



Ending disease in Africa



Regional Immunisation Technical Advisory Group (RITAG) MEETING REPORT

WHO Regional Office for Africa (AFRO)

November 2023



World Health
Organization

African Region

**Regional Immunisation Technical
Advisory Group (RITAG)
MEETING REPORT**

UHC/UCN Cluster
World Health Organization
Regional Office for Africa
Brazzaville • 2023

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Layout and design: WHO Regional Office for Africa, Brazzaville, Congo



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Abbreviations

ADI	Addis Declaration on Immunisation
AMA	African Medicines Agency
AVAREF	African Vaccine Regulatory Forum
BeSD	Behavioural and Social Drivers of vaccination
bOPV	Bivalent oral polio vaccine
CHW	Community health worker
cVDPV	Circulating vaccine-derived poliovirus
cVDPV1	cVDPV type 1
cVDPV2	cVDPV type 2
COVID-19	Coronavirus disease
EPI	Expanded Programme on Immunisation
EUL	WHO Emergency Use Listing
GPEI	Global Polio Eradication Initiative
HCW	Healthcare workers
HepB0	Hepatitis B birth dose
HPV	Human papillomavirus
IA2030	Immunisation Agenda 2030
IRC	International Rescue Committee
MAC	Multi age cohort
Men5CV	Pentavalent meningococcal conjugate vaccine targeting serogroups A, C, Y, W and X
MenACV	Meningitis A conjugate vaccine
MMCV	Multivalent meningococcal conjugate vaccine
MNT	Maternal and neonatal tetanus
MVIP	Malaria Vaccine Implementation Programme
NIS	National Immunisation Strategy
NITAG	National Immunisation Technical Advisory Group
NmA	Neisseria meningitidis A
NRA	National regulatory authority
NVI	New vaccine introduction
PHEIC	Public Health Emergency of International Concern
RI	Routine immunisation
RITAG	Regional Immunisation Technical Advisory Group
RSPI	Regional Strategic Plan for Immunisation
SAGE	Strategic Advisory Group of Experts on Immunisation
SIA	Supplementary immunisation activity
VPD	Vaccine preventable diseases
WHO	World Health Organisation
WHO/AFRO	WHO Regional Office for Africa
WPV	Wild poliovirus
WUENIC	WHO/UNICEF Estimates of National Immunisation Coverage






EXECUTIVE SUMMARY

The first post-COVID-19 pandemic in-person meeting of the African Regional Immunisation Technical Advisory Group (RITAG) took place at the WHO Regional Office for Africa (WHO/AFRO), in Brazzaville, Republic of Congo from 7 to 9 November 2023. This presented an opportunity for the newly appointed RITAG members to meet WHO/AFRO's Senior Management, the Vaccine-Preventable Diseases (VPD) team, other immunisation partners, and national health and immunisation stakeholders.

The main objectives of the meeting were to review the progress, successes, and challenges of immunisation in the WHO African Region, as well as the lessons learnt during the COVID-19 pandemic. The three-day meeting also provided an opportunity to reflect on current priorities, future direction, and key strategic shifts needed to get the region back on track towards achieving the Immunisation Agenda 2030 (IA2030) goals and targets.

Dr Matshidiso Moeti, WHO Regional Director for Africa, in her video-recorded opening remarks, acknowledged the role and contribution of the RITAG to the region's immunisation agenda. She also welcomed and called upon the newly appointed RITAG members to 'provide evidence-based advice and recommendations on regional immunisation policies to WHO/AFRO. Dr Moeti highlighted that the negative impact of the COVID-19 pandemic on countries' health systems taught us useful lessons, including implementation of the COVID-19 vaccination roll-out, behavioural change, and the critical



importance of strong political leadership. She guided that these lessons should be applied to vaccine acceleration and catch-up work across the region.

On behalf of the WHO Regional Director for Africa, Dr Joseph Cabore, the Director of Programme Management, welcomed participants, and opened the meeting. The participants present were RITAG members; Chairs of National Immunisation Technical Advisory Groups (NITAGs) from six pre-selected countries; National Managers of the Expanded Programme on Immunisation from 14 pre-selected countries; immunisation partners; civil society organizations; and WHO staff from all three levels (Headquarters, AFRO, and Country Offices).

The meeting focused on a wide range of immunisation topics, including the overview of immunisation in Africa; the Big Catch-Up and strengthening of essential immunisation services; VPD outbreaks; meningitis; polio eradication and transition; integration of COVID-19 vaccination into primary health care; malaria vaccines; and human papillomavirus (HPV) vaccination. The RITAG meeting generated strategic technical advice and recommendations for WHO/AFRO from the topics presented below.

SUMMARY OF RITAG RECOMMENDATIONS

RITAG recommends that:

SESSION 1: OVERVIEW OF IMMUNISATION IN AFRICA

◀ Re-activation of commitments in the Addis Declaration on Immunisation

- 1.1 WHO/AFRO and partners should conduct annual monitoring of Member States' progress on the 10 commitments made in the Addis Declaration on Immunisation (ADI)¹ and hold Member States accountable through the presentation of a scorecard during high-level engagements such as meetings of Heads of State and Ministers of Health.

SESSION 2: IMMUNISATION RECOVERY AND RESTORATION POST COVID-19 PANDEMIC

◀ Ensuring vaccine availability for catch-up

- 2.1 WHO/AFRO should advocate for Gavi, the Vaccine Alliance, to waive the co-financing requirement for procurement of vaccines needed for catching up the estimated 28 million unimmunised children in the African region since 2019. WHO/AFRO will proactively advocate with Health Ministers and Heads of state to Gavi, the Vaccine Alliance, for a co-financing waiver for catch-up vaccine doses so that Member States are better prepared to address the pandemic's impact on their health systems by accessing needed vaccines for Big Catch-Up with little to no financial strain given the urgency to close the immunity gaps in the zero-dose communities.

◀ Expansion of age range for the big catch-up to all children under five years

- 2.2 Countries should revise policies to expand age ranges for the big catch-up to reach all children under 5 years of age. Moreover, countries should ensure that comprehensive, flexible catch-up policies and strategies are implemented in the event of other future disruptions to routine immunisation, to prevent VPD outbreaks due to the cumulative effect of low population immunity among missed children or older individuals.

◀ Catch-up is a critical and ongoing part of immunisation programmes

- 2.3 Countries should include catch-up vaccination into costed national immunisation strategic plans (NIS), including vaccine forecasting for missed children. Catch-up should be implemented as a routine supervised norm to prevent accumulation of immunity gaps and consequential VPD outbreaks rather than as a stand-alone, time-limited activity.

◀ Leveraging technologies for operationalisation, monitoring and evaluation of catch-up activities

- 2.4 Countries should identify innovative holistic approaches for mapping out and responding to zero-dose populations. This should include the integration of immunisation services into the school health systems or the tracking of home-based hard-to-reach children with the traditional health facilities and community service delivery mode for vaccination.

◀ Involvement of community health workers to improve the denominators

- 2.5 Countries should leverage catch-up activities to improve population denominator and numerator estimates while evaluating progress through post-campaign monitoring activities. This should incorporate an assessment of behavioural and social drivers of vaccine uptake to inform the implementation of context-specific interventions intended to increase and maintain vaccine uptake.

SESSION 3A: VPD OUTBREAKS IN THE WHO AFRICAN REGION

◀ Documentation of lessons learned from Ebola outbreaks and COVID-19 pandemic and translation into actions for VPD outbreaks

- 3.1 WHO/AFRO should document lessons learned and good practices from Ebola and COVID-19 responses to build local evidence base to, inform future policies, and translate into action for effective responses to VPD outbreaks.

¹ Addis Declaration on Immunisation 10 commitments: <https://www.afro.who.int/sites/default/files/2017-12/ADI%20Commitments%20Brochure.pdf>

◀ Improving early detection, timeliness, and quality of responses

3.2 Countries should establish an integrated community and laboratory-based VPD surveillance system, including environmental surveillance, for early disease detection while ensuring readiness for timely response by arranging for a no-regrets funding and where appropriate prepositioning vaccine stocks at national level, dedicated to outbreak response.

◀ Preparedness and prevention in the inter-outbreak period

3.3 Countries should implement and regularly update risk assessments, enhanced by innovative modelling, for individual VPDs, zero-dose, emergency, conflict, and public health risks, ideally at subnational levels. These should be routinely shared in real-time with other public health and emergency structures at national and regional levels and used for preventive action.

