as meningitis, cholera, typhoid, and yellow fever. The mission of the programme is to support Member States to provide life-saving immunization services to tackle VPDs through an integrated, multisectoral

life-course approach within the broader health system, utilizing available and new vaccines and technologies to ensure equitable access to immunization and other primary healthcare services.

Pioneering innovation

As part of its commitment to fostering sustainable, country-led solutions, in February 2025, WHO introduced the VIKESA (Vaccine Introduction Knowledge Exchange Series in Africa) initiative. VIKESA provides a platform for the regular convening of countries, partners, and technical experts involved in vaccine introductions. This innovative community of practice model already has:

- Accelerated knowledge transfer through real-time peer learning.
- Strengthened country ownership by positioning African nations as both learners and teachers.
- Enhanced operational efficiency through rapid dissemination of evidence-based practices.

Building regional immunization expertise

National immunization technical advisory groups (NITAGs) are multidisciplinary bodies of national experts that provide evidence-based recommendations to policy-makers and immunization programme managers. They develop recommendations by systematically gathering, reviewing and evaluating available evidence and incorporating this into the local epidemiological and social context. WHO has worked to strengthen the functionality of NITAGs across the Region, helping to establish NITAGs in two additional Member States in 2024, bringing the total number of Member States with standing NITAGs in the African Region to 44.

In the same year, two multi-country capacity-building workshops on NITAG operations and the evidence to recommendation (EtR) process were conducted for 11 countries,[x] alongside standalone NITAG training sessions in Comoros and Mauritania. These workshops, attended by over 160 participants, led to nine Member States updating their internal NITAG procedural manuals and four developing their first set of functional tools. Additionally, eight NITAG webinars were organized, covering topics such as the EtR process, transition to hexavalent vaccines, the hepatitis B birth dose EtR toolkit, and Gavi application guidelines for the hepatitis B birth dose vaccine. In collaboration with the NITAG Support Hub, three additional webinars were held on African experiences with the deployment of novel oral polio vaccines, the Ebola preventive programme, and the mpox outbreak response.

WHO also supported NITAG self-assessments in 15 Member States[xi] and facilitated external assessments in Rwanda and South Africa using the NITAG Maturity Assessment Tool (NMAT). Over the past five years, 28 Member States have established NMAT maturity profiles and tailored improvement plans. Of these, 20 Member States (74%) have achieved an overall maturity score above 50%.

Strengthening research and innovation

WHO has been working with countries in the African Region to boost local research and innovation. In June 2025, the Chair of the Regional Immunization Technical Advisory Group (RITAG), gathered in Brazzaville to deliberate on ways of strengthening immunization across the life course.[19] RITAG, which is hosted by WHO, is a platform to shape concrete actions and generate recommendations to guide policy decisions, drive investment, strengthen partnerships and support local vaccine production – all in line with the goals of the Immunization Agenda 2030.

During the four-day deliberations, RITAG members and representatives from ministries of health, WHO, Gavi, UNICEF, Africa Centres for Disease Control and Prevention, the Gates Foundation, and other partners reviewed the latest data, identified priority actions, and formulated evidence-based recommendations. Discussions addressed strategies to reach zero-dose children, introduce new vaccines, strengthen epidemic preparedness, and expand local vaccine manufacturing.

[x] Algeria, Angola, Cabo Verde, Cameroon, Chad, Democratic Republic of the Congo, Guinea Bissau, Mozambique, Sao Tome and Principe, Senegal, and Togo.

[xi] Angola, Botswana, Burundi, Democratic Republic of the Congo, Guinea, Guinea-Bissau, Kenya, Madagascar, Mali, Mozambique, Niger, Senegal, Sierra Leone, Togo, and Zimbabwe.

Composed of leading experts in public health, epidemiology, virology, health systems and community engagement, RITAG – the principal advisory body to the WHO African Region on vaccines and immunization – has provided independent, evidence-based guidance to inform regional immunization policy, support implementation, and promote innovation across the vaccine life cycle, from research to delivery.

Amid growing financial constraints affecting the scale and pace of immunization efforts, the forum provided a critical opportunity to reinforce coordination, align technical and financial resources, and identify practical solutions to accelerate country-level implementation. Discussions also focused on advancing equity, strengthening sustainability, and supporting the region's path toward vaccine self-reliance. Participants agreed on the need for sustained collaboration, innovative financing, and stronger accountability to deliver on shared immunization goals.

Improving access to quality medical products

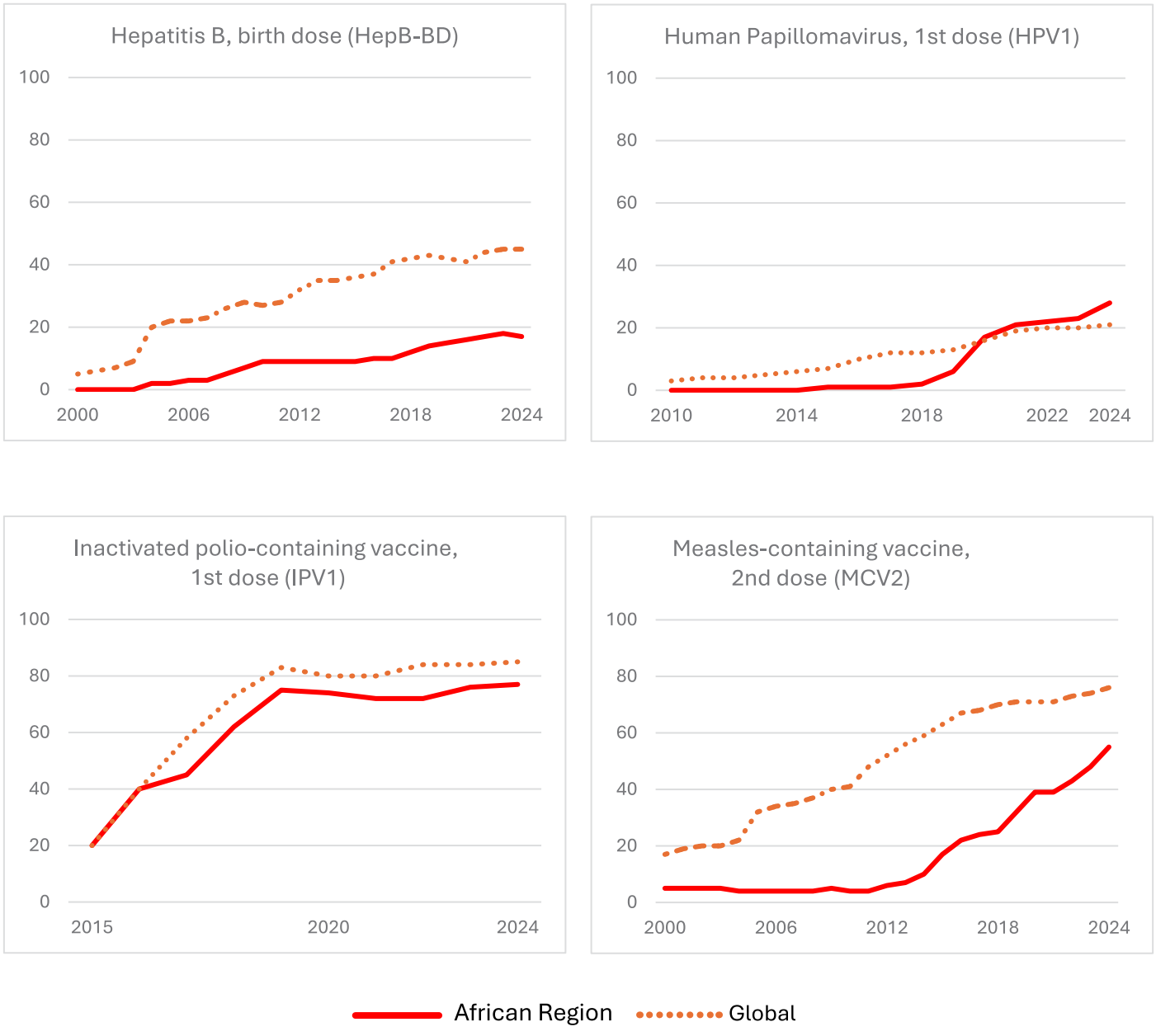
Established by WHO in 2006, the African Vaccine Regulatory Forum (AVAREF) has evolved into a strong network of partners and medical professionals who work with Member States to build capacity and improve the harmonization of regulatory practices on the African continent in support of product development. Located within the WHO African Regional office, the aim of the AVAREF Secretariat is to improve access to medical products across the continent by reducing review and approval times for clinical trial applications, while optimizing the quality of regulatory processes.

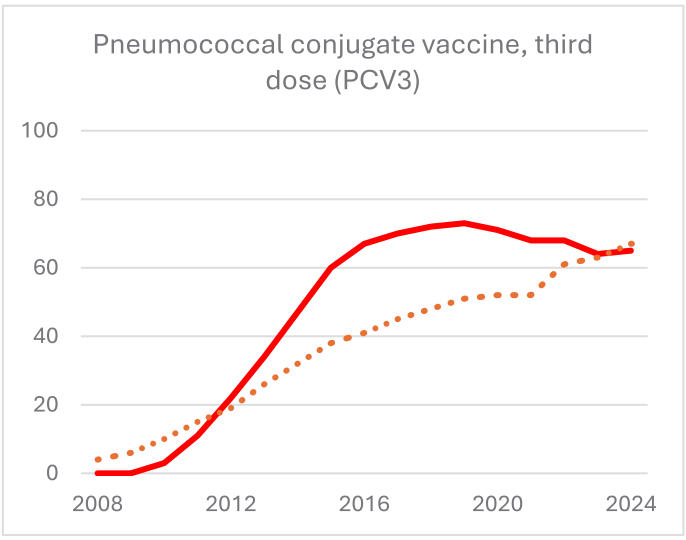
With the support of WHO, the AVAREF Secretariat recruited a full complement of staff and worked with Member States and partners, helping to strengthen regulatory and ethics oversight and ensuring heightened vaccine safety. During 2023, the Secretariat developed a comprehensive two-year strategic and operational plan (2024–2025) focusing on strengthening the core functions of AVAREF, strengthening existing partnerships and establishing new ones for effective delivery of results, provision of specialized capacity building activities and effective communication of results. The strategic and operational plan will enable AVAREF to provide the regulatory and vaccine life-cycle capacity building services required by National Regulatory Agency staff and facilitate the realization of the African Medicines Agency to have Africa producing 60% of its vaccines by 2040.