◀ Efficient coordination and accountability across partners

3.4 Countries and global, regional, and national partners are strongly urged to share information and resources across programmes to improve the efficiency of coordinating VPD preparedness, detection, outbreak response, and recovery. This collective approach is pivotal in fortifying defences against complex and dynamic health threats.

SESSION 3B: POLIO ERADICATION AND TRANSITION IN AFRICA

◀ Renewal of the highest level of political commitment of Member States for polio eradication

3B.1 Countries should maintain their commitment to ensuring implementation of effective quality responses in tackling circulating vaccine-derived poliovirus (cVDPV) outbreaks like that conducted to eradicate indigenous wild poliovirus (WPV) in the region.

◀ Inclusion of bOPV in all non-polio SIAs and the Big Catch-Up activities

3B.2 Countries should integrate bivalent oral polio vaccine (bOPV) preventive campaigns with other catch-up vaccination activities and preventative supplementary immunisation activities (SIAs).

◀ Support for planned preventive campaigns for cVDPV1

3B.3 The Global Polio Eradication Initiative (GPEI) should continue its current level of activity to address the ongoing circulation of cVDPV1 and cVDPV2, and only consider sunseting these eradication activities when the current threats posed by cVDPV1 and cVDPV2 are diminished. A premature sunset could reverse the gains made in the polio eradication initiative.

◀ Acceleration of the introduction of the second dose of the inactivated poliovirus vaccine

3B.4 Countries should accelerate the introduction of second dose of the inactivated poliovirus vaccine (IPV2) and aim for highest levels of coverage, to strengthen population immunity and reduce the risk of cVDPVs.

SESSION 4: MALARIA VACCINES

◀ Malaria vaccination as part of national malaria control programmes

4.1 Eligible countries should introduce and roll out malaria vaccination, prioritising areas of moderate and high malaria transmission. Malaria vaccine introduction should be considered as part of comprehensive national malaria control plans.

◀ Leveraging opportunities for integration in the second year of life

4.2 Countries should align the scheduling of the 4th dose of the malaria vaccine with other vaccines given in the second year of life, and should leverage on other important opportunities for integration.

◀ Community engagement for continued roll-out of malaria vaccines

4.3 WHO/AFRO and partners should support countries in developing strong communication, stakeholder, and community engagement plans and strategies to support the introduction and roll-out of the malaria vaccine (e.g. management of hesitancy, rationale of subnational introduction, and the need to sustain broader malaria control), drawing on the lessons learned in the malaria vaccine implementation programme (MVIP).

◀ **Financing malaria vaccine roll-out.**

4.4 Funding organisations should increase funding to WHO at all levels (Headquarters, AFRO, and Country Offices) to support the introduction and roll-out of the malaria vaccines in eligible countries.

SESSION 5: HPV VACCINATION IN THE CONTEXT OF CERVICAL CANCER ELIMINATION

◀ **Single-dose scheduling of HPV vaccination per SAGE recommendations**

5.1 Countries of the WHO African Region should adopt the single-dose schedule for human papilloma-virus (HPV) vaccination recommended by the Strategic Advisory Group of Experts on Immunisation (SAGE). This will achieve higher coverage, reduce dropouts, and reduce logistics and operational costs of vaccine delivery. In line with this, countries should ensure that all girls between the ages of 9 and 14 years receive one dose of the HPV vaccine.

◀ **Extended age and gender-neutral vaccination**

5.1 Where feasible, countries should conduct catch-up vaccination for multi-age cohorts (MAC) of girls aged 9 up to 20 years with a single dose, to increase direct and herd immunity protection. Depending on the local context, countries may consider offering single dose HPV vaccination to boys and older women.

◀ **HPV vaccination schedule for Immunocompromised persons**

5.2 As per SAGE recommendations, individuals known to be immunocompromised or HIV-infected (regardless of age or antiretroviral therapy status) should receive at least two HPV vaccine doses (minimum 6 months interval) and, where possible, three doses.

◀ **Advocacy and communication including at the community level**

5.3 Countries should strengthen advocacy and communication strategies to enhance the uptake of the HPV vaccine and ensure widespread community understanding of its importance in preventing cervical cancer and other HPV related cancers.

◀ **Peer to peer learning on HPV vaccination service delivery**

5.4 Countries should document and share learnings on the optimal integrated service delivery strategies for girls in and out of school, such as health facilities, schools, and community platforms for adolescent health including immunisation.

SESSION 6: DEFEATING MENINGITIS BY 2030 IN THE WHO AFRICAN REGION

◀ **Continued roll-out of Meningitis A conjugate vaccines**

6.1 WHO should encourage and support the nine remaining countries (Burundi, Cameroon, Democratic Republic of Congo [DRC], Ethiopia, Kenya, Mauritania, Uganda, Senegal, and South Sudan) to introduce Meningitis A conjugate vaccine (MenACV) into routine immunisation as soon as possible, due to the risk of resurgence of Meningitis A, as per SAGE recommendations.

◀ **Streamlining new vaccine introduction**

6.2 WHO/AFRO and partners should support countries to proactively plan for integrated new vaccine introductions, where feasible, using wide-age range SIAs and to consider opportunities for coordinated introductions of MenACV or multivalent meningococcal conjugate vaccine (MMCV) and rubella containing vaccines.

SESSION 7: COVID-19 VACCINE INTEGRATION

◀ **Simplified single-dose approach**

7.1 RITAG endorses the SAGE recommendation for a simplified single-dose regime for primary immunisation for most COVID-19 vaccines, which would improve acceptance and uptake and provide adequate protection at a time when most people have had at least one vaccine dose or prior infection.

◀ Use of XBB monovalent vaccines

7.2 RITAG endorses the SAGE recommendation on the use of monovalent XBB vaccines. However, when these are not available, any available WHO Emergency Use Listing (EUL) or prequalified bivalent variant-containing or monovalent index virus vaccines may be used as these provide benefits against severe disease in high-risk groups.

◀ Prioritising high-risk groups for vaccination

7.3 Countries should adopt a targeted approach to COVID-19 vaccination, which involves prioritising risk groups as identified in the latest SAGE roadmap. Countries can effectively protect the most vulnerable populations by aligning vaccination strategies with the latest guidelines.

◀ Prioritising COVID-19 vaccination amid other pressing public health challenges

7.4 Countries should assess their priorities in overall health spending, including immunisation spending, and consider whether COVID-19 vaccination should be continued based on competing country needs.

◀ Authorisation of COVID-19 vaccine use now that the PHEIC has been lifted

7.5 WHO should establish the status of continued use of COVID-19 vaccines that were licensed under the EUL, now that the Public Health Emergency of International Concern (PHEIC) status has been lifted and provide guidance to national regulatory authorities (NRAs) and immunisation programmes on how to proceed with the NRA licensing processes of the vaccines.

CROSS-CUTTING RECOMMENDATIONS

◀ Vaccine research and development

8.1 Governments and donors should proactively increase investments in African-led research and development, given the region's high burden of infectious diseases. This includes basic, applied, and clinical research supporting the development and introduction of vaccines and assessing their impact on public health.

◀ Vaccine approval and regulatory frameworks in countries

8.2 NRAs should ensure that vaccines prequalified by WHO are registered in the countries where they are being used, leveraging on continental capacities through the African Vaccine Regulatory Forum (AVAREF) and the African Medicines Agency (AMA).

8.3 WHO should support preparations for vaccine manufacturing in the region and continue strengthening regulatory and ethics capacity.

8.4 WHO should work on enhancing regulatory preparedness for future emergencies using experience from the Ebola and COVID-19 vaccines.

◀ Financing for immunisation and disease surveillance

8.5 WHO/AFRO and partners should establish a cross-programme, cross-country, and cross-regional collaboration that can help support sample collection, transport, laboratory analyses, and capacity building for genomic surveillance of VPDs, HIV, coronaviruses, and other infectious agents.

8.6 WHO/AFRO should advocate with Member States to prioritize investments and the protection of budgets for immunisation and surveillance, in line with the governments' commitment to the ADI to increase and sustain domestic investments and funding allocations

8.7 WHO/AFRO should review the existing funding windows to facilitate coordinated applications with particular attention paid to new initiatives such as the Pandemic Fund, which is poised to offer financing for strengthening disease surveillance systems and laboratory capacity, and honing staff expertise in public health emergency preparedness and coordination.




BACKGROUND



The African Regional Immunisation Technical Advisory Group (RITAG) serves as the principal advisory group to the World Health Organization (WHO) Regional Office for Africa (WHO/AFRO), providing strategic guidance on regional immunisation policies and programmes. The RITAG convenes biannually to deliberate on relevant issues relating to vaccines and immunisation. The RITAG members provide key recommendations to WHO/AFRO, partners, and countries to address issues identified from the presentations and discussions.