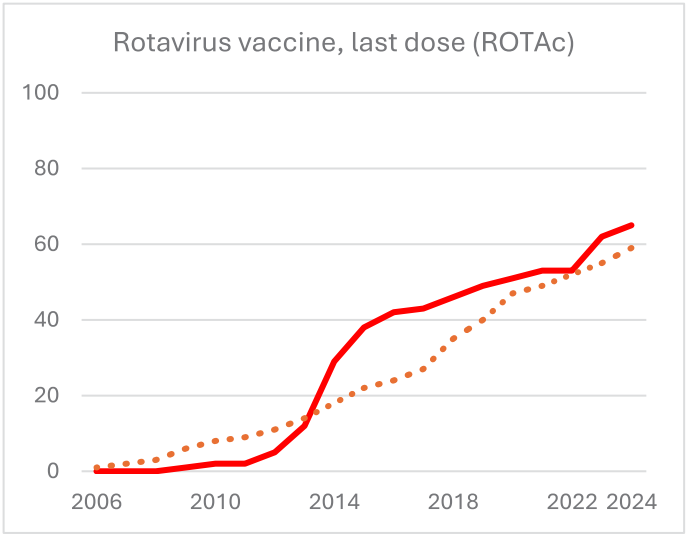
During 2024, WHO supported AVAREF to strengthen its leadership role by forging new partnerships with the US Food and Drug Administration and the Coalition for Epidemic Preparedness Innovations to enhance safety and efficacy monitoring during the introduction of new vaccines, under the African Union Smart Surveillance System project. These collaborations supported the integration of emergency preparedness into AVAREF's capacity-building initiatives. In addition, AVAREF expanded its network by engaging vaccine manufacturers, including the African Vaccine Manufacturers Initiative, International Vaccines Institute, and Malaria Vaccine Venture, in its biannual Technical Coordinating Committee and Advisory Committee meetings. These discussions focused on future initiatives and fostering valuable partnerships to drive progress in vaccine development and regulation.

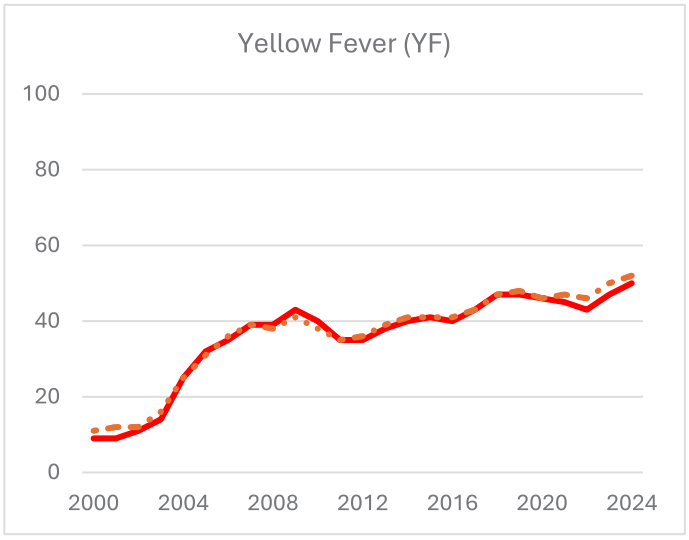
Annexes

Annex 1. Average immunization coverage (%) for seven new or underutilized vaccines, WHO African Region and global average, year of implementation to 2024









African Region Global

Annex 2. Average immunization coverage (%) for six new or underutilized vaccines by subregion, WHO African Region, year of implementation to 2024