The RITAG meeting held from 7 to 9 November 2023 at WHO/AFRO in Brazzaville, Congo, was chaired by Professor Helen Rees, the RITAG Chair. The meeting was attended by close to 160 participants from 24 countries including RITAG members and representatives from selected Ministries of Health (MoH), National Immunisation Technical Advisory Groups (NITAGs), WHO, UNICEF, Gavi, the Vaccine Alliance, and a wide range of immunisation partners and civil society organizations. NITAG members and EPI managers who attended this RITAG meeting came from Benin, Cameroon, Ethiopia, Kenya, Liberia, and Madagascar. MoH participants came from Angola, Burkina Faso, Cameroon, Chad, Central African Republic, Congo, Ethiopia, Guinea, Guinea Bissau, Madagascar, Mali, Malawi, Senegal, and South Sudan. The meeting presented an opportunity for the newly appointed RITAG members to meet WHO/AFRO Senior Management and other immunisation stakeholders.



The RITAG members were apprised on the WHO/AFRO's strategic priorities for immunisation and key areas to provide strategic guidance and recommendations towards achieving regional targets for immunisation as outlined in the Immunisation Agenda 2030 (IA2030) and the draft Regional Strategic Plan for Immunisation (RSPI). Other broad topics discussed included the “Big Catch-Up” (the strategy to catch-up children missed during the pandemic and restore and strengthen immunisation programmes), vaccine-preventable disease (VPD) outbreaks, meningitis vaccines, polio eradication and transition, coronavirus disease (COVID-19) vaccines, malaria vaccines, and human papillomavirus (HPV) vaccination. This report summarises the proceedings of the three-day meeting and key recommendations made by the RITAG per thematic area.

OPENING CEREMONY

Dr Matshidiso Moeti, WHO Regional Director for Africa, welcomed RITAG members and meeting participants through a video message, and acknowledged the critical role of the RITAG in providing strategic guidance and policy direction for immunisation activities in the WHO African Region. In reference to some of the lessons learned from the COVID-19 pandemic, Dr Moeti emphasized the pivotal role of integration of disease interventions to tackle the high disease burden in the region efficiently. “It is on this basis that, I set up a dedicated Communicable and Non-communicable Diseases cluster at the Regional Office, that includes the Vaccine-Preventable Diseases programme,” said Dr Moeti.

The meeting was officially opened by Dr Joseph Cabore, Director of Programme Management who further emphasized the critical role of the RITAG in the WHO African Region. Before formally declaring the meeting open, Dr Cabore pointed out that the COVID-19 pandemic has negatively affected health services, particularly immunisation. Due to service disruptions caused by the pandemic, millions of children in our region missed all or some of the vaccines in the immunisation schedule. Catching up with these missing children has become one of the biggest challenges in public health programmes. He urged the RITAG members to utilize the three days of the meeting to deliberate and provide guidance on how WHO/AFRO and partners can better support governments in their efforts to restore immunisation and catch up the unimmunised and under-immunised children.

Professor Helen Rees, Chair of the RITAG, welcomed participants in her introductory remarks to the biannual meeting. She appreciated the immense efforts of the African region to recover the gains lost over the past three years due to the pandemic. She acknowledged the new RITAG members and recognized the members' breadth and diversity of expertise in their various areas of work throughout the region. Prof Rees emphasised the need for meaningful interactions between the Strategic Advisory Group of Experts on Immunisation (SAGE), RITAG, and NITAGs in the context of regional perspectives, needs and priorities while taking advantage of the presence of invited countries to share lived experiences on the ground.

SUMMARY OF TECHNICAL SESSIONS

SESSION 1: Setting the Scene

RITAG Focal Point: Dr Deo Nshimirimana

A. Overview of Immunisation in Africa

Dr. Benido Impouma, Director, Communicable and Non-Communicable Diseases Cluster, WHO/AFRO

The presentation highlighted the global and regional contexts of immunisation, status of routine immunisation, VPD surveillance, and new vaccine introductions. The vaccination coverage for key antigens in the African region remains below the regional targets and the 2019 pre-COVID-19 pandemic performance in most countries. The 2022 WHO/UNICEF Estimates of National Immunisation Coverage (WUENIC) data show that the region had nearly 28 million un-vaccinated children from 2019 to 2022, representing 19% of surviving infants from the four cohorts. Below is a summary of key points from the presentation (Figure 1)

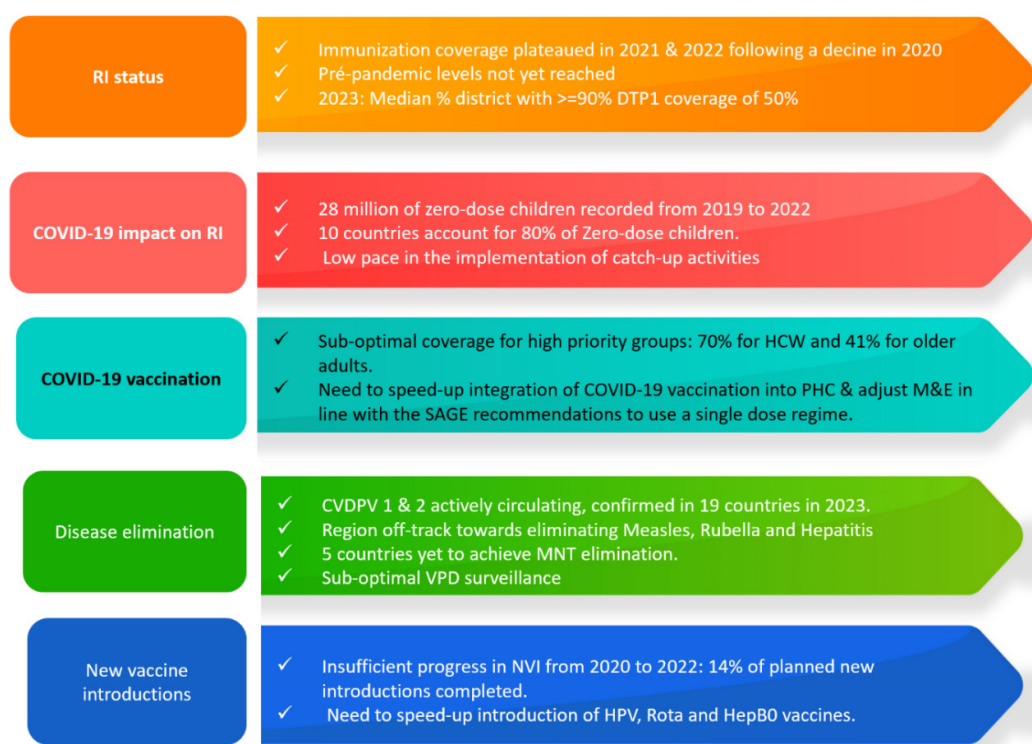


Figure 1: Key points from the presentation on the overview of immunisation in Africa

RITAG noted with concern that one of the biggest challenges facing routine vaccination efforts on the continent is the lack of adequate funding to operationalise well-known innovative strategies to reach all vaccination-eligible populations. Additionally, despite significant advancements in vaccination across many African nations, including lessons learned from the COVID-19 pandemic, progress has stalled, as health system challenges continue. The noteworthy accomplishments of vaccine science are supported by political commitment from Heads of State in the region through their endorsement of the Addis Declaration on Immunisation (ADI) in 2017. African Heads of State and Government pledged to promote universal access to immunisation through their commitment to providing fair and universal access to vaccinations.

The presentation ended with five expectations from RITAG. The first expectation was that RITAG would provide recommendations on key actions that could help to restore immunisation services negatively affected three years into the COVID-19 pandemic. The second was guidance on overcoming challenges in implementing the Big Catch-Up to reduce the burden of zero-dose children. The third is related to guidance on concrete measures to strengthen disease surveillance. The fourth expectation was guidance on how to put countries on track toward elimination of measles, rubella, and hepatitis B; and the fifth was guidance on the identification of barriers to new vaccine introductions and how to speed-up new vaccine introductions.

RITAG applauded WHO/AFRO's approach, particularly through the Regional Strategic Plan for Immunisation (RSPi), the Business Case for WHO Immunisation Activities on the African Continent 2018-2030, and a comprehensive approach to immunisation over the life-course. They also noted the ongoing efforts in the region to ensure coordination and communication with other immunisation stakeholders.