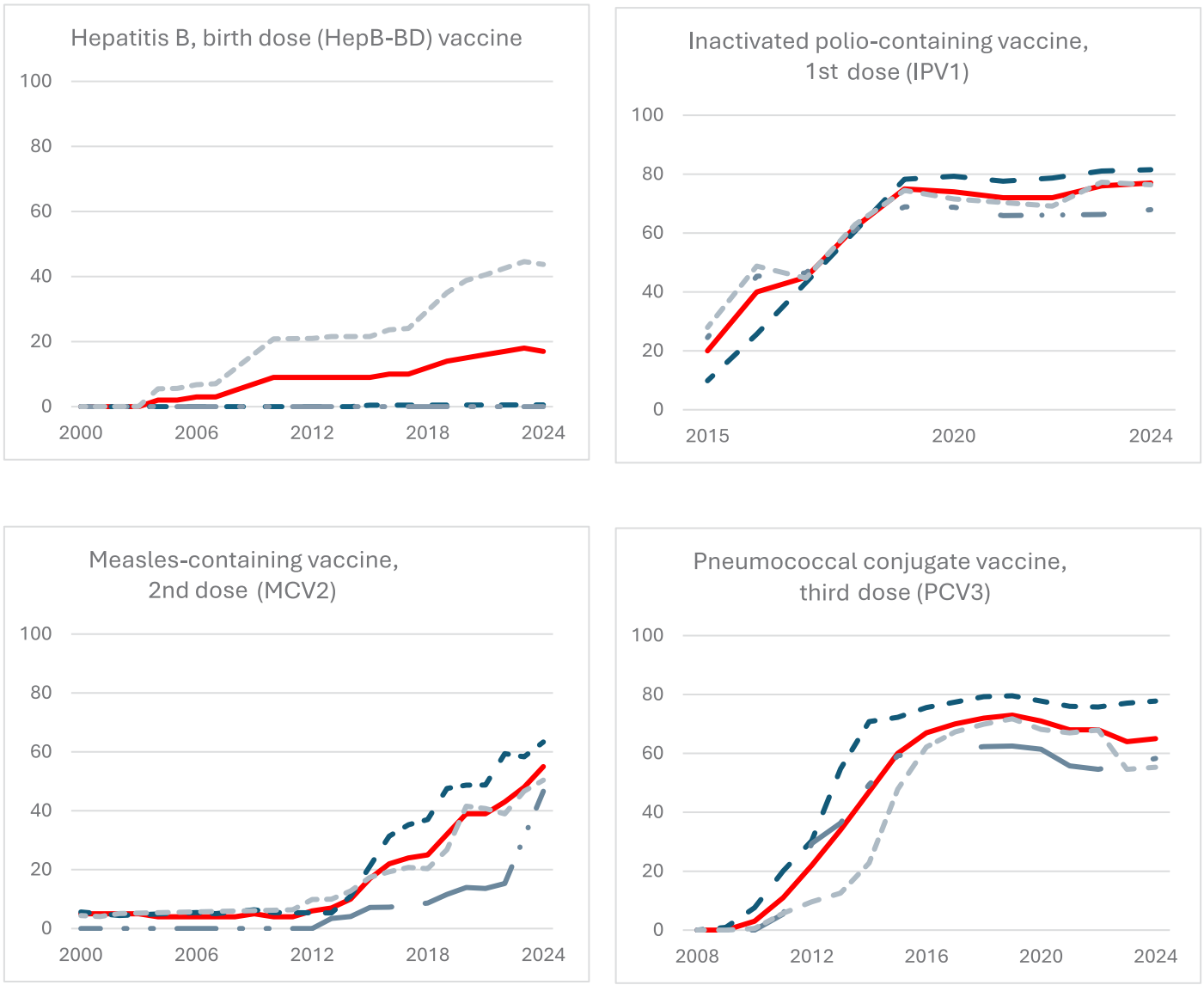
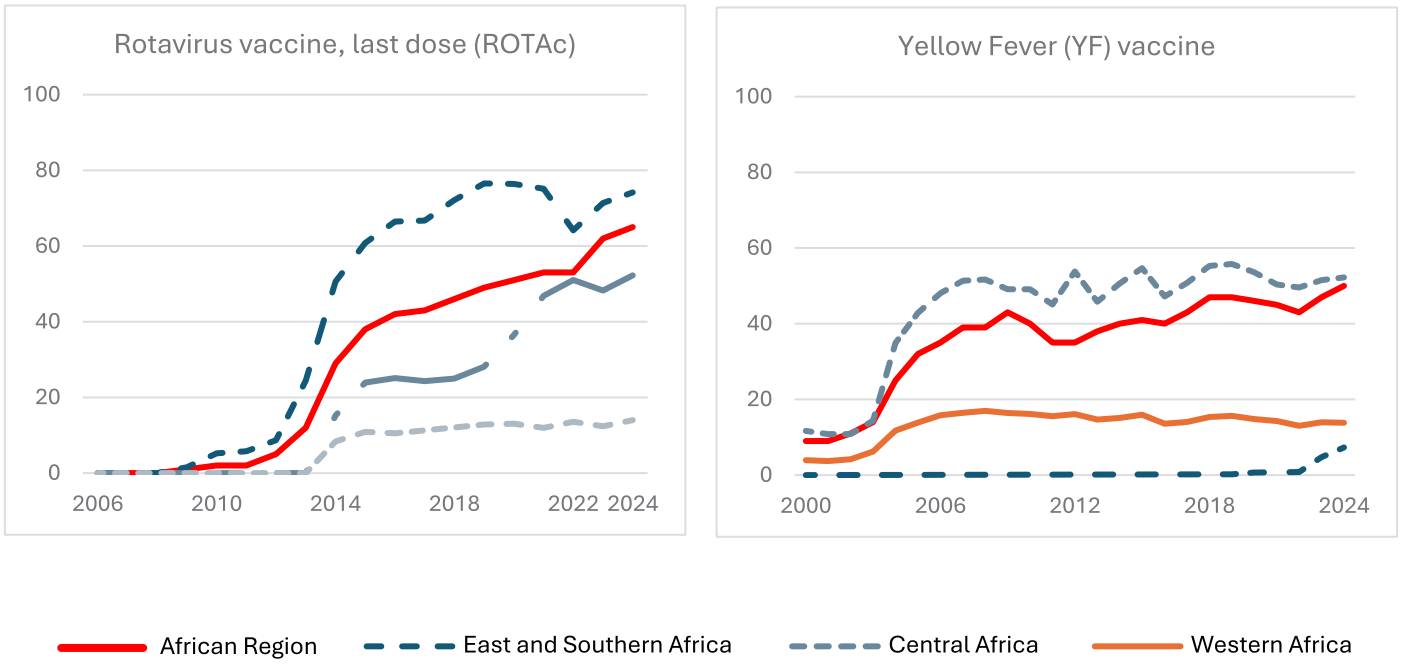


Figure notes: Given the low number of countries reporting coverage data on HPV1 WUENIC, its has not been included in subregional analyses.

African Region — East and Southern Africa — Central Africa — Western Africa


Rotavirus vaccine, last dose (ROTAc)
100
80
60
40
20
0
2006
2010
2014
2018
2022
2024
Yellow Fever (YF) vaccine
100
80
60
40
20
0
2000
2006
2012
2018
2024
African Region
East and Southern Africa
Central Africa
Western Africa

Annex 3. Average immunization coverage (%) for seven routine vaccines, WHO African Region and global average, 2000–2024

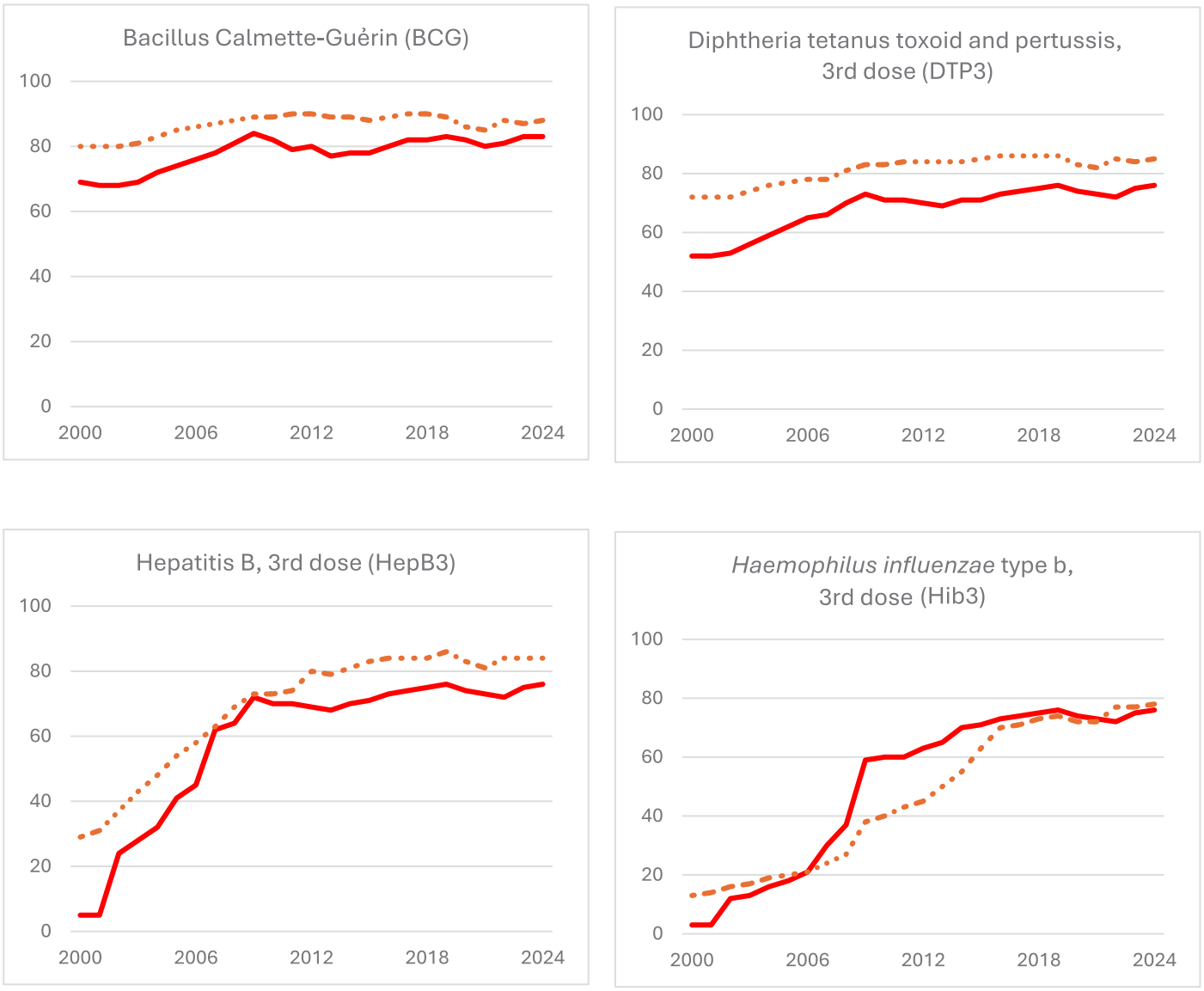
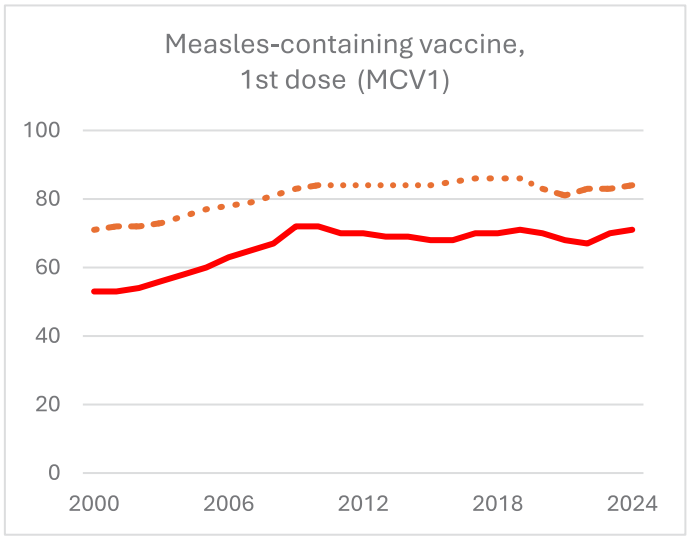
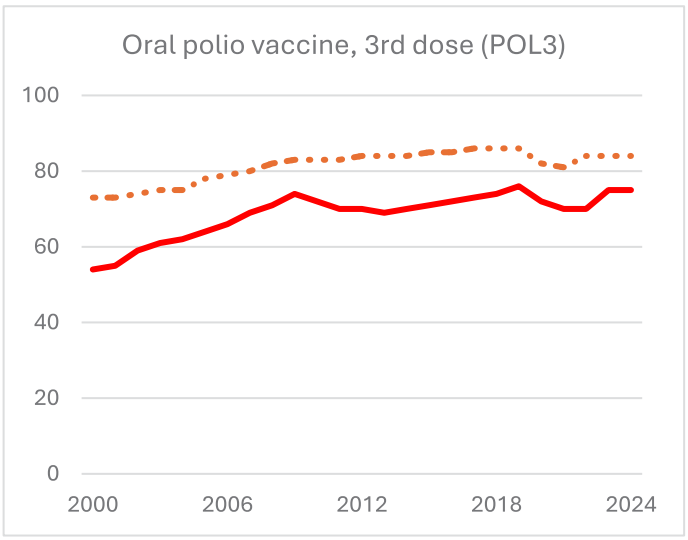
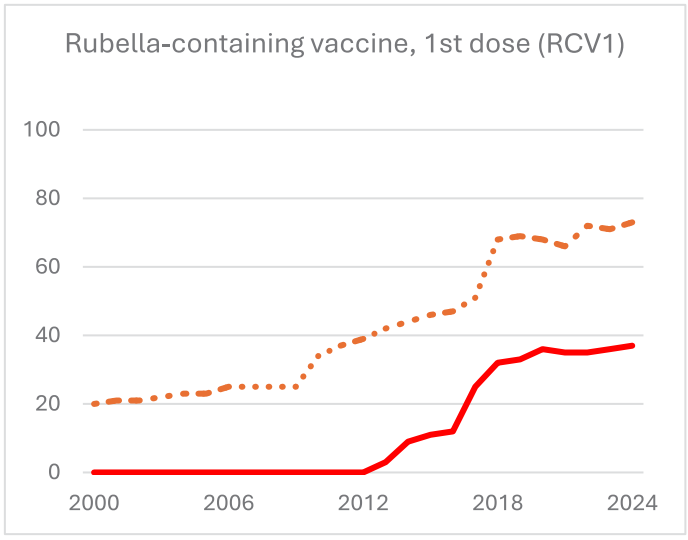