B. Progress on Gavi 5.1 Strategy, Gavi Must Wins, and Gavi 6.0 Development

Dr Stephen Sosler, Head, Vaccine Programmes, Gavi

This presentation emphasised that Gavi, the Vaccine Alliance, is accelerating its 5.1 strategy, focusing on the key programmatic areas ("must wins"). These include catch-up of zero-dose children, human papillomavirus (HPV) vaccine revitalisation, malaria vaccine launch, and COVID-19 vaccine integration. Following two years of pandemic-related increase in zero-dose children, there is now progress as 2022 saw a 17% reduction in zero-dose children across the 57 Gavi-supported countries globally, compared to 2021. There is high demand and political will for the introduction of the malaria vaccines with 12 approved applications from 18 countries that have applied. The RTS,S/AS01 malaria vaccine roll-out is underway with allocations for countries completed and technical assistance to countries being finalised. Planning for R21 /Matrix-M entry is also underway following the September 2023 SAGE recommendation, with specific country conversations started. So far, there has been good partner coordination across global, regional, and national levels, including leadership engagement. For HPV vaccination, it was noted that 16.3 million girls globally had been fully immunised by the end of 2022, a very good indication that the programme is on course to

reach the 86 million girls' target by 2025. As of November 2023, Gavi had successfully supported 37 national HPV vaccine introductions globally. Lastly, the presenter announced the closing of the COVID-19 Vaccines Global Access (COVAX) facility and its transition to the Gavi-supported C-19 programme in 2024. As of November 2023, 1.97 billion doses have been delivered to populations in 146 countries. This translated into coverage of at least 56% of the complete primary series globally for COVID-19 vaccination.

Gavi support and funding available to countries in the WHO African Region includes vaccine support, health system support, equity accelerator funding, cold chain equipment optimisation platform, partner engagement framework - targeted country assistance, COVID delivery support, innovation top-up, and middle-income country support.

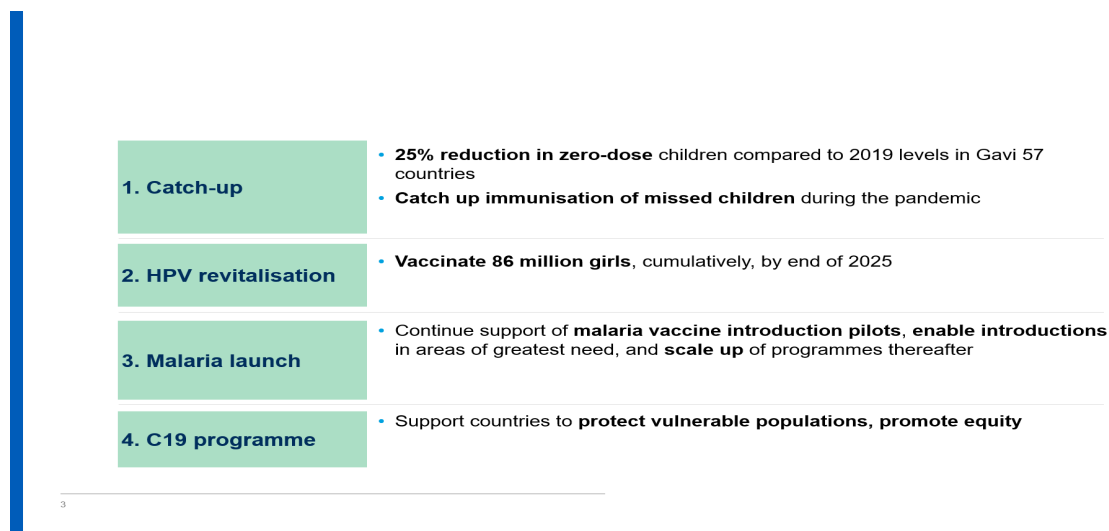


Figure 2: The four “must wins” of the Gavi 5.1 strategy

C. SAGE Update

Dr Joachim Hombach, Executive Secretary SAGE, WHO Immunisation, Vaccines & Biologicals Department

The presenter highlighted some of the key SAGE recommendations from the September 2023 SAGE meeting, particularly highlighting recommendations on COVID-19, poliomyelitis, dengue, smallpox, malaria, meningitis, and mumps vaccination. He also shared key highlights from the WHO department of Immunisation, Vaccines and Biologicals presentation at the SAGE meeting, such as the impact of climate change which has increased the spread of VPDs and contributed to the disruption of immunisation programmes. He also presented on the significant progress made with COVID-19 vaccination and the rich pipeline of new vaccines that need to be prioritised for introduction.

Key recommendations from the September 2023 SAGE meeting include: (i) emphasis on efforts to improve routine immunisation coverage and interval between vaccination rounds to prevent polio outbreaks; (ii) introduction of new dengue vaccine in settings with high dengue disease burden and high transmission intensity to maximise the public health impact and minimise any potential risks in seronegative persons; (iii) low and middle income countries (LMICs) should assess cost, supply and programmatic implications when considering the introduction of mumps-containing vaccines and should provide it in combination with measles and rubella as MMR vaccine while maintaining high coverage; (iv) reinforcement of the 2017 SAGE recommendation that all relevant target groups be included in oral cholera vaccine campaigns, including pregnant women, and that a one dose schedule be considered for vaccination; (v) simplified single-dose regime for initial vaccination for most COVID-19 vaccines and updated roadmap for COVID-19 vaccination with further simplification of recommendations for the different risk groups; (vi) use of either the R21/Matrix-M or RTS,S/AS01 vaccine in children living in malaria-endemic areas and vaccine introduction be done in the context of comprehensive malaria control efforts; and (vii) that all countries in the African Meningitis Belt should introduce the novel pentavalent meningococcal conjugate vaccine targeting serogroups A, C, Y, W and X (Men5CV) into their routine immunisation programmes in a single-dose. The timeline for publication of these recommendations is shown in Figure 3.

Recommendation item	Type of publication	Expected date
COVID-19 vaccination	➤ Updated WHO SAGE roadmap for prioritising uses of COVID-19 vaccines	02 Nov 2023
	➤ Updated good practice statement on the use of variant-containing COVID-19 vaccines	10 Nov 2023
Poliomyelitis vaccination	➤ SAGE meeting report	24 November 2023
Mumps vaccination	➤ Updated vaccine position paper	09 February 2024
Dengue vaccination	➤ Updated vaccine position paper	03 May 2024
Smallpox vaccination	➤ New position paper on orthopox vaccination, covering smallpox and Mpox vaccination	23 August 2024
Malaria vaccination	➤ Implementation guidance	13 Dec 2024
	➤ Updated malaria guidelines	
	➤ Updated vaccine position paper	
Meningococcal vaccination	➤ Addendum to Vaccine position paper for the African meningitis belt	05 Jan 2025
	➤ Full update of position paper	18 April 2025

Figure 3: Publication of SAGE policy recommendations from the September 2023 meeting

Session 1 Recommendations

Re-activation of commitments in the Addis Declaration on Immunisation

RITAG recommends that WHO/AFRO and partners conduct annual monitoring of Member States' progress on the ten commitments made in the ADI and hold the Member States accountable through the presentation of a scorecard during high-level engagements such as Heads of State and Government and Ministers of Health meetings.

- Deliverable: The submission of an annual report on Member States' progress with achieving targets set in the ADI and IA2030
- Main Responsibility: WHO/AFRO, WHO/EMRO, and the African Union Commission.

SESSION 2: Strengthening Immunisation Services Post-COVID-19 Pandemic

RITAG Focal Points: Dr Pratima Raghunathan, Dr Edward Nicol, Dr Ijeoma Edoa

A. Update on the Big Catch-Up in the African Region

Dr Ado Bwaka, Team Lead for Vaccine-Preventable Diseases, WHO Inter-country Support Team, West Africa

The presentation highlighted the significant regression in immunisation programme performance caused by COVID-19 pandemic disruptions, leading to increased zero-dose and under-immunised children. This has further exposed communities to VPD outbreaks with increased strain on the health system. The 2022 WUENIC data show that 11 African countries are among the top 20 countries with the highest number of zero-dose children globally. Drivers for zero-dose children were discussed and included: (i) lack of access to immunisation services, (ii) cumulative disadvantages due to existing social, political, economic, and health systems factors, (iii) geographical contexts such as living in remote rural areas, informal and peri-urban settlements, and conflict settings, and (iv) gender barriers such as mothers' access to education, decision-making for health care in the household, gender-based violence, early adolescent marriages, and teenage pregnancies.

To reduce the zero-dose burden in the region, WHO/AFRO has prioritised 14 countries for targeted support for the implementation of the Big Catch-Up (Figure 4). These countries are at varied levels of planning and implementation and face the challenges of availability of vaccines, financing/co-financing for additional vaccines and operational costs, and the challenge of vaccination policy change to catch up children up to five years of age. During this session, a participant from the DRC and another from South Africa shared their experiences on implementing Big Catch-Up in their respective countries. The two participants pointed out the need to integrate catch-up activities into routine planning of national immunisation programmes. This would involve ensuring the availability of adequate vaccines and sufficient funds to conduct planned catch-up activities.

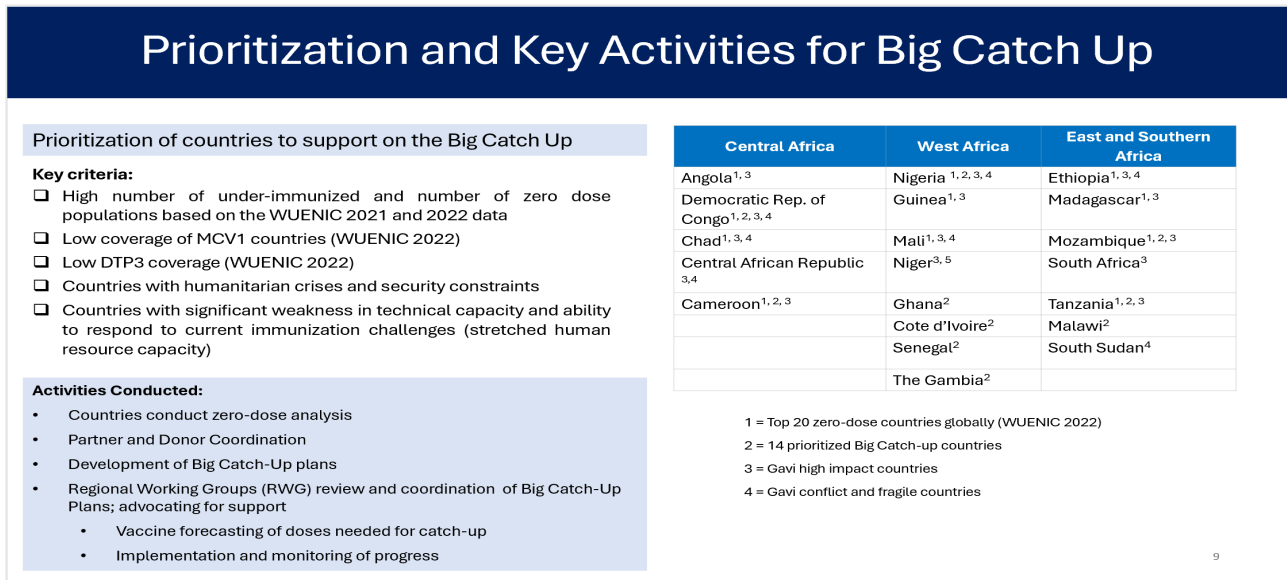


Figure 4: Prioritisation of countries for Big Catch-Up

RITAG members emphasised the importance of reaching and vaccinating the missed children. They acknowledged efforts by WHO, UNICEF, Gavi, and other partners through the Big Catch-Up initiative to catch missed children, restore immunisation vaccination coverage to at least 2019 levels, and strengthen the primary healthcare system. RITAG also acknowledged that the Big Catch-Up is an essential initiative to recover gains lost due to the pandemic and other disruptions. One key question from the RITAG was whether zero-dose communities are a good marker of what is happening in countries or a symptom of a bigger health system problem.

B. Demand Generation Strategies to Reach Zero-Dose Communities

Ms Francine Ganter-Restrepo, UNICEF Eastern and Southern African Region

The speaker presented findings from an ongoing study led by UNICEF and Ministries of Health in Angola, Ethiopia, Madagascar, Malawi, and Tanzania. The data collected expands upon the SAGE-endorsed Behavioural and Social Drivers of vaccination (BeSD) framework, with key adaptations for the African region to better measure the experience and cost of services. This study shows that the key issues driving routine immunisation uptake are trust in healthcare workers, quality of healthcare services, social norms, cost, and related access-related barriers. This work underscores the importance of going beyond communication and demand generation towards a systems' thinking approach to strengthen routine immunisation and primary health care. Governments and immunisation partners should invest in social norms programming to address the gap between individual intention and perceived norms. These efforts need to be directed to equipping and supporting service providers to deliver quality immunisation services and rebuild trust; and to tailor immunisation services to address cost and other access-related barriers.

Discussion centred around the importance of social and behavioural data, including the perspectives of both communities and healthcare workers, given the increasing burden placed on them by a growing Expanded Programme on Immunisation (EPI) schedule. Furthermore, community health workers (CHWs) were discussed as key to building back trust in health systems and leveraged for identifying zero-dose children, validating birth cohorts, and possibly even administering vaccination if they receive appropriate training and country policies allow such level of task shifting. RITAG members endorsed using social and behavioural data to include community perspectives in immunisation programming systematically. Furthermore, the regional adaptations suggested was appreciated with a suggestion that future work distinguishes between public and private care.

C. Reaching Zero-Dose Children in Conflict-Affecting Settings

Dr Sheetal Sharma, Immunisation Specialist, International Rescue Committee

The presenter discussed the strategic priorities of the International Rescue Committee (IRC) as a humanitarian agency with one of its key pillars being strengthening immunisation delivery and integration. The IRC has been working with national ministries of health, local partners, and key stakeholders to identify, reach, and vaccinate zero-dose children through a Gavi-funded project. Through this project, IRC has been implementing catch-up activities in 156 districts with missed communities in fragile, conflict, and cross-border settings in Ethiopia, Somalia, South Sudan, and Sudan. The presentation summarised how the project utilises innovative ethnographic approaches and human-centred design to understand norms, preferences, and barriers; designing and prototyping solutions, among the zero-dose communities. Insights generated from these are useful prototypes for community engagement strategies while building the capacity of health workers. Key to its success in reaching communities affected by conflict is IRC's ability to negotiate access through a phased delivery approach. Through their client-centred approach, IRC brings immunisation and other primary healthcare services to locations that are cut off from the government health system.

Session 2 Recommendations

Ensuring vaccine availability for catch-up

RITAG recommends that Gavi should waive the co-financing requirement for procurement of vaccines needed to catch up with the estimated 28 million unimmunised children in the WHO African Region since 2019.

- Deliverable: A Gavi Board Decision waiving co-financing of vaccines for catch-up activities.
- Main Responsibility: Gavi Secretariat, WHO, UNICEF.

Expansion of age range policies for the Big Catch-Up

RITAG recommends that countries expand the age range for vaccination for the Big Catch-Up to all children under five years of age, and ensure comprehensive catch-up strategies are implemented in the event of future disruptions to routine immunisation to prevent VPD outbreaks.

- Deliverable: Number and percentage of countries with catch-up vaccination policies and schedules expanded to all children up to five years of age.
- Main Responsibility: National EPI Programmes, NITAGs, WHO/AFRO, and partners.

Ensuring catch-up is a critical and ongoing part of immunisation programmes.

RITAG recommends that countries include catch-up vaccination into costed national immunisation strategic plans (NIS), and in vaccine forecasting. Catch-up should not be seen as a stand-alone time-limited activity but should be routinely conducted and supervised to prevent immunity gaps and VPD outbreaks.

- Deliverable: NIS and vaccine forecasting include catch-up targets and activities such as periodic intensification of routine immunisation (PIRI) activities and enhanced outreach that screens children for eligibility and records doses.
- Main Responsibility: National EPI Programmes, WHO-, and partners

Leveraging existing technologies for the operationalisation, monitoring and evaluation of catch-up activities

RITAG recommends that countries identify innovative and holistic approaches of mapping out zero-dose populations such as the use of multiple data sources and artificial intelligence to identify the unimmunised and under-immunised children. This should include integrating immunisation services into the school systems and tracking home-based vaccination for children who are difficult to reach through traditional health facilities and community service delivery.

- Deliverable: A report on optimised systems for identifying, reaching, and monitoring unimmunised and under-immunised children and communities.
- Main Responsibility: National EPI Programmes, WHO/AFRO, and partners.

Involvement of community health workers to improve the denominators for immunisation

RITAG recommends leveraging catch-up activities to improve denominator estimations while evaluating progress through post-campaign monitoring activities. This should incorporate an assessment of behavioural and social drivers of vaccine uptake to inform the implementation of context-specific interventions to increase and maintain high vaccination coverage

- Deliverable: Updated catch-up micro-plans and post-campaign monitoring reports from the Big Catch-Up countries
- Main Responsibility: National EPI Programmes, WHO/AFRO, and partners.