Figure notes: The WHO African Region introduced the combined DTP-HepB-Hib third dose vaccine in 2014. From that year onward, DTP3 coverage rates have reflected coverage for all three antibodies.







African Region Global

Annex 4. Average immunization coverage (%) for seven routine vaccines by subregion, WHO African Region, 2000–2024

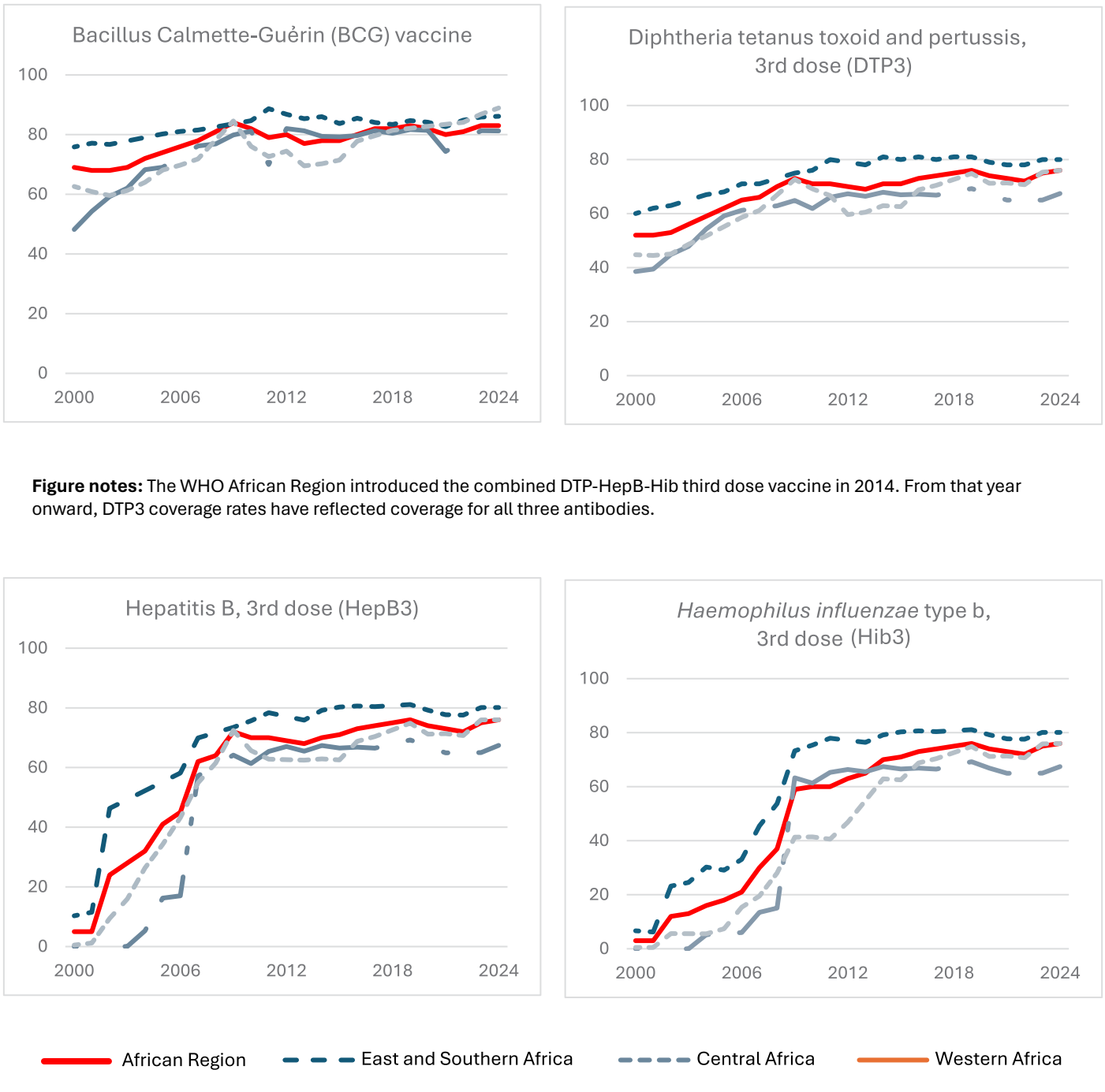
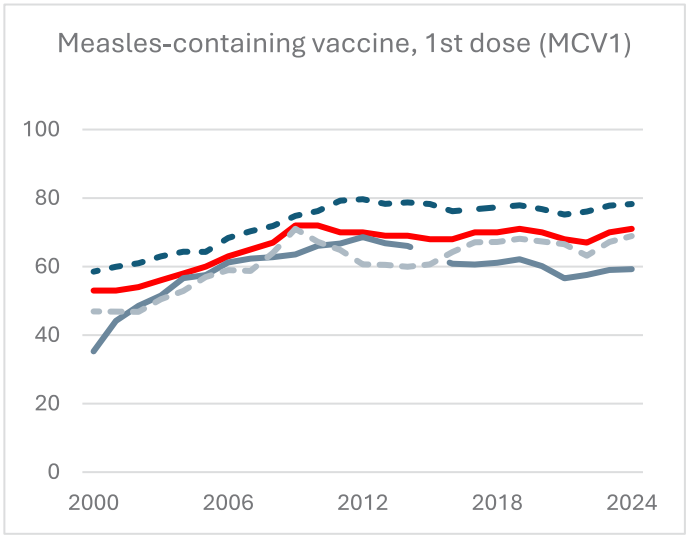
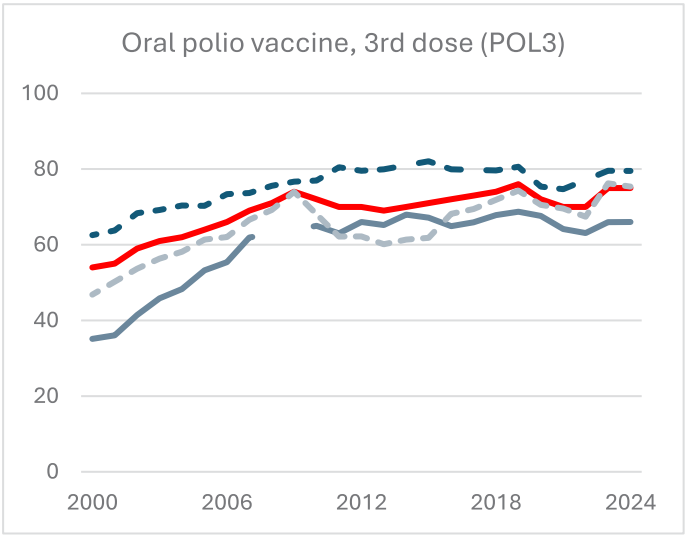
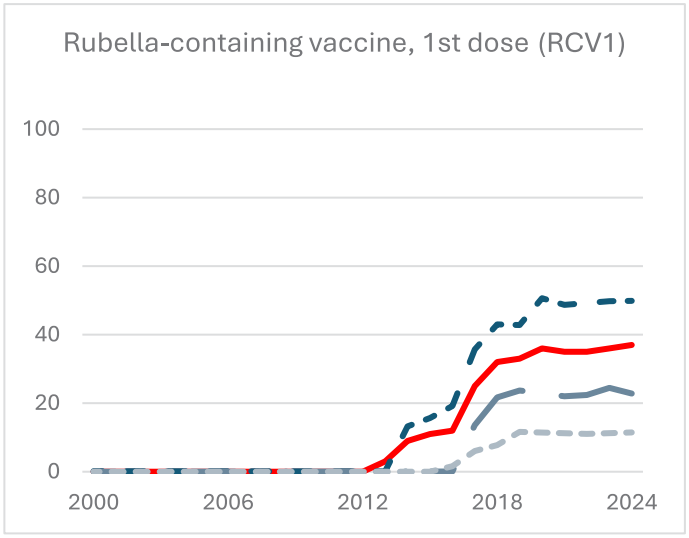


Figure notes: The WHO African Region introduced the combined DTP-HepB-Hib third dose vaccine in 2014. From that year onward, DTP3 coverage rates have reflected coverage for all three antibodies.