SESSION 3A: VPD Outbreaks in the WHO African Region

RITAG Focal Points: Dr Pratima Raghunathan and Prof Omar Sultan

Dr Reena Doshi, Emergencies Immunisation Officer, WHO/AFRO

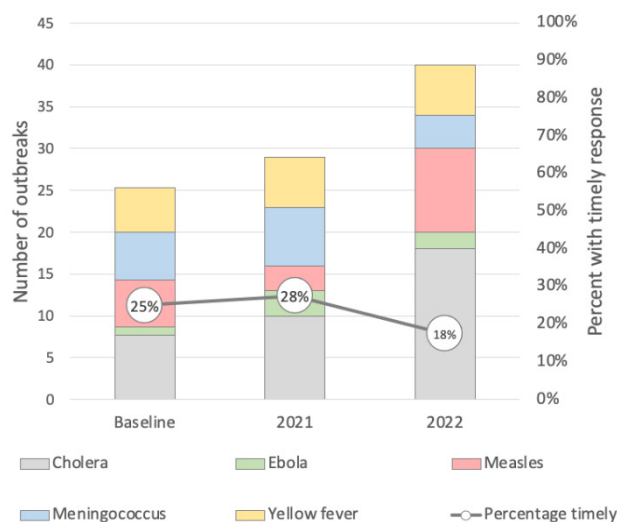
The presenter highlighted that VPD outbreaks are a potential public health crisis with a significant economic burden on many African countries. Immunisation services are critical for controlling the spread of outbreaks of VPDs, which account for an estimated 95% of the outbreaks in the WHO African Region. VPD outbreaks have significant health impacts, whether in a community, region, or a global level. Regional outbreaks of cholera, measles, yellow fever, Ebola, diphtheria, other VPDs continue to

strain even the most resilient health systems. In line with IA2030 Strategic Priority 5 (Outbreaks and Emergencies), the presenter highlighted the need for immunisation programmes to (1) anticipate, prepare for, detect, and rapidly respond to VPD outbreaks, and (2) ensure immunisation service delivery during conflict, disaster, humanitarian crises, and other emergencies.

RITAG noted with concern the upward trend in the number of VPD outbreaks and inherent challenges and risks in responding to large and disruptive VPD outbreaks in the region. Effective control of outbreaks calls for timely and high-quality outbreak responses, which can only be achieved by ensuring that vaccines and funds are available for response shortly after notification of an outbreak. This requires streamlining and simplifying administrative procedures for procuring vaccines, ensuring adequate preparation for vaccination activities while waiting for vaccine arrival, and continuous monitoring and timely and transparent sharing of information for decision-making during emergencies. The figure below summarises the timeliness of detection and response to outbreaks between 2018 and 2022 in the WHO African Region.

One of the key lessons learned from the COVID-19 pandemic was the impact of outbreaks on all countries and the importance of surveillance and preparedness for outbreaks of public health concern. Leveraging COVID-19 response lessons and best practices, WHO/AFRO is working with national immunisation programmes as well as primary healthcare systems in the Member States to reduce the number of un-immunised and under-immunised children in the region and making strategic shifts to control ongoing VPD outbreaks in the region.

Indicator SP5.1: Proportion of outbreaks with timely detection and response



Source: IA2030 scorecard and monitoring tool *Baseline is 2018-2020

Figure 5: Trends in timeliness of detection and response to VPD Outbreaks from 2018 to 2022

Session 3A Recommendations

Improving anticipation, early detection, timeliness, and quality of response to VPD outbreaks

RITAG recommends the establishment of an integrated community and laboratory-based VPD surveillance system, including environmental surveillance for early detection, improved readiness, and timely response. This includes establishing no-regrets funding and prepositioning vaccine stocks at national level dedicated for outbreak response.

- Deliverable: Number and percentage of countries with integrated community and laboratory-based VPD surveillance systems, no-regrets funds, and prepositioned vaccine stocks for outbreak response.
- Main Responsibility: National EPI Programmes, NITAGs, WHO/AFRO, and partners.

Preparedness and prevention in the inter-outbreak period

RITAG recommends that countries should integrate and automate a risk assessment that is regularly updated for individual VPD, zero-dose, emergency, conflict, and public health risks, ideally at subnational levels, and share real-time assessments for action, while leveraging on innovative modelling to predict outbreaks, for response action.

- Deliverable: Percentage of countries with a routinely updated risk assessment that is integrated for all VPDs.
- Main Responsibility: Ministries of Health, WHO/AFRO, and partners.

Efficient coordination and accountability across partners

RITAG strongly urges countries and national partners to share information and resources across programmes through the two African regional working groups to improve coordination and efficiency of VPD preparedness, detection, outbreak response, and recovery. This collective approach is pivotal in fortifying our defence against outbreaks and other health threats.

- Deliverable: Regional working group report documenting reinforced coordination mechanisms with the groups.
- Main Responsibility: WHO/AFRO and partners

Documentation of lessons learned from Ebola outbreaks and COVID-19 pandemic and translation into action for VPD outbreaks

RITAG recommends that WHO/AFRO should support countries to document lessons learned and good practices from Ebola and COVID-19 responses. These should be used to build a local evidence base and inform future policies, actions, and preparedness for effective responses to VPD outbreaks and translated into action.

- Deliverable: A report of lessons learned from various country contexts
- Main Responsibility: WHO/AFRO

SESSION 3B: Polio eradication and transition in Africa

RITAG Focal Points: Dr Deo Nshimirimana and Dr Steve Ashuka

Dr Jamal Ahmed, Polio Eradication Programme Coordinator, WHO/AFRO

The presenter started this session with a dedication to all frontline workers, including those who lost their lives saving African children from polio, those who continue to serve knowing the risk to their lives, and those who came before us and brought polio to the brink of eradication. He highlighted the success of the polio programme and the activities undertaken to control the spread of wild poliovirus type 1 (WPV1) detected in 2021 in Malawi and Mozambique. The region is on track to meet its milestone of ending WPV1 and circulating vaccine-derived poliovirus type 1 (cVDPV1) outbreaks in Southern Africa, as there has been no new case in more than 12 months. There are ongoing efforts to stop the spread of cVDPV2, with the number of affected districts continuing to decline yearly. He noted that Lake Chad basin countries and the DRC have contributed the highest number of cases and have been the source of international spread.

RITAG noted with concern that cVDPV1 is now the primary poliovirus circulating in the region. Madagascar has seen sustained transmission of cVDPV1 and is on course to implement four major rounds of supplementary immunisation activities (SIAs), including subnational rounds targeting all age groups, to end transmission altogether by the end of 2024. Current plans are inadequate to address the increased risk of cVDPV1 spread due to low population immunity. Thus, there is a need to strengthen routine immunisation systems coupled with regular preventive SIAs targeting missed cohorts.

On polio transition, the presenter noted that as the Global Polio Eradication Initiative (GPEI) progresses towards sunset, there is a need to align on who will be accountable and own polio essential functions. Ongoing transition activities are utilising the infrastructure developed by the programme to strengthen broader health under the leadership of national authorities. For instance, to date, child survival interventions leveraged the polio SIAs in 2023, with seventeen countries integrating their polio SIAs with other child survival interventions. The Post-2023 Strategic Framework will set a clear direction and align efforts to operationalise, establish roles and responsibilities, and determine accountability for polio transition. See the figure below for the key milestones of GPEI. See Figure 6 below for the key milestones of GPEI.



Figure 6: Milestones of the Global Polio Eradication Initiative

Session 3B Recommendations

Renewal of high-level political engagement of Member States for polio eradication

RITAG recommends an effective quality response in tackling cVDPV outbreaks like that conducted to eradicate WPV in the region.

- Deliverable: Report of High-level advocacy during ministerial and Heads of State fora
- Main Responsibility: WHO/AFRO, GPEI, partners, and Member States.

Inclusion of bOPV in all non-polio SIAs and the Big Catch-Up activities

RITAG recommends the integration of bivalent oral polio vaccine (bOPV) preventive campaigns with ongoing catch-up activities in the countries.

- Deliverable: Percentage of bOPV SIAs that include catch-up vaccination for other antigens.
- Main Responsibility: Member States, WHO/AFRO, GPEI, and partners.

GPEI support for planned preventive campaigns for cVDPV1

RITAG recommends that the GPEI should continue its current level of activity to address the ongoing circulation of cVDPV1 and cVDPV2, and only consider sunsetting these eradication activities when the current threats posed by cVDPV1 and 2 are diminished

- Deliverable: Continued existence of GPEI until certification of the eradication of all polioviruses.
- Main Responsibility: GPEI, WHO/AFRO, UNICEF, and partners.

Accelerated introduction of the second dose of inactivated poliovirus vaccine

RITAG recommends the accelerated introduction of the second dose of the inactivated poliovirus vaccine (IPV2) for all the countries that have yet to introduce it.

- Deliverable: Percentage of countries that have introduced IPV2.
- Main Responsibility: Member States, WHO/AFRO, GPEI, and partners.

SESSION 4: Malaria Vaccines

RITAG Focal Point: Prof Richard Adegbola

Dr Mgaywa Magafu, Malaria Vaccine Focal Point WHO/AFRO

Dr Mary J Hamel, Senior Technical Officer & Team Lead, Malaria Vaccines, WHO

The presenters highlighted the additional protection obtained from malaria vaccination over and above protection obtained from existing malaria prevention interventions. Lessons from pilot implementation in Ghana, Kenya, and Malawi show that there is high community demand and acceptance for the vaccine. By October 2023, over six million doses of the RTS,S/AS01 malaria vaccine had been administered to more than two million children in the three pilot countries. This resulted in high impact with a 13% vaccine-attributable reduction in all-cause mortality and a 22% reduction in severe malaria during the four years of the pilot programme (use of insecticide-treated bed nets, uptake of other vaccines and vitamin A, and care-seeking behaviour remained balanced in the vaccinating and comparator areas). They also presented the updated WHO recommendations on malaria vaccines, which now include RTS,S/AS01 and R21/Matrix-M, and includes a recommendation for use in areas where malaria is endemic, prioritising areas of moderate and high transmission. They emphasised that the highest impact of malaria vaccination is obtained when vaccination is used together with other malaria interventions. WHO recommends the programmatic use of malaria vaccines for the prevention of *Plasmodium falciparum* malaria in children living in malaria-endemic areas, prioritising areas of moderate and high transmission. The recommended schedule includes four doses for children from around five months of age. A fifth dose can be administered one year after dose four and may be considered in areas where there is a significant malaria risk remaining in children a year after receiving dose four. Countries should prioritise vaccination in areas of moderate and high transmission but may also consider providing the vaccine in low transmission settings. Countries may consider providing the vaccine using an age-based, seasonal, or a hybrid approach in areas with highly seasonal malaria or areas with perennial malaria transmission with seasonal peaks. RITAG discussions emphasised that vaccine introduction should be considered in the context of comprehensive national malaria control plans. With two malaria vaccines available, supply constraints will most likely be removed starting in 2024, enabling more countries to introduce and scale up more rapidly.

Session 4 Recommendations:

Malaria vaccination as part of national malaria control programmes

RITAG recommends that malaria vaccine rollout should be implemented in the context of comprehensive national malaria control plans,

- Deliverable: Percentage of countries, where Plasmodium falciparum is endemic and which have moderate-to-high transmission, that introduced malaria vaccination.
- Main Responsibility: NITAGs, National Ministries of Health.

Leveraging opportunities for integration in the second year of life

RITAG recommends that countries align the scheduling of the 4th dose of the malaria vaccine with other vaccines and leverage other important opportunities for integration in the second year of life.

- Deliverable: Percentage of countries that aligned the 4th malaria vaccine dose with other vaccines
- Main Responsibility: NITAGs, National Ministries of Health.

Community engagement for continued roll-out of malaria vaccines

RITAG recommends that countries should be supported to develop strong communication, stakeholder, and community engagement plans and strategies to support the introduction and roll out of the malaria vaccine (management of hesitancy, rationale of subnational introduction, and the need to sustain broader malaria control).

- Deliverable: Percentage of countries supported.
- Main Responsibility: WHO/AFRO and partners.

Financing malaria vaccine roll-out

RITAG urges funding organisations to increase funding to WHO at all levels (Headquarters, AFRO, and Country Offices) to support the introduction and roll-out of the malaria vaccines in eligible countries.

- Deliverable: Amount of new funding received by funding source.
- Main Responsibility: WHO/AFRO and partners.

SESSION 5: HPV Vaccination Relaunch in the Context of Cervical Cancer Elimination

RITAG Focal Points: Prof Djuidje Ngounou Marceline and Prof Siphon Dlamini

Dr Anissa Sidibe, HPV Vaccination Focal Point, WHO/AFRO

The WHO African Region records more than 120,000 cervical cancer cases each year, representing 17.4% of all global cases reported annually. The HIV epidemic amplifies Africa's cervical cancer burden. However, tools to address and eliminate cervical cancer exist. One of the three strategies

for cervical cancer elimination is human papillomavirus (HPV) vaccination and the African region has set a target to fully vaccinate at least 90% of girls with HPV vaccine before they reach 15 years of age. By December 2023, twenty-eight out of 47 WHO African countries had introduced the HPV vaccine in routine immunisation schedules. Due to supply constraints, ten of the 28 countries have yet to conduct multi-age cohort (MAC) catch-up. By October 2023, three countries vaccinated boys (Cameroon, Cabo Verde, and Mauritius) and girls. Seychelles also plans to introduce gender-neutral vaccination in 2024. Several Middle-Income Countries (MICs) are considering gender-neutral and extended MAC vaccination for girls up to 20 years.

Currently available high-certainty evidence shows that a single dose of an HPV vaccine provides a similar level of protection against initial and persistent HPV infection as a multidose regimen. Following the single-dose recommendation for HPV vaccination made by SAGE in December 2022, sixteen countries have NITAG recommendations for a single-dose schedule, four of which have started implementing the single-dose schedule. WHO/AFRO and partners are supporting countries by reviewing single-dose evidence and developing operational plans for switching to single-dose schedules. Specific challenges for HPV vaccination in the region include budgetary constraints, vaccine hesitancy, micro-planning challenges, and limited training for health workers and teachers on integrating HPV vaccination into adolescent health services.

Session 5 Recommendations

Single-dose scheduling of HPV Vaccination per SAGE recommendations

RITAG recommends that countries should adopt the single-dose schedule for HPV vaccination as recommended by SAGE.

- Deliverable: Percentage of countries that have introduced the single-dose schedule.
- Main Responsibility: Member States, WHO/AFRO, and partners.

Expanding the HPV vaccination target age range

RITAG recommends that countries should conduct catch-up vaccination for MACs of girls aged 9 to 20 years with one dose, to lead to faster and greater population protective impact. Countries, depending on their context, may also consider the relative benefits of offering HPV vaccination to boys and older women.

- Deliverable: Percentage of countries conducting MAC catch-up vaccination.
- Main Responsibility: Member States, WHO/AFRO, and partners.

Schedule for immunocompromised persons

RITAG recommends that individuals known to be immunocompromised or HIV-infected (regardless of age or antiretroviral therapy status) should receive at least two HPV vaccine doses (minimum 6 months interval) and, where possible, three doses; as per SAGE recommendations.

- Deliverable: Percentage of countries with a different schedule for people living with HIV.
- Main Responsibility: Member States, WHO/AFRO, and partners.

Advocacy and communication including at the community level

RITAG recommends that countries should strengthen advocacy and communication strategies to enhance the uptake of the HPV vaccine and ensure widespread community understanding of its importance in preventing cervical cancer.

- Deliverable: Percentage of countries with HPV vaccine advocacy and communication plans.
- Main Responsibility: Member States, WHO/AFRO, and partners.

Peer to peer learning on HPV vaccination service delivery

RITAG recommends that countries should document and share learnings on the optimal integrated service delivery strategies for girls in and out of school, such as health facilities, schools, and community platforms for adolescent health including immunisation.

- Deliverable: Percentage of countries with reports on HPV vaccine introduction and roll out, including integrated service delivery.
- Main Responsibility: Member States, WHO/AFRO, and partners.

SESSION 6: Defeating Meningitis by 2030 in the African Region

RITAG Focal Points: Prof Marceline Djuidje Ngounoue, Prof Richard Adegbola, Dr Pratima Raghunathan

Dr Andre Bita, Meningitis Focal Point, WHO/AFRO

The presentation demonstrated the dramatic impact of meningitis A conjugate vaccine (MenACV) introduction and roll out in the African Meningitis Belt, which significantly reduced meningitis cases in the region. Before 2010, *Neisseria meningitidis* A (NmA) was the leading cause of meningitis in the meningitis belt, accounting for almost 90% of epidemics. Since the introduction of MenACV, no outbreak of NmA has been reported since 2010. As of October 2023, twenty four of the twenty-six countries of the meningitis belt had conducted preventive SIAs, vaccinating over 350 million people aged 1-29 years. To date, fifteen countries have introduced the vaccine into routine immunisation (see Figure 7 below). However, nine countries in the meningitis (Burundi, Cameroon, DRC, Ethiopia, Kenya, Mauritania, Uganda, Senegal, and South Sudan) have not yet introduced the MenACV into routine immunisation. Therefore, despite considerable progress in combating meningitis over the past 20 years, including the MenACV roll-out, bacterial meningitis epidemics remain a major public health challenge in African meningitis.