African Region — East and Southern Africa — Central Africa — Western Africa

Data sources

The annual WHO and UNICEF estimates of national immunization coverage (WUENIC) provide the world's largest dataset on aggregated immunization coverage trends for 14 antigens.

Each year in mid-July, WHO and UNICEF jointly release updated WUENIC estimates for 195 Member States, describing the performance of routine childhood immunization programmes. These estimates are based on a comprehensive review of immunization coverage data submitted by Member States through the WHO/UNICEF Joint Reporting Form on Immunization (JRF). They also incorporate evidence from published and grey literature (such as vaccination coverage surveys, demographic and health surveys, and UNICEF's multiple indicator cluster surveys), as well as expert input from national Expanded Programme on Immunization (EPI) managers and WHO regional office staff. This triangulated approach enables WHO and UNICEF to estimate the most likely immunization coverage levels for each country.

Endnotes

1. Health topics: Immunization [website]. Brazzaville: WHO Regional Office for Africa; 2024 (https://www.afro.who.int/health-topics/immunization, accessed 30 July 2024).
2. Over 50 million lives saved in Africa through expanded immunization programme. Brazzaville: WHO Regional Office for Africa; 24 April 2024 (https://www.afro.who.int/news/over-50-million-lives-saved-africa-through-expanded-immunization-programme, accessed 20 June 2024).
3. Ibid.
4. Ibid.
5. Number of future deaths averted through immunization – WHO African Region. IA2030 Scorecard [website]. Immunization Agenda (IA2030), 2025 (https://scorecard.immunizationagenda2030.org/ig1.1?reg=AFR, accessed 2 October 2025).
6. Ending disease in Africa: responding to communicable and noncommunicable diseases, progress report 2020–2022. Brazzaville: WHO Regional Office for Africa, 2023 (https://www.afro.who.int/publications/ending-disease-africa-responding-communicable-and-noncommunicable-diseases-progress, accessed 25 July 2025).
7. Ending disease in Africa: Responding to communicable and noncommunicable diseases in 2023. Brazzaville: WHO Regional Office for Africa; 2024 (https://www.afro.who.int/sites/default/files/2024-04/UCN%20Cluster%20Report_2023.pdf, accessed 25 July 2025).
8. Ibid.
9. Ibid.
10. Petu A, Masresha B, Wiysonge CS, et al. Reflections on 50 years of immunisation programmes in the WHO African Region: an impetus to build on the progress and address the unfinished immunisation business. BMJ Glob Health 2025;10:e017982 (https://gh.bmj.com/content/10/5/e017982).
11. Impactful partnership in action: Global Fund, Gavi, and WHO. December 2024.
12. Explaining the Immunization Agenda 2030. Geneva: World Health Organization (https://www.who.int/teams/immunization-vaccines-and-biologicals/strategies/ia2030/explaining-the-immunization-agenda-2030).
13. Setting up the Strategic Initiative for the Acceleration of Malaria Vaccine Introduction and Rollout Across Africa (AMVIRA). Concept note. Brazzaville: WHO Regional Office for Africa; 2024 (https://www.afro.who.int/sites/default/files/2024-02/Concept%20note_AMVIRA_2.0%20.pdf).
14. World malaria report 2023. Geneva: World Health Organization; 2023. Licence: CC BY-NC-SA 3.0 IGO (https://www.who.int/publications/i/item/9789240086173).
15. Ibid.
16. First malaria vaccine in Africa: a potential new tool for child health and improved malaria control. Geneva: World Health Organization, 2019 (https://www.who.int/publications/i/item/WHO-CDS-GMP-2018.05).
17. Datoo MS, Dicko A, Tinto H, Ouédraogo J-B, et al. Safety and efficacy of malaria vaccine candidate R21/Matrix-M in African children: a multicentre, double-blind, randomised, phase 3 trial. The Lancet 2024; 403(10426): p533–544. DOI: https://doi.org/10.1016/S0140-6736(23)02511-4.
18. Berkley S. As the world's first ever malaria vaccine is approved, we cannot let it be the last. The Telegraph: 3 December 2021 (https://www.telegraph.co.uk/global-health/science-and-disease/worlds-first-ever-malaria-vaccine-approved-cannot-let-last/).
19. Immunization experts urge stronger action to close vaccination gaps in Africa. Brazzaville: WHO Regional Office for Africa, 4 July 2025 (https://www.afro.who.int/news/immunization-experts-urge-stronger-action-close-vaccination-gaps-africa).

The WHO Regional Office for Africa

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Africa is one of the six regional offices throughout the world, each with its own programme geared to the particular health conditions of the Member States it serves.

Member States

Algeria
Angola
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
Lesotho
Liberia
Madagascar
Malawi
Mali
Mauritania
Mauritius
Mozambique
Namibia
Niger
Nigeria
Rwanda
Sao Tome and Principe
Senegal
Seychelles
Sierra Leone
South Africa
South Sudan
Togo
Uganda
United Republic of Tanzania
Zambia
Zimbabwe

World Health Organization
Regional Office for Africa
Health Promotion
Disease Prevention and Control Cluster
Cité du Djoué
PO Box 6, Brazzaville
Congo
Telephone: +(47 241) 39402
Fax: +(47 241) 39503
Email: afrgocom@who.int
Website: https://www.afro.who.int/