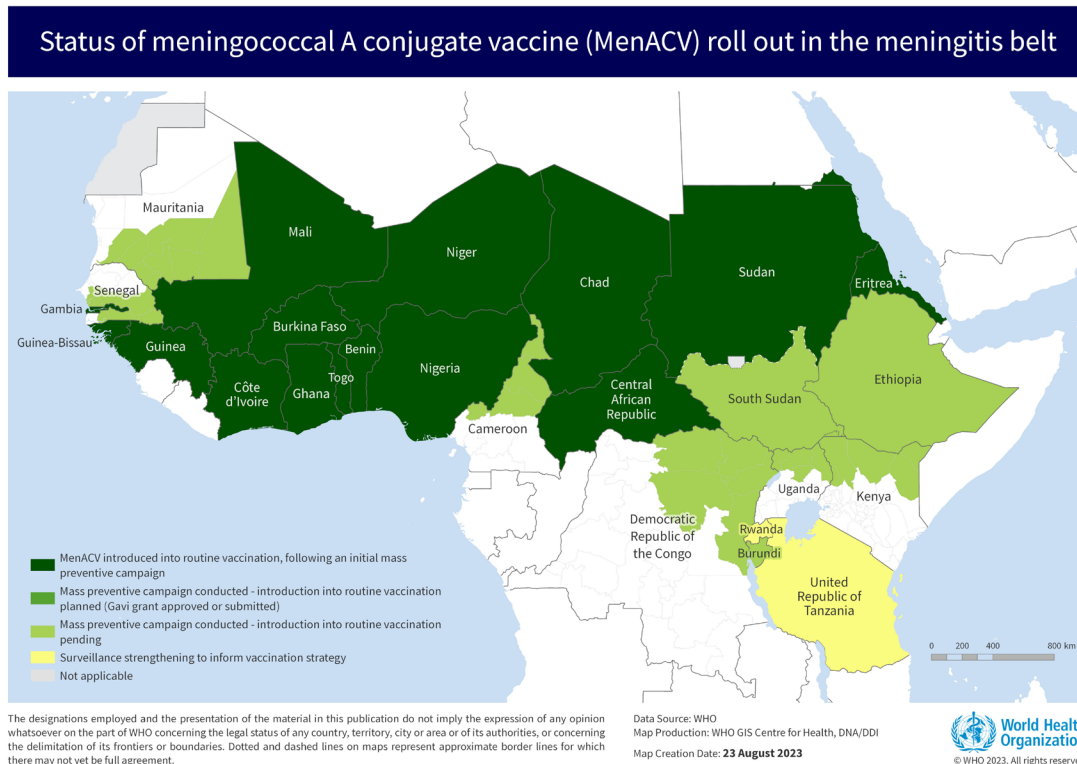


Figure 7: Meningitis A conjugate vaccine roll out in the African Meningitis Belt

The recent SAGE meeting in September 2023 noted that the new multivalent meningococcal conjugate vaccine (MMCV) offers new opportunities to eliminate meningococcal meningitis epidemics in the African meningitis belt and recommended it.

Session 6 Recommendations

Continued roll-out of meningitis A conjugate vaccines

RITAG recommends that the nine countries that have not yet introduced MenACV into routine immunisation should do so as soon as possible, due to the risk of resurgence of meningitis A, as per SAGE recommendations.

- Deliverable: Percentage of countries in the meningitis belt that have introduced MenACV.
- Main Responsibility: Member States, WHO/AFRO, and partners.

Streamlining new vaccine introduction

RITAG recommends that countries should proactively plan for integrated new vaccine introductions, where feasible, using wide-age range SIAs and to consider opportunities for coordinated introductions of MenACV or MMCV and rubella-containing vaccines.

- Deliverable: Percentage of countries with integrated introduction of new vaccines.
- Main Responsibility: Member States, WHO/AFRO, and partners.

SESSION 7: COVID-19 vaccine integration

RITAG Focal Point: Dr Djuidje Ngounoue Marceline, Dr Siphon Dlamini

Dr Reena Doshi, Emergencies Focal Point for Immunisation, WHO/AFRO

The COVID-19 situation towards the end of 2023 has changed and population-level immunity has increased significantly due to substantial and increasing vaccine use, infection-induced immunity, or the combination of both (hybrid immunity). While the SARS-CoV-2 virus continues to circulate, there have been significant reductions in rates of hospitalisation and deaths. RITAG recognises that the risk of COVID-19 is still present, and that the SARS-CoV-2 virus continues to circulate and mutate. RITAG noted that certain subgroups continue to be at greater risk of severe disease and death, accounting for much of the current COVID-19-related mortality. In addition, RITAG noted that available data suggest the monovalent Omicron XBB vaccines provide modestly enhanced protection compared to bivalent variant-containing vaccines and monovalent index virus vaccines. Finally, RITAG noted the marginal benefit associated with vaccines based on the index virus and encouraged countries to have access to the most up-to-date available formulations.

Session 7 Recommendations

Simplified single-dose approach

RITAG endorses the SAGE recommendation for a simplified single-dose regime for primary immunisation for most COVID-19 vaccines, which would improve acceptance and uptake and provide adequate protection at a time when most people have had at least one prior infection.

- Deliverable: Percentage of countries adopting the simplified single-dose regime.
- Main responsibility: Member States, WHO/AFRO, and partners

Prioritising COVID-19 vaccination amid other pressing public health challenges

➤ RITAG recommends that countries should assess their priorities in overall health spending, including immunisation spending, and consider whether COVID-19 vaccination should be continued based on competing country needs. Deliverable: Percentage of countries providing COVID-19 vaccination.

- Main responsibility: Member States, WHO/AFRO, and partners.

Prioritising substantial risk groups for vaccination

RITAG recommends that countries which chose to continue offering COVID-19 vaccines, should adopt a targeted approach to COVID-19 vaccination, which involves prioritising risk groups as identified in the latest SAGE roadmap (older adults, adults with comorbidities or severe obesity, adolescents and children with immunocompromising conditions, pregnant adults and adolescents, and health workers). Countries can effectively protect the most vulnerable populations by aligning vaccination strategies with the latest guidelines.

- Deliverable: Percentage of countries with a targeted approach to COVID-19 vaccination.
- WHO/AFRO and partners are mainly responsible for supporting Member States.

Authorisation of COVID-19 vaccine use now that the PHEIC has been lifted

RITAG recommends WHO should establish the status of continued use of COVID-19 vaccines that were licensed under the EUL, now that the Public Health Emergency of International Concern (PHEIC) status has been lifted and provide guidance to national regulatory authorities (NRAs) and immunisation programmes on how to proceed with the NRA licensing processes of the vaccines.

- Deliverable: WHO guidance.
- Main responsibility: WHO/AFRO.



CONCLUSION AND WAY FORWARD

In the closing session, NITAG representatives requested to receive RITAG reports after every meeting. In addition, NITAGs would like to receive RITAG views on WHO position papers before they (NITAGs) commence their deliberations on the policies. The RITAG chair, Professor Rees, summarised the draft recommendations and extended gratitude to RITAG members and participants for their extensive contributions. She acknowledged NITAG representatives' input, highlighting their valuable insights drawn from ongoing country deliberations on vaccine and immunisation policies.

Closing the session, Dr. Joseph Cabore, Director of Programme Management at WHO/AFRO, encouraged all participants to leverage the meeting's momentum, integrating its insights into ongoing efforts to fortify health systems and national immunisation programmes. Dr Cabore also urged partners and immunisation stakeholders present to capitalize on the momentum generated by the Addis Declaration on Immunisation and the revitalization of the WHO Regional Office, driving the immunisation agenda in Africa forward.

Looking ahead, RITAG, in collaboration with WHO/AFRO, aims to reinforce strategic priorities for immunisation and key focus areas. They aim to provide vital strategic guidance and recommendations aligning with the Immunisation Agenda 2030 and the Regional Strategic Plan for Immunisation to achieve regional and global immunisation targets.

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